EDUCATION AND HEALTH STANDING COMMITTEE

DESTINED TO FAIL:
WESTERN AUSTRALIA'S HEALTH SYSTEM

VOLUME 1- HOSPITAL SECTOR

Report No. 6
in the 38th Parliament

2010

Published by the Legislative Assembly, Parliament of Western Australia, Perth, May 2010.

Printed by the Government Printer, State Law Publisher, Western Australia.

Education and Health Standing Committee

Destined to Fail: Western Australia's Health System

Volume 1- Hospital Sector

Volume 2- Community Health Sector

ISBN: 978-1-921355-83-7

(Series: Western Australia. Parliament. Legislative Assembly. Committees. Education and Health Standing Committee. Report 6)

328.365

99-0

Copies available from: State Law Publisher
10 William Street
PERTH WA 6000

Telephone: (08) 9426 0000
Facsimile: (08) 9321 7536
Email: sales@dpc.wa.gov.au
Copies available on-line: www.parliament.wa.gov.au

EDUCATION AND HEALTH STANDING COMMITTEE

DESTINED TO FAIL:
WESTERN AUSTRALIA'S HEALTH SYSTEM

VOLUME 1- HOSPITAL SECTOR

Report No. 6

Presented by:
Dr J.M. Woollard, MLA
Laid on the Table of the Legislative Assembly
on 6 May 2010

COMMITTEE MEMBERS

Chairman	Dr J.M. Woollard, MLA Member for Alfred Cove
Deputy Chair	Ms L.L. Baker, MLA Member for Maylands
Members	Mr P.B. Watson, MLA Member for Albany
	Mr P. Abetz, MLA Member for Southern River
	Mr I.C. Blayney, MLA Member for Geraldton

COMMITTEE STAFF

Principal Research Officer	Dr David Worth, PhD, MBA
Research Officers	Ms Erin Gauntlett, BA, Dip. Ed
	Ms Renee Gould, BA, PGDipA
	Mr Timothy Hughes, BA (Hons)

COMMITTEE ADDRESS

Education and Health Standing Committee
Legislative Assembly
Parliament House
Harvest Terrace
PERTH WA 6000

Tel: (08) 9222 7494
Fax: (08) 9222 7804
Email: laehsc@parliament.wa.gov.au
Website: www.parliament.wa.gov.au

TABLE OF CONTENTS

COMMITTEE'S FUNCTIONS AND POWERS

The functions of the Committee are to review and report to the Assembly on:

(a) the outcomes and administration of the departments within the Committee's portfolio responsibilities;

(b) annual reports of government departments laid on the Table of the House;

(c) the adequacy of legislation and regulations within its jurisdiction; and

(d) any matters referred to it by the Assembly including a bill, motion, petition, vote or expenditure, other financial matter, report or paper.

At the commencement of each Parliament and as often thereafter as the Speaker considers necessary, the Speaker will determine and table a schedule showing the portfolio responsibilities for each committee. The annual report of government departments and authorities tabled in the Assembly will stand referred to the relevant committee for any inquiry the committee may make.

Whenever a committee receives or determines for itself fresh or amended terms of reference, the committee will forward them to each standing and select committee of the Assembly and Joint Committee of the Assembly and Council. The Speaker will announce them to the Assembly at the next opportunity and arrange for them to be placed on the notice boards of the Assembly.

INQUIRY TERMS OF REFERENCE

The EHSC review Western Australia's current and future hospital and community health care services to determine whether population needs are taken into account in assessing, planning, implementing and evaluating those services with particular reference to -

(a) monitoring the compliance with and any departure from the Reid Report and the 2005-15 health clinical services framework;

(b) identifying any outstanding needs and gaps in health care services; and

(c) considering the ramifications of the Royal Perth Hospital Protection Bill 2008.

The Committee will report to the House by 6 May 2010.

CHAIRMAN'S FOREWORD

I am pleased to table the sixth Report from the Education and Health Standing Committee to this Parliament. The report is titled *Destined to Fail: Western Australia's Health System*. The report makes some major recommendations to help improve our health care system and to ensure that changes are made so that our health care system does not continue to be "destined to fail". Had the Committee had more time and resources, it could have looked closer into each of the areas identified in this report. In addition the Committee could have reviewed other health care services.

A Committee's work is to make inquiries to enable it to make recommendations to Parliament according to the relevant portfolio. Unfortunately committee hearings are often like trying to extract "blood from a stone". Instead of providing information to facilitate change, some public servants are more focused on minimising the damage that could occur if they reveal how their department or agency is performing.

Instead of withholding information to "protect their Minister" they should be open and transparent so that the Minister of the day, who is often unaware of departmental failings, is made aware of these failings and given an opportunity to say to the public, "the Government may not have adequately addressed community needs and concerns in this area in the past, but hopefully now we are more aware of these failings we will try to improve service delivery".

Some of the Report's chapters provide readers with a summary of the identified area while others make recommendations to assist the Government to consider how service delivery could be improved.

Chapter One is an introduction to the Report. As such it has general recommendations designed to improve the management, efficiency and effectiveness of health care services including:

- amalgamating the North and South Metropolitan Area Health Service;
- introducing area specific hospital boards;
- improving reporting arrangements to the community on available services; and
- decreasing the number of people on elective surgery waiting lists by allocating additional funds.

Chapter Two presents the Reid Report which gave the rationale for change to health care services and made recommendations to assist such change. Chapter Three examines the previous Government's response to the Reid Report, entitled *Clinical Service Framework 2005- 2015*, (CSF 2005) which was to implement the Reid Report's recommendations.

Chapter Four presents the current Government's *Clinical Service Framework 2010-2020* (CSF 2010) which is the current blue print directing future health care service delivery. The major change in CSF 2010 which will affect health care delivery is the decision to retain Royal Perth Hospital (RPH) as a **tertiary hospital**. This will reduce the beds available to people in the

southern suburbs at Fiona Stanley Hospital. In addition it will delay the allocation of tertiary services to people living around the Joondalup Health Campus and decrease, to a lesser extent, the number of beds at that hospital.

The Reid Report key recommendation that health care services are situated within or close to the communities they serve has also not been adopted by the current Government. The result will be some members of the community having to travel longer for medical assistance and as a result some will die before they receive care.

Associated with this is a large increase in the population due to the economic boom and the fact that through medical advances more people are living longer, health care delivery must be more focused on keeping people healthier, and more services must be provided in the community and/or in the home.

Major findings in this area include:

(a) CSF 2010 projections showing 171 fewer beds in 2015 across the metropolitan hospital network compared to projections in the original CSF 2005;

(b) the decision to retain RPH as a tertiary hospital having an adverse effect on health care delivery for the people living in Perth's northern and southern suburbs, where the population growth has created a high demand for health services;

(c) a reduction in the number of beds and thus their ability to deliver services at metropolitan secondary hospitals, including: Armadale-Kelmscott, Joondalup, Rockingham and Swan Districts; and

(d) a failure to upgrade Joondalup Health Campus (JHC) to a tertiary hospital by 2015-16.

Chapter 5 looks at health service modelling. The report identifies how poor economic, management and political decisions can have devastating effects on our health care system in the metropolitan and regional areas.

Our health care service will be destined to fail if health care budget forecasting does not utilise accurate projections for population growth in the modelling determinants for capital expenditure, resource allocation and service delivery.

This chapter recommends that the Government use high-growth population projections to plan health expenditure. It is hoped such planning will:

(a) prevent the annual bed closures due to financial constraints;

(b) prevent the constant increase in waiting lists for hospital services; and

(c) prevent the increase in waiting lists for community health care services in particular child health.

Chapter 6 reviews our public hospitals in both the metropolitan and regional areas. In terms of the retention of RPH as a tertiary hospital, the Committee recommends the Government review their decision to keep RPH as a tertiary facility in light of the costs resulting from this decision on other tertiary and secondary hospitals. The Committee appreciates the community have requested RPH be kept as a hospital and recommends to the Government that with the close proximity to Sir Charles Gairdner Hospital (SCGH) which has tertiary services, the Government can fulfil the wishes of the thousands of people who signed petitions to save RPH by retaining RPH as a Level 4 hospital.

The chapter recommends the expeditious redevelopment of King Edward Memorial Hospital adjacent to the children's hospital. This move will not only reduce the costs resulting from a duplication in services because of the distance between the hospitals, but will in addition lead to improved service delivery to women, mothers and their babies.

The chapter highlights the finding that regional hospitals have similar problems in terms of staffing and resources because of their isolation. The Committee recommends supporting senior nurses in their role through policy guidelines to provide care and treatments which the limited number of GP's in these areas are obliged to provide over a 24 hour period. This would in turn reduce the workload on country GP's. In addition the Committee were repeatedly made aware of the lack of basic medical equipment and have asked the Department of Health to table an inventory of all outstanding clinical and non-clinical requirements for Regional Resource Centres and Integrated District Health Services.

Major findings in this chapter include:

(a) the three major goals of the reform program for health – the reduction of health expenditure, the promotion of efficiency gains and the distribution of the most appropriate care in the most appropriate setting — have been significantly compromised by the decision to retain Royal Perth Hospital as a 410–bed tertiary facility;

(b) SCGH: if bed numbers are adjusted to take out the Rehabilitation and Mental health beds which were included in CSF 2005 for 2015-2016, then under CSF 2010 there will a decrease in 339 beds available at SCGH;

(c) FSH: under CSF 2005, by 2015-16 there were to be 1,058 beds available at Fiona Stanley Hospital. Under CSF 2010 there will only be 798 beds available in 2014-15 — a decrease of 260 beds. By 2020-21 only an additional 40 beds are opened up at FSH making the final decrease 220 beds. As Table 6.5 in the Report shows, this is unacceptable when we know that between 30 June 2004 and 30 June 2009 the population increase for three local government areas whose ratepayers will attend FSH is 47,000 compared with the catchment for the two tertiary hospitals north of the river (SCGH and RPH) where the population increase for three of the councils whose ratepayers will attend SCGH or RPH is 30,911; and

(d) JHC: in CSF 2005, Joondalup was to become a tertiary hospital, and by 2015-16 was to have 623 beds servicing people in the northern suburbs. In CSF 2010 there are only 471 beds available at Joondalup in 2014-15 a decrease of 152 beds.

Chapter 7 again recommends the Government review the costs of retaining RPH and SCGH in such close proximity. It suggests RPH be maintained as a level 4 hospital thus permitting future health spending to be allocated to hospitals servicing high population areas.

Chapter 8 is on children's health. Parliament is aware that we have neglected the care of children in their early years and that waiting lists for essential front-line child development services reached a peak of 6,405 children in the metropolitan area alone on waiting lists for therapy in January 2010. The Government had been made aware in 2008 that there were 366 FTE shortages in this area and with the increase in population since this date we know that this number of FTE shortages will have increased.

The Committee is very hopeful that funding will be provided in the next budget to address child health resources and service delivery. The Committee's earlier reports to Parliament have highlighted the gross neglect by previous governments in this area. In particular this chapter recommends the Government establish a Ministerial Portfolio and a Government Department responsible for early childhood education and development, family services and children.

Earlier in Chapter 6, Table 6.7 shows a 7.4% increase in the budget expenditure to Child Health Services from 2008-09 to 2009-10. While supporting an increase into this vital area, on closer inspection of the increase:

- approximately 80% was allocated to acute care services at Princess Margaret Hospital, with a 10% increase in their budget.
- the remaining 20% was allocated to the non-acute sector including Child & Adolescent Community Health, with a reduction in expenditure of 2%.

Again the Committee recommend the Government increase funding to Child and Adolescent Community Health Care services.

Chapter 9 is on women's and men's health. Other states have separately funded initiatives to improve health care services based on gender. The Committee support either a re-allocation or additional funding for these services.

Chapter 10 addresses the need for a major boost into primary and preventative health programs. A proactive approach to health promotion and disease prevention must start before birth, and continue throughout life with a greater emphasis and more funding being allocated towards preventative health care.

Lifestyle choices are the cause of many of the major chronic diseases that people present with at hospital accident and emergency departments. It is the increase in the number of people living with chronic diseases that has led to the need to provide additional services in the community or the home. New initiatives need to be adopted by Government departments and within the community to encourage people to adopt healthier lifestyles. We are all aware of the slogan 'prevention is better than cure', however, even those of us who agree with this sentiment often find it hard to 'practice what we preach'.

Chapter 11 presents a brief review of the State's country health services. As with regional hospitals, the WA Country Health Service has difficulties attracting staff, in particular nurses, doctors, and Aboriginal health workers. The Committee was told that one of the major reasons why this occurs is the lack of quality, affordable housing in regional areas. Obviously if there are no suitable living quarters, there will be a lack of staff and thus people living in these areas will not be given the health care they need. The Committee IS hopeful with the Royalties for Regions money provided so far, improved health care in the Regions will not continue to be a "catch cry" by candidates standing in future elections to represent regional people.

Chapter 11 suggests how the Government can commence to "close the gap" in the health (or ill-health) of Aboriginal people. Just as the Committee suggests services should be provided where they are needed in the metropolitan area, it recommends the Government provide health care services in the regions based on community needs.

While this Government and the previous one have encouraged Indigenous people to work in the health care system, there is still a great need for more Indigenous health professionals in all areas. Greater flexibility in the provision (including time and place) of educational courses may assist many who commence study to complete these courses.

Most people are aware, and accept the fact, that their lifestyle affects their current and future health status. The Committee were told how alcohol in particular has had a detrimental effect in some Aboriginal communities on unborn children for many years. There is now a second-generation of Aboriginal people suffering from Foetal Alcohol Spectrum Disorder and this condition continues to affect too many aboriginal people.

Funding is desperately needed for early childhood programs in regional areas, and for smoking cessation programs as smoking rates are more than double for indigenous people than for non-indigenous people.

Some wonderful initiatives have been commenced in regional areas to educate children in relation to healthy food choices and a healthy lifestyle. The Government is to be congratulated on supporting these initiatives which include encouraging school children to care for vegetable gardens and to participate in physical education programs.

Chapter 13 reviewed services available in WA responsible for the urgent transport of those people who require acute care. In the case of the Royal Flying Doctor Service, which many people consider a "state treasure", funding does not always permit this service to be provided as quickly as both community members and health care professionals would like. In the case of St John's Ambulance, again a private service supported by the Government, lack of funding can mean people wait longer in WA for "the ambulance" to arrive than in other states.

Chapter 14 in this report is titled "Out of Sight: Out of Mind". The chapter makes many recommendations in relation to our under-funded mental health services. The Government is to be congratulated on appointing a Minister for Mental Health and a Commissioner for Mental Health. This area has been under-funded for many years and statistics now show between 20-25% of people will suffer a mental illness at some stage in their life. Some will require acute care in mental health beds in tertiary or secondary settings. It is felt that many could be prevented from

requiring acute care if there were more government or non-government support services available in the community to support these people. A particular area where the Committee was advised such support is required is in regional areas for young people.

Many believe there will always be a need for some secure long-term residential accommodation for those with a mental illness and that our prisons are currently providing such care for these incurable people who are not able to cope because of their mental illness. Because such a large percentage of prisoners have mental health problems the Committee has recommended that current proposals to upgrade mental health facilities in prisons be adopted. This may prevent many of the prisoners who have mental health problems being discharged and then re-offending and returning to the secure place they consider "home".

The sometimes weak relationship between acute mental health care and community mental health care is particularly noticeable in relation to people who are discharged following an attempted suicide. The Committee recommends to the Government that national guidelines be adopted to ensure that at least 90% of these patients are contacted within seven days of discharge to prevent a second attempt.

Chapter 16 provides a brief review of dental health services. Once again lack of funding for children's health in relation to dental care is a concern. At the moment when some children start school and have their first dental check their teeth are in very poor condition. Many of them may have suffered because of dental problems, and on review they are sent to PMH for teeth extraction. At a rally of dental nurses it was reported that on one occasion a child was sent to PMH and had 17 teeth extracted. The Committee recommends dental services be available from kindergarten to the end of year 12 in high school. Again dental clinic waiting list times were a concern particularly for those people living in pain with inadequate income to seek private dental care. The Government is asked to introduce strategies to reduce current waiting list times.

The final chapter is on end of life care: palliative and aged-care. We are aware that the battle of cost shifting between the State and Federal Government often leaves the person who needs care as the ultimate loser. This is particularly evident when it comes to aged-care where elderly people are "managed" in busy tertiary or secondary hospitals. We need more aged-care beds and facilities in WA and as part of any funding injections there could be a requirement for continuing education for nursing staff to enable elderly people who require acute but not life threatening medical or nursing assistance to be cared for in a residential aged-care setting. The lack of beds for people requiring aged-care will escalate with an ageing population in the metropolitan and regional areas. The Committee recommends that Royalties for Regions funding be utilised to develop new aged-care centres or add beds to regional hospitals or centres for the elderly requiring residential aged-care or residential dementia aged care.

The need for palliative care services is escalating with an ageing population. With an ageing population more people are being diagnosed with cancer. Because of this, the Government should be planning for the acute and long term care of these patients. The acute care requirements must address the high costs of additional equipment required to treat cancer. In addition we will need more oncologists, technicians, nursing staff and acute care beds for cancer patients undergoing treatment. We will also need to ensure that palliative care beds for cancer and other conditions are available for long term and respite care for these people requiring palliative care.

In tabling the report I would like to particularly thank the other Committee members and the professional research staff who have assisted the Committee with this inquiry.

Dr David Worth, our Principal Research Officer, who in addition to supporting Committee members also provides exemplary leadership to our other research officers. Dave has the ability to quietly keep us on track working towards the completion and delivery of a Report which we hope will help influence changes to improve health care.

Mr Tim Hughes has been our Research Officer for each of our previous inquiries. Tim has a friendly disposition and his expertise and commitment have been rewarded with his appointment as the Principal Research Officer for the Public Accounts Committee. We thank Tim for his dedication and wish him well in his new role.

The Speaker and the Clerk allowed the Committee to have the support from Ms Renee Gould as Research Officer for the early part of this inquiry. This was appreciated particularly during the time when we were gathering data by holding hearings in Perth, regional areas and interstate. Renee was a quiet and diligent worker who had the ability to make Committee members, and the people and groups who made presentations to the Committee, feel their work was valued.

Finally I would like to thank Ms Erin Gauntlett who assisted the Committee with the child health section of the Report. Her dedication and expertise in preparing our interim report *Invest Now or Pay Later: Securing the Future of Western Australia's Children* will hopefully be rewarded by additional Government funding being allocated to this area.

Janet Woollard

DR J.M. WOOLLARD, MLA
CHAIRMAN

ABBREVIATIONS AND ACRONYMS

ABHI	Australian Better Health Initiative
ABS	Australian Bureau of Statistics
ACAT	aged-care assessment team
ACCHO	Aboriginal Community Controlled Health Organisation
ACFI	Aged-care Funding Instrument
AEDI	Australian Early Development Index
AHCA	Australian Health Care Agreement
AHHA	Australian Healthcare and Hospitals Association
AHMC	Australian Health Ministers' Conference
AHS	Area Health Service
AIDS	Acquired Immune Deficiency Syndrome
AIHW	Australian Institute of Health and Welfare
AIN	Assistants-In-Nursing
ALOS	Average Length of Stay
AMA	Australian Medical Association
AMS	Aboriginal Medical Service
AMSC	Aboriginal Medical Service Council
AMWAC	Australian Medical Workforce Advisory Committee
ANPHA	Australian National Preventative Health Agency
AOD	Alcohol and other drugs
ARACY	Australian Research Alliance for Children and Youth
ART	assisted reproductive technologies
ASR	Age-standardised rate
BAC	blood alcohol concentration
BGHS	Bega Garnbirringu Health Service

BMI	Body Mass Index
CACP	Community Aged-care Package
CAHS	Child and Adolescent Health Service
CALD	Culturally and Linguistically Diverse
CAP	Care Awaiting Placement
CAT	Computerised Axial Tomography
CBD	Central Business District
CCR	Cervical Cytology Registry
CCU	Critical Care Unit
CDHP	Commonwealth Dental Health Program
CEO	Chief Executive Officer
CHSR	Country Health Services Review
CIS	Centre for Independent Studies
CMHT	(DOH) Community Mental Health Team
COAG	Council of Australian Governments
CPDSS	Country Patients Dental Subsidy Scheme
CRCC	Commonwealth Respite and Care Link Centres
CRROH	Centre for Rural and Remote Oral Health
CSF 2005	*WA Health Clinical Services Framework 2005-2015*
CSF 2010	*WA Health Clinical Services Framework 2010-2020*
DAO	(DOH) Drug and Alcohol Office
DCS	Department of Corrective Services
DEECD	Department of Education and Early Childhood Development (Victoria)
DHAC	District Health Advisory Council
DHS	(DOH) Dental Health Service
DMFT	decayed, missing and filled teeth
DNA	deoxyribonucleic acid

DOH	Department of Health (Western Australia)
DPI	Department for Planning and Infrastructure
DSC	Disability Services Commission
EACH	Extended Aged-care at Home
EACH-D	Extended Aged-care at Home - Dementia
ED	Emergency Department
EHSC	Education and Health Standing Committee
EMS	Emergency Medical Service
ERC	Expenditure Review Committee
ESRD	end-stage renal disease
ESRG	Extended Service Related Groups
ESSU	Emergency Short Stay Unit
FACEM	Fellow of the Australian College of Emergency Medicine
FaHCSIA	Department of Families, Housing, Community Services and Indigenous Affairs (Federal)
FASD	Foetal Alcohol Spectrum Disorder
FESA	Fire and Emergency Services Authority of Western Australia
FINE	Friend in Need - Emergency program
FSH	Fiona Stanley Hospital
FTE	full-time equivalent
GP	General Practitioner
GSDC	Great Southern Development Commission
HACC	Health and Community Care Program
HCC	Health Consumers' Council (WA)
HCN	Health Corporate Network
HDU	High Dependency Unit
HiAP	Health in All Policies Framework (South Australia)
HISG	Health Infrastructure Steering Group

HiTH	Hospital in the Home
HIV	Human Immunodeficiency Virus
HPV	human papilloma virus
HRC	Health Reform Committee
HREOC	Australian Human Rights and Equal Opportunity Commission
HRISC	Health Reform Implementation Steering Committee
HRIT	Health Reform Implementation Taskforce
ICCWA	Injury Control Council of WA
ICU	Intensive Care Unit
IDHS	Integrated District Health Service
IHPT	Inter-Hospital Patient Transport
IREG	Indigenous Regions
IT	Information Technology
JHC	Joondalup Health Campus
KEMH	King Edward Memorial Hospital
KPI	Key Performance Indicator
LGA	Local Government Area
LHAG	Local Health Advisory Group
LRA	long run average
MBS	Medicare Benefits Schedule
MHSB	Metropolitan Health Service Board
MIDP	Metropolitan Infrastructure Development Plan
MND	Motor Neurone Disease
MPS	Multipurpose Service
MRI	Magnetic Resonance Imaging
MS	Multiple Sclerosis
nd	no date

NDSHS	National Drug Strategy Household Survey
NeHTA	National e-Health Transitional Authority
NGO	Non-government organisation
NHA	(COAG) National Health Care Agreement
NHHRC	National Hospital and Health Reform Commission
NHS	National Health Service (United Kingdom)
NHTP	Nursing Home Type Patients
NMAHS	North Metropolitan Area Health Service
NPHT	National Preventative Health Taskforce
NPP	(COAG) National Partnership Payment
NSW	New South Wales
OECD	Organisation for Economic Co-operation and Development
OH&S	Occupational Health and Safety
OHCWA	Oral Health Centre of WA
PATS	Patient Assisted Travel Scheme
PBS	Pharmaceutical Benefits Scheme
PCA	Palliative Care Australia
PCP	Primary Care Partnership (Victoria)
PCT	Primary Care Trust (United Kingdom)
PCT	Palliative Care Team (Western Australia)
PCU	Palliative Care Unit
PCWA	Palliative Care Western Australia
PECN	People with Exceptionally Complex Needs Project
PFI	Private Finance Initiative
PHC	Primary Health Care
PHO	Primary Health Organisation (New Zealand)
PHS	Prison Health Services

PHU	Public Health Unit
PlHC	Peel Health Campus
PMH	Princess Margaret Hospital
PPH	potentially preventable hospitalisations
PPP	Public Private Partnerships
PSA	prostate specific antigen
PWC	Pricewaterhouse Coopers
QALY	quality-adjusted-life-year
QEII	Queen Elizabeth II Medical Site
RFDS	Royal Flying Doctor Service
RFR	Royalties for Regions
RGS	(Royalties for Regions') Regional Grant Scheme
RiTH	Rehabilitation in the Home
RPH	Royal Perth Hospital
RRC	Regional Resource Centre
SARC	Sexual Assault Resource Centre
SCGH	Sir Charles Gairdner Hospital
SDS	School Dental Service
SES	Socio-economic status
SHIP	State Health Infrastructure Plan
SIDS	Sudden Infant Death Syndrome
SJA	St John Ambulance
SMAHS	South Metropolitan Area Health Service
SPC	Specialist Palliative Care
SPP	(COAG) Special Purpose Payments
STD	Sexually Transmitted Disease
SUC	Sobering Up Centre

UFPA	Unity of First People of Australia
UHI	Unique Health Identifier
UK	United Kingdom
UWA	University of Western Australia
WA TAP	Western Australian Tobacco Action Plan 2007-11
WACCPP	WA Cervical Cancer Prevention Program
WACHS	WA Country Health Service
WASON	WA School of Nursing
WHO	World Health Organisation
WNHS	Women and Newborn Health Service
WSC	Royal Perth Hospital (Wellington St Campus)

GLOSSARY[1]

Allied Health	includes disciplines such as physiotherapy, occupational therapy, clinical psychology, speech pathology, social work, nutrition and dietetics, podiatry, audiology, orthotics and prosthetics, and orthoptics.
Ambulance bypass	hospital emergency departments are bypassed by ambulances when the emergency department has reached maximum capacity and the treatment of patients already in the emergency department could be significantly compromised by the ambulance arrival of additional cases, which are always taken to the nearest hospital.
Ambulatory Care	medical care including diagnosis, observation, treatment and rehabilitation that is provided on an outpatient basis. Ambulatory care is given to persons who are able to ambulate or walk about.
Average length of stay	the average number of days a patient might expect to spend in hospital for a particular procedure or diagnosis.
Bed-day	the occupancy of a hospital bed by an inpatient for up to 24 hours.
Burden of disease	a method developed by the World Health Organisation for estimating a high level measure of the health of a community by taking into account the amount and type of disease and injury and their causes.
Care Awaiting Placement patients	elderly hospitalised patients awaiting hostel or nursing home placement.
Chronic	comes from the Greek chronos, time and means lasting long time.
Comorbidity	the co-existence of two or more disease processes.
Continuum of care	the aim of continuum of care is to provide a seamless transition for individuals from community to hospital and back to the community.
Elective surgery	surgery that is subject to choice (election). The procedure is beneficial to the patient but does not need to be done at a particular time as opposed to urgent or emergency surgery.
Encryption methodology	procedures around the transfer of information into an unreadable form for the purpose of making the information unintelligible to unauthorised users.
Epidemiology	the study of the incidence and distribution of diseases, and their control and prevention.

[1] This glossary is the one used in the Reid Report, Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p137.

Inpatient	people who have been formally admitted to hospital for care and/or treatment.
Intermittent care	temporary or respite care for individuals with disabilities, illness, dementia or other health concerns to give relief to caregivers from the demands of ongoing care.
Major trauma	refers to a serious or critical bodily injury, wound, or shock.
Medi hotel	provides supported overnight accommodation and hotel type services for patients and their families during or prior to treatment, tests and surgery. This facility is best suited to patients who are generally self sufficient in terms of their care and medication, as the hotel is staffed by only one nurse, who will arrange for hospital transfer if emergency care is required.
Multi-day separation	a multi-day separation results when an inpatient is admitted and separated on different calendar days.
Nurse practitioner	a registered nurse who has acquired expert knowledge base, complex decision making skills and clinical competencies for expanded practice.
Occupancy levels	number of patient days provided by a hospital expressed as a percentage of the total number of bed days potentially available at that hospital.
Older person	a person aged 65 years and over.
Practice nurse	a registered nurse who works in a general practice setting
Primary care	the medical care a patient receives upon first contact with the health care system, before referral elsewhere within the system.
Quaternary	this category is usually reserved for more specialised care. These services are provided with access to specialist medical, nursing and allied health staff, and supported by round-the-clock diagnostic imaging and pathology services.
Same-day separations	a same-day separation results when an inpatient is admitted and separated on the same calendar day. It includes inpatients that are transferred to another hospital or inpatients who died on the day of admission.
Secondary	secondary health care is generally provided to patients with conditions which require specialised professional skills and facilities for more complex treatment.
Separation	a separation is a discharge, transfer or death of a patient.
Summary Speciality-Related Groups	a classification of clinical specialities based on Diagnosis Related Groups (DRGs) and other diagnosis, operation and type of care (eg. acute/non-acute) information.

Step-down services	hospital beds or facilities with specialised staff and equipment to care for patients who no longer need coronary or intensive care but are not yet ready to move to a general hospital ward.
Sub-acute	rather recent onset or somewhat rapid change. Designates the mid-ground between acute and chronic.
Tertiary	tertiary health care is provided to people with less common conditions or those who require complex and costly forms of diagnosis and treatment.
Transitional care	the transfer of patient care and information between settings, health professionals and services.
Triage	the process of sorting people attending emergency departments based on their need for immediate medical treatment as compared to their chance of benefiting from such care.
Weighted separation	a measure of the total resource consumption of a patient based on their diagnosis and time spent in hospital.
Western Australian Division of General Practice network	refers to the 14 Divisions of General Practice in Western Australia and their peak body, General Practice Division of Western Australia Ltd.

EXECUTIVE SUMMARY

The Committee has spent the past 18 months collecting evidence from across Western Australia on the State's substantial hospital and community health care system. Despite the goodwill, dedication and hard work of the staff employed by the Department of Health (DOH) and in the non-government sector, the health system has moved away from being based on population needs. While Western Australia has sustained a high quality and safe health system, the Committee has found that the current design is 'destined to fail'.

In 2003 the Gallop Government called for a sweeping review of the Western Australian health system. The end result of this process was the 'Reid Report', a comprehensive document, which confirmed that, "the need for change in the public health system is clear". The system was beset with an inordinate demand for hospital services and workforce shortages, faced a looming population surge, and operated in a manner described as financially unsustainable.

A total of 86 recommendations were made that were designed to improve the quality of health services and restrain the growth of the system's costs. The Liberal Party, then in Opposition, supported all but two of these recommendations.

In 2005, then-Health Minister, Hon Jim McGinty, said the implementation of the Reid Report's recommendations through the projected capital works program outlined in the *Clinical Services Framework 2005-2015 (CSF 2005):*

> *will give Western Australians the finest health care system in the nation, if not the world, and will deliver health care closer to where people live.*

However, the previous Government failed to deliver on major aspects of the capital works program pivotal to the reforms. This pushed the health system closer to the edge as the State continues to witness unprecedented population growth. Examples of these delays include:

- **Fiona Stanley Hospital** - original completion date of 2011, now due to open in 2014;
- **Sir Charles Gairdner Hospital** - $400 million upgrade due for completion in 2011, now revised to a smaller $115 million project due in 2012-13;
- **Princess Margaret Hospital** - the period 2005-08 was spent deciding to move the hospital to the QEII site, now due to open 2014;
- **Albany Hospital** - original redevelopment with a completion date 2007-08, now a new hospital is due to open 2015.

Loss of beds

The retention of Royal Perth Hospital (RPH) as a **tertiary hospital** by the current Government — contrary to the preference expressed in the Reid Report — may push the hospital system over the edge. Premier Barnett (then-Opposition Leader) argued in August 2004 that the retention of RPH

"will deliver a net gain of 620 beds- an additional 430 beds compared with the number of beds that will be delivered under Labor's policy" and "a cost saving of $400 million". Significantly, the *Clinical Services Framework 2010-2020* (CSF 2010) provides 171 fewer beds in the Perth hospital system for 2015 than did CSF 2005. This represents a 330-bed turnaround from the forecast requirements made by the Department of Health to the Committee in March 2009.

The biggest losers of beds will be the new Fiona Stanley Hospital (FSH) and Sir Charles Gairdner Hospital (SCGH). FSH loses 29% (197 beds) of its Medical, Surgical and Emergency Care beds planned for 2015. SCGH loses 39% (339 beds) of its Medical, Surgical and Emergency Care beds. Additionally, the CSF 2005 plan for Joondalup Hospital was for it to become a tertiary hospital by 2015-16, but the CSF 2010 states that Joondalup will remain a general hospital until at least 2021.

The financial impact of the decision to retain RPH has not yet been fully quantified. The Under Treasurer recently stated that the decision to retain RPH as a tertiary hospital will have "significant recurrent cost implications for the health system".

Duplication of services

As a result of the decision to retain RPH, many expensive tertiary services will be duplicated, directly undermining a key goal of the Reid Report's reforms. As an example, the Reid Report argued that "a cardiac surgical unit is likely to be most safe, effective and sustainable when it manages around 800 cases a year." Current demand for this expensive surgery would be easily serviced within two tertiary facilities, but will now stay distributed over three (RPH, SCGH and Fremantle/Fiona Stanley hospitals). Forecast demand data below provided by DOH through to 2014-15 indicates that cardiothoracic surgery activity will remain at a level well within the capacity of two tertiary hospitals.

Table ES1- Projected cardiothoracic surgery separations by hospital, 2011-15

Hospital	2011-12	2012-13	2013-14	2014-15
Royal Perth Hospital	390	396	402	376
Sir Charles Gairdner Hospital	460	466	473	413
Fremantle (to 2014) Fiona Stanley Hospital	279	284	286	410
TOTAL	**1,129**	**1,146**	**1,161**	**1,199**

The cost burden of maintaining these extra tertiary services at RPH means that funds for major capital works for the health system will now need to be provided by the Federal Government and facilities may need to be built by the private sector (eg the new Midland Health Campus). Alternatively, vital projects may be cancelled or further delayed.

The Education and Health Standing Committee believes that the State's hospital and health system will not be able to meet its obligations to Western Australians over the period covered by the CSF 2010, because of six key failures:

1 The current use of low-growth population projections by the Department of Health when modelling future service demands.

2 The retention of Royal Perth Hospital as a **tertiary facility** and the subsequent move away from the provision of hospital services based on population need.

3 The disregard by current and former governments of the long-term savings that can be made by a substantial commitment to preventative and primary health care programs.

4 The lack of a systematic approach to utilising any spare capacity in the private hospital sector, which already provides about 35% of Perth's hospital services.

5 The poor coordination between the State and Federal Governments over the planning and provision of aged-care facilities.

6 The failure of the Department of Treasury and Finance (DTF) to improve its budget forecasting methods which lead to budget cuts in the State's health system. DOH's budget will be reduced by $600 million over five years in order to meet spending cuts prompted by DTF budget forecasts that have proven before to be unreliable.

System Failures

Failure 1- the use of low population projections

Under the current Government, DOH modelling has moved to **low-growth** population projections provided by the Australian Bureau of Statistics to estimate future health demands for the *Clinical Services Framework 2010-2020*. Previously, DOH used the **medium-growth** ABS data to calculate the projections contained in the *Clinical Service Framework 2005-2010*. Under both governments population growth rates in Western Australia, but particularly Perth, have consistently exceeded even the ABS **high-growth** projections. This means that the CSF 2010 will fail to accurately predict future health demands as population growth is about 45,000 people per annum higher than DOH current forecasts.

Failure 2- the retention of RPH as a *tertiary* hospital

There was substantial public support before the last State election for the retention of RPH as a hospital. However, the current Government has retained it as a 410-bed 'tertiary' hospital. This decision has contributed substantially to the projection of 171 fewer beds for the Perth hospital system for 2015 contained in the recently released CSF 2010, despite the rapid population growth that has continued over the past four years. An earlier prediction by DOH that CSF 2010 would need to deliver a 160-bed increase (using low-growth population projections) by 2015-16 means that the reduction of beds is over 330 from what will actually be needed.

The greatest loss of beds in the CSF 2010 is in the four general hospitals servicing outer suburbs, such as Wanneroo and Rockingham. These regions have had the highest population growth in Western Australia for most of the past nine years yet will have 249 fewer beds in 2015 than recommended in the CSF 2005.

The situation at the Joondalup Health Campus (JHC) is so acute that it has the largest rate of ambulance ramping of Perth hospitals and at times has to place adult patients into children's wards! Under CSF 2005 JHC was due to become a tertiary hospital by 2015-16, but under CSF 2010 there are no plans to upgrade it before at least 2021.

The Reid Report emphasised the necessity of expanding the size of the general hospitals in the outer metropolitan area to meet population needs. This would reverse the trend — still evident today — where up to 80% of people are presenting to Perth's tertiary hospitals with conditions requiring only secondary level care. Ideally these treatments should be provided closer to where patients live and where general hospital care is up to $380 per day cheaper than in tertiary facilities.

The Committee recommends that the Government maintain Royal Perth Hospital as a general hospital for treating Level 4 emergency presentations and the provision of secondary level care for Perth's inner-city population. It also recommends that planning commence so that JHC is upgraded to a tertiary hospital by 2020, and that the proposed tertiary services retained at RPH be distributed to JHC, SCGH and FSH.

Failure 3- the lack of emphasis on prevention programs

In the face of predictions of an obesity 'epidemic' and a rapidly ageing generation of 'baby boomers', the current and past governments have run down the State's preventative health and education programs. The Reid Report in 2004 called for substantial investment in health promotion and prevention strategies as "50% of cancers, 75% of cardiovascular disease and 90% of type 2 diabetes can be prevented" by such programs. Over the five-year period since the launch of the Reid Report in 2004, the Gallop and the Carpenter Governments increased the overall health appropriation by 39.7%, but increased the funding for prevention and promotion services by about one-third of this (14.1%).

The State's public health budget in 2007-8 was only 2.6% of the total health budget, one of the poorest public health investment rates of any OECD jurisdiction. Previous Committee reports showed that the economic returns of preventative health programs, including sport and recreation, can be in the order of $17 for every dollar spent. Patients with chronic diseases that develop because of the current low rate of investment in prevention strategies will ensure a continuing high demand for costly hospital services for decades to come.

Failure 4- the lack of integration with private hospital services

Western Australia has a healthy private hospital system that already provides about 35% of Perth's hospital services (see Appendix Eight for a full list of these hospitals). Many of the metropolitan public hospitals are co-located with a private hospital (eg Sir Charles Gairdner and Hollywood hospitals) while the new Fiona Stanley Hospital will be co-located with St John of God Murdoch.

The retention of RPH as a tertiary hospital with no adjoining private facility means that potential private patients are treated by publicly-funded services. Other States have implemented a system where senior staff are located in Emergency Departments to liaise with appropriate patients to assist them in receiving services in an adjacent private hospital, if they so choose. In 2008-09 there were 168,000 bed-days provided in public hospitals for private patients. Using the Reid Report's 2004 figure of an average of $1,100 per tertiary bed-day, this has cost the Western Australian Government as much as $185 million in 2008-09, of which only $42.2 million was recouped from health insurance companies.

The CSF 2010 includes just one paragraph discussing the merit of a strategy to 'optimise public and private services'. Private hospitals provide about 1,500 beds in Perth and employ over 4,000 staff. They offer the same range of services to the State's public hospitals, from Emergency Departments to palliative care. The Committee heard that public hospitals operate most effectively when they are at about 80-85% of their bed capacity. Most of Perth's public hospitals are operating at capacities above 95%.

Both the former and current governments have failed to develop a systematic approach to utilising the spare capacity in the private hospital sector. For example, the Committee heard that the highest demand during a week for beds at RPH is generally on a Sunday or Monday, yet this is when the Mount Hospital (the closest private hospital) is at its quietest. Many specialists operate at both these hospitals.

Failure 5- the failure to properly plan for additional aged-care facilities

The responsibility for the provision of aged-care facilities lies with the Federal Government, but those patients not able to find places end up in the State's hospital system. The average cost of a tertiary hospital bed was about $1,100 a day in 2004, compared with about $200 for an aged-care bed. The State's Health Minister recently estimated that about 370 people are in State-funded care and could be discharged if there were suitable aged-care facilities available. If these people were provided with the appropriate accommodation, the Health budget would save at least $300,000 per day.

Of these people, about 70 are in expensive hospital beds when they should be in more appropriate aged-care facilities. The State Government needs to do more to ensure that aged-care facilities funded by the Federal Government meet projected demands so that hospital beds are filled by those who genuinely need them. It needs to be proactive in overcoming the current situation where the State's aged-care sector is handing back bed licenses, rather than building new facilities.

Failure 6- poor Department of Treasury and Finance budget forecasting

The health budget accounts for about a quarter of the State's expenditure, and any errors in DTF's economic projections that lead to government decisions to cut departmental budgets have a significantly larger impact on DOH than other departments. A clear example of the hardship created in the health sector by poor DTF forecasts were the savage cuts made to the mental health sector by then-Health Minister, Hon Jim McGinty. The 2003 State Budget was framed in an environment of international uncertainty with forecast real declines in State revenues, and continuing cost and demand pressures in key areas such as health. DTF forecast a surplus of just

$83 million for the year. The final budget position for 2003-04 was actually a $799 million surplus, with revenues $1.7 billion higher than forecast. Despite the improved fiscal result, there is no evidence that the cuts made in the mental health sector were unwound. DTF's forecasts seem to have been less accurate over the past four years than similar-sized jurisdictions such as South Australia and Queensland.

The Committee has found that, despite such claims, the State's budget is not under pressure because of the growing financial demands from the health sector. The Table below shows the health budget having grown at about the same rate as the State's economy over the past two decades, despite pronouncements from many politicians that it will soon 'consume all of the State's budget'. The health budget tripled in this time, but so did the State's overall budget. The Premier recently said that the State was "the world's leading mining economy." As the Western Australian economy continues to grow in future decades, so the State will be able to afford a larger health budget, and a better health system.

Table ES2- WA health budget as proportion of total government appropriations, 1990-2009

Year	Total general government recurrent appropriation	Total health recurrent appropriation	Health budget as % of government appropriation
1990-91	$4.94 billion	$1.25 billion	**25.2%**
2000-01	$7.79 billion	$1.88 billion	**24.1%**
2008-09	$15.29 billion	$4.08 billion	**26.7%**

Structure of the Report

This Report has been prepared in two volumes.

Volume 1

Chapter 1 summarises some key deficiencies within the Department of Health, the Minister's management of the health portfolio and other economic aspects of the health system. Chapters 2-4 look at the State's hospital system and reports on the compliance with, and departures from, the Reid Report in 2004 and the later Clinical Services Frameworks produced in 2005 and 2009.

Chapter 5 provides details on how DOH models the future demand for health services and produces projections which are included in CSF 2010. Chapter 6 profiles the impact of the reform process on five of the State's tertiary hospitals as well as the Joondalup Health Campus, Albany Hospital (a Regional Resource Centre) and Katanning Hospital (an Integrated District Health Service). Chapter 7 considers the ramifications of the *Royal Perth Hospital Protection Bill 2008* that was introduced by the Government but has not been debated by Parliament since early 2009.

Volume 2

The second volume summarises the State's key community health care programs, identifies some outstanding needs and gaps in health care services and recognises the important roles non-government organisations play in delivering many health programs throughout the State.

This volume commences with Chapter 8 briefly summarising key issues to do with child health that were unable to be covered in the Committee's recent *Invest Now or Pay Later* report. Chapter 9 follows with an overview of important women's and men's health issues. Chapter 10 covers in detail the key role preventative and primary health programs play in keeping Western Australians healthy, and the low rate of investment made by recent State governments in these areas.

Chapter 11 provides a summary of the unique nature of health challenges faced by people living in rural and regional areas of the State. A key theme running through both volumes is the difficulty for any government to address the health needs of the State's country residents given the low population densities outside of Perth and the vast distances to be covered by health services. WA Country Health Service hospitals see more emergency presentations than DOH's metropolitan network and they deliver as many babies as King Edward Memorial Hospital in Perth. Despite this contribution of WACHS staff and other organisations, the health status of country residents remains poorer than city residents- especially for the 78,000 Indigenous people living in Western Australia. The Committee recommends in this Report that a substantial proportion of the Government's 'Royalties for Regions' funds be allocated to enhancing the State's country hospital and health services.

Chapter 12 includes data on the challenges faced in 'closing the gap' in Indigenous health. Chapter 13 provides an overview of the key role played by the staff and volunteers at the Royal Flying Doctor Service and St John Ambulance, who deserve the iconic status given to their organisations. They provide the critical transport services in the State's regions that allow the DOH 'hub-and-spoke' model to operate with the State's tertiary health services based in Perth.

Chapter 14 provides information on the State's mental health programs and the areas that need additional funds. Mental illness will affect about 20% of Western Australian adults in any one year, representing over 337,000 people. Of these, about 21% will suffer from a severe mental episode, 33% a moderate illness and just under half will experience a milder condition. Chapters 15 and 16 are short ones providing an overview of alcohol and illicit drug issues, and the State's dental health programs, respectively.

The Report concludes with Chapter 17 which analyses two major aspects of the end-of-life experience that also impact on the demand for acute hospital beds: aged-care and palliative care. These two areas are considered jointly in this chapter given the significant impact that the rapidly growing 'baby boomer' cohort aged over 65 years of age will have on the State's health resources.

The Federal Government's proposal to fund 60% of the national hospital system and 100% of parts of the health system is yet to be agreed to by the Western Australian Government. Therefore, findings and recommendations in this Report have been developed assuming the current State Government control of Western Australia's hospitals and community health care systems will continue into the foreseeable future.

FINDINGS

CHAPTER 1 INTRODUCTION

Page 7

Finding 1

Given the challenges of health, future Ministers should have this portfolio as their only responsibility.

Page 8

Finding 2

Five different individuals have held the position of Western Australian Director General of Health in the past decade. The high turnover rate has hindered the efficient administration of public health in this State during a period of significant reform.

Page 10

Finding 3

The geographical basis to the current area health service model, as recommended in the Reid Report, has been undermined with the retention of Royal Perth Hospital within the South Metropolitan Area Health Service.

The Department of Health has not undertaken any modelling or planning as to how the State's hospitals might be grouped into alternative area health services or 'local hospital networks'.

Page 11

Finding 4

The Department of Health has not provided details of the consultation process that was used, and the participants involved, to determine what services would be retained at Royal Perth Hospital, as outlined in the *Clinical Services Framework 2010-20*.

Page 12

Finding 5

The Department of Health, through the Health Corporate Network, has difficulties in paying its staff in an efficient and timely manner.

Page 14

Finding 6

There is no formal mechanism for the Department of Health to gain feedback from the Western Australian public on issues to do with the operation of the State's health system.

Page 17

Finding 7

Compared to other jurisdictions, the Western Australian Department of Health's web site does not provide easy access to relevant and up-to-date health information.

Page 19

Finding 8

The Western Australian health budget between 1990 and 2009 has risen at a similar rate to the increase in Government's income and has remained at about 25-26% of the general government appropriations.

Page 22

Finding 9

Future services delivered at hospitals in Western Australia that have been built using Public Private Partnerships may prove to be more expensive or of poorer quality than government-provided services.

Page 24

Finding 10

The State Government has not added to Federal funding aimed at lowering elective surgery wait lists in the Budget's out-years.

Page 30

Finding 11

The Department of Treasury and Finance's recent budget estimates for the State's expenditure and revenue has not been as accurate as other similarly-sized jurisdictions, especially for prior-year estimates.

Page 32

Finding 12

The Government's 3% efficiency dividend has been a crude and untargeted strategy to cut government expenses and has placed a substantial burden on staff to continue to provide the same level of front-line services. These pressures have been exacerbated by an unexpected growth in demand for services by the State's rapidly increasing population.

Page 33

Finding 13

Western Australia's economy has emerged from the economic downturn with strong growth predicted over the coming years. Western Australia can clearly afford the additional resources required for a properly funded health service.

Page 33

Finding 13

Western Australia's economy has emerged from the economic downturn with strong growth predicted over the coming years. Western Australia can clearly afford the additional resources required for a properly funded health service.

Page 33

Finding 14

The health portfolio represents about 25% of all Government expenditure and yet the Minister for Health is not a member of the Western Australian Government's Expenditure Review Committee.

CHAPTER 2 A HEALTHY FUTURE FOR WESTERN AUSTRALIANS – THE REID REPORT

Page 37

Finding 15

The key outcome of the Reid Report was for the State's health services to be developed to overcome the mismatch between the existing distribution of hospital beds and the areas of major population growth.

Page 41

Finding 16

Actions by the Western Australian Government to strengthen primary health services and better integrate them within the broader health care sector (not necessarily more hospital beds) were seen as the key to improving the future efficiency and productivity of the State's health system.

Page 43

Finding 17

The Reid Report clearly articulated the case for just one tertiary hospital to service the needs of Perth's northern suburbs, and one to service the southern suburbs. However, a third tertiary hospital would need to be built within 20 years in Perth's northern suburbs to cater for its rapidly growing population.

Page 44

Finding 18

The Reid Report proposed that the two tertiary hospitals in metropolitan Perth be supported by four general hospitals offering a comprehensive range of core clinical services for populations to the north, south, east and south east of the Central Business District. These general hospitals would be supported by others provided specialist mental health, aged-care, and rehabilitation services.

Page 49

Finding 19

The Reid Report endorsed WA Country Health Service's 'hub and spoke' proposal for providing secondary health services in regional areas, with patients requiring tertiary services to be transported to one of the two tertiary hospitals in Perth.

CHAPTER 3 WA HEALTH'S FIRST CLINICAL SERVICES FRAMEWORK

Page 66

Finding 20

The Gallop Government in 2004 agreed to all but one of the Reid Report's recommendations for reforming the State's health system. Its opposition to the co-location of Princess Margaret Hospital with the King Edward Memorial Hospital was later reversed.

Page 66

Finding 21

The Liberal Party agreed with all but two of the Reid Report's recommendations for reforming the State's health system. It opposed the plan to close Royal Perth Hospital and Osborne Park Hospital's obstetric service.

Page 66

Finding 22

Public petitions opposed the closure of Royal Perth Hospital and requested the Government to retain its name. The Liberal Party's election commitment was to maintain Royal Perth Hospital as a tertiary hospital.

CHAPTER 4 CLINICAL SERVICES FRAMEWORK 2010-2020

Page 68

Finding 23

The Reid Report's prediction of a reform-driven average 2% per annum reduction in the growth of health expenditure over 2004-09 has not been realised.

Page 68

Finding 24

The decision to retain Royal Perth Hospital necessitated a major adjustment to the timing of the clinical planning process of the Department of Health for the *Clinical Services Framework 2010-20*.

Page 71

Finding 25

The Clinical Services Framework 2010-20 projections for 2015 show 171 fewer beds across the metropolitan hospital network compared to the projections in the original Clinical Services Framework 2005-15.

Page 74

Finding 26

The proposed redistribution of tertiary beds in CSF 2010 works to the clear detriment of people living in both Perth's northern and southern suburbs. This redistribution is inconsistent with the intent of the Reid Report and the original Clinical Services Framework 2005-15.

Page 78

Finding 27

Despite acknowledgement in the Reid Report that there was some 'unnecessary duplication' of services north of the Swan River between Royal Perth Hospital and Sir Charles Gairdner Hospital, the CSF 2010 restores the status quo (and in-built duplication) in high-cost areas including adult neurosurgery, cardiothoracic surgery, orthopaedic surgery and Emergency Department services.

Page 78

Finding 28

Retention of high-cost tertiary services at Royal Perth Hospital has left them based where staff currently work, rather than in the northern and southern suburbs where population growth has created a high demand for health services.

Page 79

Finding 29

The projected 2015 bed allocation in CSF 2010 removes 249 beds across the following general hospitals: Armadale-Kelmscott Memorial, Joondalup Health Campus, Rockingham and Swan District. This represents a significant departure from the CSF 2005 strategy of providing 'care in the most appropriate setting' to patients.

Page 83

Finding 30

The successful implementation of the Four Hour Rule program may help relieve pressures on Perth's tertiary hospitals.

Page 86

Finding 31

Uncertainty exists as to whether the entire 10-year plan for health reform as articulated in the *Clinical Services Framework 2010-20* will be fully funded by the Government.

CHAPTER 5 HEALTH SERVICES MODELLING

Page 90

Finding 32

Demand and capacity modelling predicts future activity levels for health services and influences the Department of Health's infrastructure, workforce and recurrent cost planning. A failure to accurately estimate future requirements can have a profound impact on the Department's financial viability and operational efficiency.

Page 92

Finding 33

The modelling process used by Department of Health caps the true projected activity levels in the State's hospitals to allow for operational constraints attributable to broader Government policy decisions and internal workforce, infrastructure and budgetary limitations.

Page 93

Finding 34

The effectiveness of demand and capacity modelling for determining the distribution of health services can be undermined by a general lack of understanding of the process by policy makers and resistance to change among health practitioners.

Page 94

Finding 35

The decision to retain Royal Perth Hospital as a tertiary facility meant that the role delineation across the metropolitan hospital network had to be revised. This was a lengthy process, which delayed the preparation of the Clinical Services Framework 2010-20.

Page 97

Finding 36

The retention of 410 tertiary beds at Royal Perth Hospital has produced a redistribution of beds away from hospitals in the outer metropolitan area where significant population growth is occurring.

Page 97

Finding 37

The placement of 410 tertiary beds in the City's centre appears arbitrary in light of the recommendations based on population data presented by the Reid Report, and detrimental to the longer term reform outcomes the Report advocated.

Page 101

Finding 38

Despite recent record population growth in Western Australia, the Department of Health has moved from using medium-growth projections provided by the Australian Bureau of Statistics to low-growth ones.

Page 104

Finding 39

The Committee has received no evidence that, despite receiving regular briefings, the Department of Treasury and Finance recognise the structural flaws arising from the decision of the Department of Health to use low-growth population projections in its modelling.

Page 106

Finding 40

Under the current estimates for key parameters used by Department of Health in its modelling, it is likely that the efficiency gains attributable to reduced length of stays for hospital patients and the provision of hospital care in the most appropriate setting will prove to be overstated. As a result hospitals will remain under continued pressure to meet service demands beyond their budgeted capacity.

CHAPTER 6 PUBLIC HOSPITAL PROFILES

Page 113

Finding 41

The status of the redevelopment plan for Royal Perth Hospital proposed by the current Government remains uncertain. Even if the project is funded, it may not commence until 2014-15.

Page 114

Finding 42

Three major goals of the reform program for health—the reduction of health expenditure, the promotion of efficiency gains and the distribution of the most appropriate care in the most appropriate setting—have been significantly compromised by the decision to retain Royal Perth Hospital as a 410-bed tertiary facility.

Page 121

Finding 43

From 2005 onwards, infrastructure projects designed to improve the operability of Sir Charles Gairdner Hospital, and enhance the productivity of its staff, have been consistently delayed.

Page 127

Finding 44

Based on current estimates, the expected opening of Fiona Stanley Hospital is May 2014, three years beyond the original forecast. The extent of this delay was acknowledged as early as April 2008 by the then-Carpenter Government.

Page 127

Finding 45

Twice in the past 18 months, the Health Minister Hon Dr Kim Hames, seems to have misled Parliament as to the Government's plans for the new Fiona Stanley Hospital.

Page 129

Finding 46

Under the *Clinical Services Framework 2010-2020*, there is no increase planned for the bed capacity of Fiona Stanley Hospital between 2014-15 and 2020-21 despite a likely population increase of more than 40,000 in just three of the closest Local Government Areas within the hospital's catchment area.

The *Clinical Services Framework 2010-2020* has reduced the projected beds at Fiona Stanley Hospital in 2015 by 260 beds, whilst the Stage Two capacity of Fiona Stanley Hospital has been reduced by 220 beds.

Page 130

Finding 47

The retention of Royal Perth Hospital as a 410-bed tertiary facility will create major logistical difficulties for the Department of Health in terms of workforce management.

Page 132

Finding 48

The decision to retain the State's heart and lung transplantation unit at Royal Perth Hospital was announced just 10 days after the Health Minister had confirmed that this facility would be transferred to Fiona Stanley Hospital.

Page 134

Finding 49

The Government has increased investment in acute services at Princess Margaret Hospital. Additional funding should be provided for non-acute child health services, such as speech pathology.

Page 139

Finding 50

The *Clinical Services Framework 2010-2020* has increased the projected capacity of tertiary and non-tertiary obstetric and neonatal services at King Edward Memorial Hospital, Princess Margaret Hospital and the four general hospitals. This is a positive development that is responsive to the original reform goals of providing more appropriate care.

Page 142

Finding 51

The failure to relocate King Edward Memorial Hospital to the QEII site will exacerbate the operational difficulties currently experienced at the State's main maternity hospital.

Page 148

Finding 52

The commitment in 2005 made by the previous government to redevelop Joondalup Health Campus into a 500-bed facility by 2009 has yet to be realised.

Page 150

Finding 53

The Government's $227 commitment to redevelop Joondalup Health Campus is unlikely to resolve the operational difficulties currently affecting that hospital. Further expansion of Joondalup Health Campus is necessary to cater for the rapid population growth in the northern metropolitan area. The Joondalup Health Campus should be upgraded to a tertiary hospital, as recommended by both the Reid Report and the *Clinical Services Framework 2005-2015*.

Page 151

Finding 54

Under the current Department of Health modelling process that caps the number of beds in the metropolitan area to allow for changes in government policy, the decision to retain Royal Perth Hospital as a tertiary hospital has significantly undercut the resources available for health services at the Joondalup Health Campus to meet the rapid population growth that is occurring in that region.

Page 155

Finding 55

The previous Government did not achieve its plan to redevelop Albany Hospital into a Regional Resource Centre by 2007-08.

Page 158

Finding 56

The Government has not clarified whether the funding committed to the development of the new Albany Health Campus is sufficient to provide the full requirements of a Regional Resource Centre.

Page 161

Finding 57

Without appropriately maintained and furnished accommodation options, it will remain difficult to attract and retain the required nursing staff to rural and remote health facilities managed by the WA Country Health Service.

Page 165

Finding 58

The Emergency Department at Katanning's Integrated District Health Service is in urgent need of renovation. A business case was completed ten years ago for this purpose but was never implemented.

Page 176

Finding 64

The retention of Royal Perth Hospital as a provider of tertiary services will have many adverse implications for the Western Australian health system that far outweigh the benefit of maintaining an extra inner city tertiary hospital.

VOLUME 2

CHAPTER 8 CHILDREN'S HEALTH

Page 181

Finding 65

The State's paediatric acute care services are generally well staffed compared to other parts of the health system.

Page 183

Finding 66

Two other Australian jurisdictions have established portfolio responsibility for early childhood education and development. The experience in these states has shown benefits for children and their families.

CHAPTER 9 WOMEN'S AND MEN'S HEALTH

Page 185

Finding 67

Western Australia does not have a women's health strategy.

Page 197

Finding 68

The Government has deviated from a key recommendation of the Reid Report by not proceeding to co-locate Princess Margaret Hospital and the King Edward Memorial Hospital at the QEII site. This has major medical implications for the treatment of the patients and their very young children.

Page 210

Finding 74

Since the publication of the Reid Report in 2004, and its summary of the clear economic benefits to the State health system from a greater focus on preventative health programs, all State governments have increased funding for these programs at a lower rate than the acute health services.

Page 214

Finding 75

Some of the most severe physical costs from the main chronic illnesses will be faced by Western Australia's future generations. Effective preventative health programs aimed at children may deliver the largest cost savings to the State's health system.

Page 218

Finding 76

Currently the Department of Health does not publish in its annual report a clear set of key performance indicators, and its performance in meeting them, for the main chronic disease challenges faced by Western Australians.

Page 227

Finding 77

One of the most critical challenges facing the Western Australian Government is obtaining, and sustaining the required health work force in remote and regional areas of the State.

A key issue is developing new approaches to delivering health services in the face of the current severe shortage of GPs.

CHAPTER 11 COUNTRY HEALTH

Page 238

Finding 78

The Department of Health's planning to 2021 does not include the development of any Level 6 tertiary medical services to be provided in WA Country Health Service regions.

Page 243

Finding 79

A key challenge for the WA Country Health Service is retaining sufficient nursing staff, including nurse practitioners, especially for regions such as the Kimberley.

Page 248

Finding 80

Western Australia has far fewer general practitioners (GPs) per capita of population than other jurisdictions and this has been known to State governments for many years. Despite the recruitment of GPs being a Federal Government responsibility, the State Government can help entice and retain GPs to country areas through a variety of measures, including the provision of quality accommodation.

Page 251

Finding 81

The Royalties for Regions program has committed substantial funds for country health projects, but there is no single location that records all of the health-related projects funded by the scheme.

CHAPTER 12 CLOSING THE GAP — INDIGENOUS HEALTH

Page 253

Finding 82

The Reid Report identified major inequities in health status and access to health care for Indigenous Western Australians.

Page 260

Finding 83

Indigenous people's primary identification is to their own extended families.

Page 262

Finding 84

A greater number of Indigenous health staff within the Department of Health is an important part of the strategy to deliver health services to Indigenous Western Australians.

Page 266

Finding 85

Early childhood programs for Indigenous children need to address both their education and health outcomes.

Page 268

Finding 86

Significantly reduced levels of smoking by Indigenous people is a major factor in closing the gap between Indigenous and non-Indigenous life expectancies, and would reduce future health costs for the Western Australian health system.

Page 273

Finding 87

It is cheaper to provide dialysis treatment for non-metropolitan diabetes patients either in their home or in WA Country Health Service hospitals, rather than providing it in metropolitan hospitals.

Page 274

Finding 88

High insulin levels in Indigenous people indicate future adverse health impacts for them far beyond just diabetes.

Page 274

Finding 89

Well-run preventative health programs are the key to lowering insulin levels in Indigenous people.

Page 275

Finding 90

Access to fresh food is an important part of any strategy to lower the rate of diabetes in Indigenous people.

Page 278

Finding 91

Many Indigenous patients who travel long distances for treatment find it difficult to return to their homes after being discharged from a Regional Resource Centre.

Page 281

Finding 92

There is evidence that mothers who have been affected by Foetal Alcohol Spectrum Disorder are now having their own children, resulting in second-generation Foetal Alcohol Spectrum Disorder babies.

Page 283

Finding 93

The Department of Health needs to ensure its staff are culturally sensitive in their description of mental health conditions in programs provided within Indigenous communities.

Page 285

Finding 94

Sexually transmitted diseases and human immunodeficiency virus are major issues for Western Australia's Indigenous populations, especially in regions with mining operations.

CHAPTER 13 TRAVELLING TO HEALTH- THE ROYAL FLYING DOCTOR SERVICE AND THE ST JOHN AMBULANCE

Page 293

Finding 95

The new RFDS Hawker-800 jets cost $5,000 more per hour to operate than the existing turboprop planes.

Page 296

Finding 96

There is currently no registration body to regulate paramedics.

Page 313

Finding 97

The transport functions provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) are a critical element of the Western Australian health system, especially in rural and regional areas.

Page 315

Finding 98

The roles and resources provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) are currently not incorporated into the Department of Health's *Clinical Services Framework 2010-2020* model of projecting future health resource needs.

CHAPTER 14 OUT OF SIGHT: OUT OF MIND — UNDERFUNDED MENTAL HEALTH SERVICES

Page 319

Finding 99

Mental health issues affect a large number of Western Australians and their families, and offer a complex challenge to health staff. Patients often have comorbid conditions including a physical illness or addiction to alcohol or illegal drugs, which require treatment over long periods.

Page 322

Finding 100

The cost of mental health is far broader than just the expenditure provided by State government departments each year and includes the health and social costs associated with suicide, crime and homelessness. The impact this has on the State health budget is under-stated as less than 40% of Western Australians with a mental illness access services. Those who do, usually see GPs who are subsidised by the Federal Government.

Page 329

Finding 101

The State's strategy to develop a broader range of acute inpatient mental health services closer to where patients live has been delayed by up to three years due to the retention of Royal Perth Hospital as a tertiary hospital and the delay in the construction of Fiona Stanley Hospital.

Page 332

Finding 102

Despite its vibrant economy, Western Australian funding of mental health services lags well behind that of other Australian jurisdictions.

Page 338

Finding 103

As in other major parts of Western Australia's health system, resources are skewed toward acute hospital-based services while other Australian jurisdictions have placed greater emphasis on community-based rehabilitation and accommodation services.

Page 343

Finding 104

Western Australia's current focus on acute in-patient mental health facilities has led to higher costs for the mental health sector and poorer health outcomes for mental health patients who require community residential accommodation (step-down) facilities.

Page 348

Finding 105

The Department of Health has continuing difficulty filling mental health nursing places, especially in regional locations.

Page 351

Finding 106

The Auditor General has highlighted severe shortcomings in the practices of Department of Health's community mental health services, including inconsistent care programs that do not meet the needs of patients.

Page 353

Finding 107

Historically about 5-7% of children with a mental illness were being treated in Western Australia, but that rate has declined to under 1%. The State's mental health services for young people, particularly in regional areas, need a dramatic funding boost. A significant proportion of these funds need to be spent on providing suitable community residential accommodation facilities.

Page 356

Finding 108

The Auditor General has found that the Department of Health is not currently meeting national guidelines such as those contained in the National Mental Health Benchmarking Project (2008) and the Key Performance Indicators for Australian Public Mental Health Services (2005) and needs to do more for patients leaving institutions, especially in the first month, to ensure that they are discouraged from attempting suicide.

Page 359

Finding 109

Despite the plans of the current and past Governments, there is not one secure mental health bed north of metropolitan Perth.

Page 363

Finding 110

The health of prisoners in Western Australia is worse than that of the general public, and the Committee was told that the State's prisons are our largest 'psychiatric hospital'.

Page 363

Finding 111

Western Australia is one of the last jurisdictions in Australia to transfer the responsibility for the health of its prisoners to the Department of Health.

Page 364

Finding 112

Substantial planning work has been completed by departments to improve mental health facilities in Western Australian prisons, but the proposals remain unfunded by the Western Australian Government.

CHAPTER 15 ALCOHOL AND ILLICIT DRUGS

Page 370

Finding 113

Alcohol is the main, and most serious, drug problem in Western Australia.

Page 372

Finding 114

Illicit drug use has been declining in Western Australia since 1988 but cannabis remains the most widely used illicit drug. The problems flowing from the use of illegal drugs is greater in more remote regions containing large numbers of miners and Indigenous people.

Page 377

Finding 115

The initial government actions at limiting alcohol use in Indigenous communities in the Kimberley have shown additional benefits such as a reduction in violence and injuries requiring attention at medical facilities.

CHAPTER 16 DENTAL HEALTH

Page 383

Finding 116

The manual booking process used by the Dental Health Service is a key factor limiting its further improvement.

Page 386

Finding 117

There has been a substantial rise in patients on the metropolitan dental clinic waiting list with a 45% increase over the December 2008 quarter figure.

CHAPTER 17 END OF LIFE CARE: PALLIATIVE AND AGED-CARE SERVICES

Page 396

Finding 118

Providing residential aged-care to Western Australians is costly, but not as expensive to the State as having them receive care in an acute hospital setting.

Page 399

Finding 119

Programs such as Hospital in the Home and Friend in Need - Emergency are excellent examples of low cost ways of providing appropriate non-hospital based care to aged Western Australians.

Page 401

Finding 120

The ageing of the Western Australian population has had a greater impact on regional communities given their isolation from many of the State's health programs which are based in Perth.

Page 403

Finding 121

One of the major impacts on regional communities of the ageing of the Western Australian population is the difficulty communities have in providing and staffing cost-effective aged-care facilities.

Page 407

Finding 122

Every Western Australian has a fundamental right to a palliative approach to their health care. To enable this right to be met, issues regarding the equity, access and affordability of palliative care need to be considered for both current and future populations.

Page 407

Finding 123

The Department of Health's information systems do not capture the complete range of data on the experience of Western Australian's requiring and receiving palliative care.

Page 411

Finding 124

The Western Australian health system will continue to have insufficient public palliative care beds to meet the demand for these services, even at the end of the *Clinical Services Framework 2010-20* planning period in 2021.

Page 417

Finding 125

The use of 'link nurses' has proven beneficial to the end-of-life experience for palliative care patients in aged-care facilities in other jurisdictions.

Page 419

Finding 126

People with a terminal illnesses requiring palliative treatment receive a substantial proportion of their care from friends and family. This results in far less cost to the State's health system than if their treatment was provided in a hospital.

RECOMMENDATIONS

CHAPTER 1 INTRODUCTION

Page 8

Recommendation 1

The Director General of Health's public comments should be restricted to administrative matters and all other issues should be addressed by the Premier, Minister for Health or Minister for Mental Health.

Page 10

Recommendation 2

The Government combine the North Metropolitan Area Health Service and South Metropolitan Area Health Service into one Metropolitan Area Health Service. Administrative savings arising from this could be allocated to services that the Committee feels are currently under-funded, such as community and preventative health care programs.

Along with this centralisation of metropolitan area health services, the Minister should establish local hospital boards.

Page 12

Recommendation 3

The Auditor General report to Parliament on the current efficiency and effectiveness of the Health Corporate Network systems.

Page 14

Recommendation 4

The Department of Health develop a strategy for systematically gaining public feedback from Western Australians on the State's health system and include new mechanisms for providing information to the community on its web site.

Page 15

Recommendation 5

The Government implement the recommendation of the Reid Report to establish community advisory committees or boards to provide feedback to the Department of Health for the:

- proposed Metropolitan Area Health Service;
- WA Country Health Service; and
- Child and Adolescent Health Service.

Page 17

Recommendation 6

The Department of Health should develop a strategic web communication plan by the end of 2010 that includes a separate health portal for Western Australians to more easily access health information of direct use to them. This new portal should include important performance data to assist Western Australians using their health system.

Page 22

Recommendation 7

The Western Australian Government include in each annual health budget an outline of the cost of services to be provided at public private partnership health facilities and a comparison with the cost of these services provided at government-provided facilities.

Page 24

Recommendation 8

The State Government should allocate an additional $10 million in funds in 2010-11 and 2011-12, in addition to any Federal funds, to lower the State's elective surgery wait lists.

Page 30

Recommendation 9

The Government should develop a strategy for managing the impact of inaccurate economic forecasts provided by the Department of Treasury and Finance. This would assist the Department of Health to maintain the State's critical health infrastructure and programs.

Page 33

Recommendation 10

In light of the deteriorating performance of an already under-resourced State health service and the likely rebound in the State's economy, the Government's 3% efficiency dividend should not continue to be applied to the Department of Health.

Page 34

Recommendation 11

The Premier should immediately include the Health Minister as a member of the Expenditure Review Committee.

CHAPTER 4 CLINICAL SERVICES FRAMEWORK 2010-2020

Page 78

Recommendation 12

The Minister for Health provide to Parliament within three months of this report being tabled the number of cardiac surgical procedures carried out at Royal Perth Hospital, Sir Charles Gairdner Hospital, the Mount Hospital and Fremantle Hospital for 2007-08, 2008-09 and 2009-10; and the average annual cost of these procedures for each of the four hospitals.

Page 79

Recommendation 13

The CSF 2010 be amended to ensure that tertiary services are provided according to population needs.

Current population projections indicate a need for tertiary services at the Joondalup Health Campus and the Government should upgrade the Joondalup Health Campus to a tertiary facility by 2020.

Page 83

Recommendation 14

The Department of Health report to Parliament by the end of 2010 on successful strategies used in other jurisdictions that can reduce avoidable admissions to Western Australian hospitals.

CHAPTER 5 HEALTH SERVICES MODELLING

Page 104

Recommendation 15

The Department of Health must use at least the ABS Series A (high-growth) population projections in its demand modelling for its current planning for recurrent and reform-based funding requirements. This will present the Government with a more realistic account of the future operational and financial needs of the State's health system.

Page 104

Recommendation 16

The Auditor General evaluate the veracity of the Department of Health's demand and capacity modelling process, with particular attention given to determining the cost of using a more accurate population projection.

CHAPTER 6 PUBLIC HOSPITAL PROFILES

Page 115

Recommendation 17

The Government maintain Royal Perth Hospital as a facility for treating Level 4 emergency presentations and the provision of secondary-level care for Perth's inner-city population.

Page 115

Recommendation 18

A revised clinical services delineation be undertaken by the Department of Health, using ABS Series A high-growth population data, to determine the appropriate distribution of hospital services when Royal Perth Hospital is maintained as a facility for treating Level 4 emergency presentations and the provision of secondary-level care for Perth's inner-city population.

Page 121

Recommendation 19

Tertiary services currently at Royal Perth Hospital should be distributed between Fiona Stanley Hospital, Joondalup Health Campus and Sir Charles Gairdner Hospital once Fiona Stanley Hospital is operational.

Page 132

Recommendation 20

The final capacity of the Fiona Stanley Hospital should be expanded from its current projections as contained in CSF 2010. The size of the expansion should be determined by a revised clinical services delineation that uses realistic population projections and accounts for the Committee's recommendation to reclassify Royal Perth Hospital to a secondary-level facility.

Page 132

Recommendation 21

The Minister for Health provide to Parliament the full details of the parties with whom he consulted before reversing his position and made the decision to retain the heart and lung transplant unit at Royal Perth Hospital.

Page 132

Recommendation 22

As recommended by the *Clinical Services Framework 2005-15*, the heart and lung transplant unit at Royal Perth Hospital be transferred to Fiona Stanley Hospital.

Page 142

Recommendation 23

The Government expedite the redevelopment of King Edward Memorial Hospital, along with the new children's hospital, on the QEII site. This project should be completed no later than five years after the new children's hospital becomes operational.

Page 151

Recommendation 24

The Government should upgrade the Joondalup Health Campus to a tertiary hospital by 2020.

Page 157

Recommendation 25

All WA Country Health Service Regional Resource Centres be staffed to allow on-site 24-hour coverage by medical practitioners.

Page 158

Recommendation 26

The Government provide the full projected cost of the new Albany Health Campus, including the proportion that will be funded via any partnerships with the private sector or provided by the Royalties for Regions program, in the 2010-11 Health budget, or by the end of 2010.

Page 163

Recommendation 27

To compensate for the chronic shortage of General Practitioners, WA Country Health Service revise its current Standard Operational Procedures to incorporate a consistent policy across all Integrated District Health Services advising on basic treatments that Nurse Practitioners can undertake with the consent of the on-call General Practitioner.

Page 165

Recommendation 28

The Minister for Health Service provide to Parliament by December 2010 an inventory of all outstanding clinical and non-clinical requirements for the State's Regional Resource Centres and Integrated District Health Services.

CHAPTER 7 RAMIFICATIONS OF THE ROYAL PERTH HOSPITAL PROTECTION BILL 2008

Page 173

Recommendation 29

The Auditor General should investigate all of the costs associated with the duplication of services in Perth's tertiary hospitals caused by the retention of Royal Perth Hospital as a tertiary hospital, and report to Parliament by the end of March 2011.

Page 176

Recommendation 30

The Government should maintain Royal Perth Hospital as a secondary-level facility. This will allow planning to continue in a manner that is more appropriate to Perth's population growth patterns, future budgetary pressures and the potential impact of the new national hospital arrangements proposed by the Federal Government.

To that end, the Royal Perth Hospital Protection Bill 2008 should be amended to delete the words "as a tertiary hospital" from section 6.

VOLUME 2

CHAPTER 8 CHILDREN'S HEALTH

Page 183

Recommendation 31

That the Government establish a Department with a Minister with portfolio responsibility for early childhood education and development, family services and childcare.

Page 184

Recommendation 32

To assist in developing a whole of government approach to child health issues, the Government establish a Children's Services Coordination Board consisting of the senior executives of:

- Department of Health;
- Department of Education;
- Commissioner for Children and Young People;
- Department of Planning;
- Department of Communities;
- Department of Child Protection;
- Department of Disability Services;
- Department of Indigenous Affairs;
- Department of the Premier and Cabinet;
- Department of Treasury and Finance;
- Commissioner for Mental Health; and
- Commissioner WA Police.

CHAPTER 9 WOMEN'S AND MEN'S HEALTH

Page 185

Recommendation 33

The Department of Health must develop a State-wide women's health strategy by 1 July 2011.

Page 201

Recommendation 34

The Department of Health provide an estimate in its annual report of the proportion of its budget that is spent on women's health services for the current financial year and the out-years.

Page 204

Recommendation 35

The Government should increase its resources for men's preventative health programs, especially those aimed at men in rural regions of the State.

CHAPTER 10 *BY NOT ACTING, WE ARE KILLING PEOPLE* — PRIMARY & PREVENTATIVE HEALTH PROGRAMS

Page 217

Recommendation 36

The Premier request all Western Australian Senators to support the legislation to establish the new Australian National Preventative Health Agency.

Page 218

Recommendation 37

The Department of Health should publish in its annual report a clear set of key performance indicators, and its performance in meeting them, for the main chronic disease challenges faced by Western Australians.

Page 219

Recommendation 38

The Government must urgently increase the Department of Health's budget for health prevention, promotion and protection programs. It must aim to double the budget for these programs by the end of 2012 from $9.3 million to $19 million, with a further doubling by the end of 2015.

These funds should continue to be listed as separate line items in future health budgets.

Page 220

Recommendation 39

The Department of Health should establish a health research centre, with collaboration from universities, other government departments and the private sector, to ensure that the Department has the most up-to-date data on population epidemiology and the challenges posed by chronic diseases.

This research centre should have the capability to track the long-term savings accruing from the State's investment in preventative health and promotion programs.

Page 221

Recommendation 40

The Minister for Health should obtain Cabinet approval for a 'Health in all Policies' project in Western Australia as part of the State's strategy to contain health costs.

Page 230

Recommendation 41

The Department of Health engages the community by sponsoring a competition for suggestions for new low-cost preventative health programs.

CHAPTER 11 COUNTRY HEALTH

Page 243

Recommendation 42

The WA Country Health Service should prioritise programs to attract nurses, nurse practitioners and Aboriginal health workers to staff its health facilities in the Kimberley.

Page 248

Recommendation 43

The Government should urgently boost the funds available to provide housing in country Western Australia for health staff, especially nurses and medical staff employed by the WA Country Health Service, to assist in the recruitment and retention of these staff.

Page 251

Recommendation 44

The Department of Health include in the WA Country Health Service annual report all of the projects funded, or partially-funded, from the Royalties for Regions program.

Page 251

Recommendation 45

To alleviate some of the major challenges facing the WA Country Health Service, the Government should commit at least 10% of the Royalties for Regions funds (or about $300 million between 2009-13) to health projects in regional and rural areas. This extra funding should be directed towards improving WACHS' physical infrastructure and clinical equipment.

CHAPTER 12 CLOSING THE GAP — INDIGENOUS HEALTH

Page 261

Recommendation 46

In addition to gathering regional data, the Department of Health should establish processes that monitor the health of Indigenous Western Australians in regional areas. Services should be provided based on regional needs, and where appropriate, within a family context.

Page 262

Recommendation 47

The Western Australian Government needs to increase its support for the education of more Indigenous people to work in the health system, either as nurses and doctors, or as allied health workers.

Page 263

Recommendation 48

In its annual report to Parliament, the Department of Health should report the total expenditure on Indigenous health programs in Western Australia broken down by:

(a) State funding.

(b) Federal funding.

This should include data on the number of Indigenous and non-Indigenous staff employed in these programs.

Page 267

Recommendation 49

The Western Australian Government should increase the funding for early childhood programs for Indigenous children, especially in regional areas.

Page 268

Recommendation 50

Consistent with the Reid Report and CSF 2010, the Western Australian Government should provide additional funds to the Department of Health and non-government agencies to make an urgent priority the cutting of Indigenous smoking rates over the next five years to a level closer to that of the general population.

Page 269

Recommendation 51

The Minister for Health fund and develop a smoking reduction plan for Indigenous people by the end of 2010 and provide additional funding to employ people to work in this area throughout the State.

Page 270

Recommendation 52

The Department of Corrective Services and the Department of Health undertake an urgent campaign to lower smoking rates among Indigenous prisoners in Western Australia's prisons and to make the State's prisons smoke-free by the end of 2011.

Page 275

Recommendation 53

The Western Australian Government work with the Federal Government to establish a national office to coordinate the food supply chain to remote communities.

Communities should be encouraged and supported to produce fresh food for their own consumption. Assistance should be provided to help remote communities to purchase and maintain equipment to grow and store fresh produce.

Page 278

Recommendation 54

The Department of Health must organise, prior to discharge, transport home for Indigenous patients attending Regional Resource Centres from remote communities.

The Department should include in its annual report the statistics on transport assistance offered in this way for each WA Country Health Service Regional Resource Centre.

Page 282

Recommendation 55

With 15% of Australia's Indigenous population living in Western Australia and a growing incidence of second-generation Foetal Alcohol Spectrum Disorder, funding should be provided by the Department of Health for Foetal Alcohol Spectrum Disorder programs in regions beyond the Kimberley.

Page 284

Recommendation 56

The Department of Health should ensure that culturally appropriate mental health programs are associated with the development of alcohol management accords and alcohol and drug education programs in Indigenous communities.

Page 285

Recommendation 57

The Government should urgently increase the resources allocated to dealing with sexually transmitted diseases (STDs) and human immunodeficiency virus (HIV), especially in regional areas. In its annual report, the Department of Health should report on new initiatives, including:

- any additional WA Country Health Service funds for education programs on STD and HIV;
- the establishment of additional sexual health clinics in regional areas; and
- programs to encourage companies involved in the mining sector to pay for the assessment and treatment of staff with STDs.

CHAPTER 13 TRAVELLING TO HEALTH- THE ROYAL FLYING DOCTOR SERVICE AND THE ST JOHN AMBULANCE

Page 293

Recommendation 58

The Minister for Health should request the Royal Flying Doctor Service to base the Hawker-800 jets in a large centre in the North West, such as Broome or Port Hedland, as part of the trial of their use in Western Australia.

Page 296

Recommendation 59

The Western Australian Government should cooperate with the Federal Government in recognising paramedics as a professional group by establishing a registration scheme to ensure accountability for their activities, enhance quality standards and support robust clinical governance of their activities.

Page 311

Recommendation 60

The Government require St John Ambulance to offer:

- where clinically appropriate, patients with private health insurance the opportunity to be transported to a private hospital.
- patients with work place injuries the opportunity to be transported to a private hospital.

Page 314

Recommendation 61

The Department of Health (DOH) establish 'Health Related Transport Reference Groups' comprising a representative of DOH, St John Ambulance Service, the Royal Flying Doctor Service and the Department of Transport, for each area health service.

Page 316

Recommendation 62

The roles and resources provided by the Royal Flying Doctor Service and St John Ambulance (Western Australia) need to be incorporated into the next version of the Department of Health's Clinical Services Framework.

Page 316

Recommendation 63

In light of the significant expenditure provided under contract to the Royal Flying Doctor Service and the St John Ambulance by the State Government, the Department of Health should table their annual reports in Parliament with an analysis of their performance against their contracts.

CHAPTER 14 OUT OF SIGHT: OUT OF MIND — UNDERFUNDED MENTAL HEALTH SERVICES

Page 338

Recommendation 64

Given their past under-funding and the high level of unmet need, the State's mental health programs should be isolated from any further cuts flowing from the Government's 3% efficiency dividend.

Page 339

Recommendation 65

The State's mental health strategy should clearly outline a way to further boost the State's rehabilitation and accommodation mental health services in Perth and in regional Western Australia, especially for those services operated by non-government organisations.

Page 343

Recommendation 66

A key thrust of the new Western Australian mental health strategy should be for the rapid development of new community residential accommodation (step-down) facilities in both metropolitan Perth and in regional communities to the north of Perth.

Page 348

Recommendation 67

The Department of Health should give an urgent priority in its regional workforce strategy to employing mental health staff, particularly graduate nurses, and seek ways in which to ensure staff in regional areas are encouraged to stay in those communities.

Page 351

Recommendation 68

Before any of the Department of Health's mental health services are transferred to the Mental Health Commission, the Department needs to introduce a standard approach to providing and evaluating mental health programs that meet the needs of its patients in a transparent fashion.

Page 353

Recommendation 69

Like other child health services in Western Australia, the State's mental health services for young people, particularly in regional areas, need a dramatic funding boost.

Page 356

Recommendation 70

The Department of Health needs to put in place measures to counter the alarmingly high rate of suicides occurring within seven days of discharge from treatment facilities. These measures should follow nationally recognised benchmarks guidelines, such as those contained in the *National Mental Health Benchmarking Project* (2008) and the *Key Performance Indicators for Australian Public Mental Health Services* (2005), which require 90% of patients to be contacted by mental health staff within seven days of leaving a mental health facility.

Page 357

Recommendation 71

The Mental Health Commission should report annually on its evaluation of the success of the State's *Suicide Prevention Strategy 2009-2013.*

Page 362

Recommendation 72

The Government should report to Parliament by the end of 2010 on new and existing strategies aimed at lowering the rate of criminal activity among Indigenous youth.

Page 365

Recommendation 73

The Government should urgently fund existing departmental proposals to upgrade mental health facilities in Western Australian prisons over the next four years.

CHAPTER 16 DENTAL HEALTH

Page 381

Recommendation 74

The School Dental Service should provide dental services for students from Kindergarten to Year 12 in high school.

Page 383

Recommendation 75

The Government should fund the Clinical Information Systems Infrastructure in the School Dental Service business case developed in June 2009 by the Department of Health to transfer the existing card booking system to a computer-based one.

Page 386

Recommendation 76

The Government report by the end of 2010 on strategies it has adopted to reduce the metropolitan dental clinic waiting list and provide an update on current waiting list numbers.

CHAPTER 17 END OF LIFE CARE: PALLIATIVE AND AGED-CARE SERVICES

Page 396

Recommendation 77

The Department of Health should urgently improve the information it provides to Western Australian families on access to non-hospital based residential aged-care.

Page 396

Recommendation 78

As a matter of urgency, the State Government should immediately undertake negotiations with the Federal Government aimed at overcoming the boycott by providers in building new aged-care facilities in Western Australia.

Page 396

Recommendation 79

In its annual report to Parliament, the Department of Health should include data on the number of patients who are admitted to the State's tertiary and secondary hospitals when they could receive more appropriate care in a residential aged-care setting.

Page 396

Recommendation 80

The State Government should ensure that there is ongoing education and support for aged-care staff employed in residential facilities to assist them to provide a high level of care to their residents and thereby prevent unnecessary hospital admissions.

Page 398

Recommendation 81

The Department of Health should transfer, if appropriate, the management of Hospital in the Home (HiTH) patients from the existing tertiary hospitals to secondary hospitals to ensure that patients are being serviced closer to their homes.

Page 399

Recommendation 82

Programs such as Hospital in the Home and Friend in Need - Emergency need to be isolated from any further cuts to the Western Australian health Budget.

Page 400

Recommendation 83

In its annual report to Parliament, the Department of Health should include data on the number of beds in the State's tertiary and secondary hospitals freed up by patients participating in the Home and Friend in Need - Emergency programs.

Page 401

Recommendation 84

The Government should give priority to further Royalties to Regions funding to supplement existing State and Federal funds to boost effective regional health care programs, such as the Home and Community Care program.

Page 404

Recommendation 85

As an urgent priority the Government should provide Royalties for Regions funds to regional communities to assist them develop residential aged-care and dementia facilities.

Page 408

Recommendation 86

The Department of Health's information systems should be improved to allow the better collection of data on the experience of people requiring and receiving palliative care in the State's public and private health system.

Page 411

Recommendation 87

The Government should increase the funding at the four general hospitals in the metropolitan area to provide at least an additional 35 palliative care beds.

Page 417

Recommendation 88

The State Government should allocate additional funds to providers, such as Silver Chain, to allow the provision of comprehensive palliative care services to people living in aged-care facilities.

Page 419

Recommendation 89

The Government develop a specialised strategy to address the needs of carers who are friends and family of those receiving palliative care, which particularly addresses the needs of special groups, such as younger and older carers, those from Indigenous and Culturally and Linguistically Diverse backgrounds, and those living in rural areas.

Page 419

Recommendation 90

The Department of Health coordinate palliative care service funding and service provision across all levels of government (Federal, State and local) to ensure the equitable social and geographical distribution of services in Western Australia.

Page 419

Recommendation 91

The Government should develop a strategy to meet the increased future demands for cancer services and palliative care, and incorporate it into the next version of the Clinical Services Framework.

MINISTERIAL RESPONSE

In accordance with Standing Order 277(1) of the Standing Orders of the Legislative Assembly, the Education and Health Standing Committee directs that the Premier and Ministers for Health, Indigenous Affairs, Mental Health and the Treasurer report to the Assembly as to the action, if any, proposed to be taken by the Government with respect to the recommendations of the Committee.

CHAPTER 1 INTRODUCTION

1.1 Background

This Report represents nearly 18 months of work by the Education and Health Standing Committee in gathering evidence for its *Review of WA's Current and Future Hospital and Community Health Care Services*. The Committee has already tabled an interim report, *Invest Now or Pay Later*, in March 2010 on the current state of Western Australia's community child health services.

This Inquiry followed the Committee's *Healthy Child — Healthy State: Improving Western Australia's Child Health Screening Programs* report tabled in May 2009. That report found that approximately 35,000 pre-primary and 119,000 primary school students were screened by hard working and committed health and education staff across the State who have regularly suggested ways in which the system could be improved.

This current Inquiry has found little that has improved in the past 12 months since the tabling of the *Healthy Child — Healthy State* report, and many indicators, such as waiting times, have got substantially worse. The data gathered during this Inquiry on child health issues was so dramatic that the Committee resolved to publish it as an interim report *Invest Now or Pay Later: Securing the Future of Western Australia's Children* in March 2010. This interim report included moving evidence from parents on the broader social impacts of children requiring treatment in the under-resourced metropolitan Child Development Service.

1.2 Inquiry conduct

This Inquiry's Terms of Reference were announced to the Legislative Assembly on 4 December 2008 and were placed on the Committee's web site following the Speaker's Statement. Advertisements inviting submissions to the Inquiry appeared in *The West Australian* on 27 June 2009 and in *The Countryman* on 2 July 2009. Submissions were also sought from a number of State Government agencies, as well as other relevant stakeholders. In response, the Committee received 50 submissions which are listed in Appendix One. More than 60 public hearings were conducted during which the Committee heard evidence from over 120 witnesses who are listed in Appendix Two.

The Committee gathered evidence during 2009 from a wide range of stakeholders in the four regional centres of Merredin, Kalgoorlie, Katanning and Albany, as well as from witnesses in Perth. The regional hearings allowed the Committee to take additional evidence from witnesses for its *Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia*.

The Committee was briefed on initiatives in four other jurisdictions that impacted on both this and the *Alcohol and Illicit Drug Inquiry*. Senior public servants from these jurisdictions briefed the Committee on issues including the establishment by the Victorian Government of a Minister for

Children and Early Childhood Development[2] and the efforts by the Tasmanian and NSW Governments to remodel their hospital services.

Members of the Committee attended the Australian Research Alliance for Children and Youth (ARACY) National Conference in Melbourne between 2-4 September 2009 and heard of research that confirmed that delayed interventions for a child's health actually cost governments more in the long run. The Committee also attended the national conference of the Australian Healthcare and Hospitals Association (AHHA) in Hobart between 6-9 October 2009 where it heard critical presentations from the Federal Health Minister, Hon Nicola Roxon, and international speakers on efforts to reform hospital systems. The people in other jurisdictions who briefed the Committee are listed in Appendix Three.

1.3 Background to Inquiry

The importance of universal access to health care is widely recognised. The Australian Institute of Health and Welfare's (AIHW) snapshot in 2008 of Australia's health articulated this point:

> *Access to health care and advice is regarded as essential to quality of life, so the size, distribution and effectiveness of the health workforce is the subject of much scrutiny by governments, the media and the community*.[3]

Recent scrutiny of Australian public health care has revealed concern over the issue of access and affordability. The recently released report of the National Hospital and Health Reform Commission (NHHRC), while acknowledging the 'many strengths' within the Australian system, nonetheless observed that:

1. Inconsistent and unequal access to appropriate services and health outcomes is causing many Australians unnecessary suffering; and

2. The current distribution of the health workforce across Australia does not match the population distribution.[4]

In response, the NHHRC listed as the first of three main reform goals, "Tackling major access and equity issues that affect health outcomes for people now."[5] The Federal Government is now

---

2 See www.education.vic.gov.au/about/ministers/ministerchildren.htm.

3 Australian Institute of Health and Welfare, 'Australia's Health 2008', 24 June 2008. Available at: www.aihw.gov.au/publications/aus/ah08/ah08.pdf, p431. Accessed on 26 March 2010.

4 National Health and Hospitals Reform Commission, 'A healthier future for all Australians - Final Report', June 2009. Available at: www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/CHAPTER%201.pdf, p52. Accessed on 26 March 2010.

5 National Health and Hospitals Reform Commission, 'A healthier future for all Australians - Final Report June 2009', June 2009. Available at: www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/CHAPTER%201.pdf, p3. Accessed on 26 March 2010.

discussing with all states and territories how it intends implementing a new hospital plan that addresses the relevant recommendations made by the NHHRC. In light of these general observations about health administration nationally, this Inquiry by the Education and Health Standing Committee investigates whether Western Australia's hospital and community health care services are distributed in a manner that appropriately serves the current needs of the State's population.

Pivotal to this task is a study of several major documents which, collectively, have a major bearing on future health planning in Western Australia:

- *A Healthy Future for Western Australians, Report of the Health Reform Committee* (known as the *Reid Report*);
- *WA Health Clinical Services Framework 2005-2015* (CSF 2005); and
- *WA Health Clinical Services Framework 2010-2020* (CSF 2010).

The Reid Report was a comprehensive undertaking that identified cost pressures and service deficiencies within Western Australia's health system that were similar to those observed interstate (and internationally). Consequently, the Report called for a "fundamental reprioritisation of the public health system"[6] by way of a decade-long major reform and capital investment program.

Eighteen months later, after health staff, expert clinicians and community stakeholders engaged in an extensive consultation process based on the recommendations made in the Reid Report, the *Clinical Services Framework 2005-2015* (CSF 2005) emerged as the 'foundation' guide for the reform program to be undertaken by the Department of Health (DOH). An updated framework, *Clinical Services Framework 2010-20*, was published on 3 December 2009. This document has revised aspects of the health reform program to take into account policy changes announced after the current Government came to power in 2008, most notably the decision to retain Royal Perth Hospital as a tertiary hospital.

A common theme throughout the Reid Report and the two Clinical Services Frameworks was that significant change was required and that future planning of health services needed to "reflect where the State's population growth is occurring and its changing demographics."[7] The Reid Report and the CSF represent the cornerstones of a proposed major reconfiguration of the State's health system designed to improve access to services. Hence the Committee's interest, as stated in its terms of reference, in the level of compliance to these documents.

While the Education and Health Standing Committee focussed considerable resources on gathering evidence on the State's hospital system it also collected substantial data and heard

---

6 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

7 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p41.

evidence from numerous witnesses on the State's non-hospital health systems. The data it has collected and the recommendations it has made on the State's non-hospital services are contained in the second volume of this Report.

1.4 Federal changes to the health system

At the time the Committee was finalising this report the proposal from the Federal Government to fund 60% of the national hospital system and 100% of parts of the health system was still being debated by the Council of Australian Governments (COAG).[8] The early focus of the Prime Minister's comments on the proposals has been around the management of the hospital system. This emphasis has created concern in the community health sector and a response that "Globally, the centre of gravity of health care is clearly shifting from hospital-based care with occasional **outreach** only at the convenience of administrators and clinicians, to community-centred care with **in-reach** to hospitals only as necessary."[9]

In discussing the emerging new national agreement, Professor Ian Hickie said:

> *we need to end up with a national health plan, not just a national hospital plan and it seems the solution at the moment is to keep throwing more money at Emergency Departments and elective surgery, when the big areas - and they're on page 92 of the Prime Minister's most recent report - mental health, dental health, prevention, Alcohol and Drug Services,… E-Health and information technology, are all put aside.*[10]

There has been no final decision agreed to at COAG by all state and territories. While Western Australia has not agreed with the proposed national plan, the NSW Premier has already signed with the Prime Minister an inter-governmental agreement on 28 April 2010 "rubber-stamping Canberra's takeover of the state's [NSW] hospital funding."[11] Therefore, recommendations in this Report have been developed assuming the current State Government control of Western Australia's hospitals and community health care systems will continue into the foreseeable future.

---

8 Mr David Penington, 'Prime Minister Rudd's plan for reforming Australian public hospitals', 9 March 2010. Available at: www.mja.com.au/public/rop/penington/pen10243_fm.html. Accessed on 23 March 2010.

9 Assoc Professor Alan Rosen, 'Open letter to the PM, re health reform (part 1)', 31 March 2010. Available at: http://blogs.crikey.com.au/croakey/2010/03/31/open-letter-to-the-pm-re-health-reform-part-1/. Accessed on 1 April 2010.

10 ABC 7.30 Report, 'Ian Hicke and Paul Gross discuss COAG', 19 April 2010. Available at: www.abc.net.au/7.30/content/2010/s2877060.htm. Accessed on 20 April 2010.

11 Mr Miles Godfrey, 'Hospital money starting to flow: Rudd', 28 April 2010. Available at: http://news.smh.com.au/breaking-news-national/hospital-money-starting-to-flow-rudd-20100428-trz4.html. Accessed on 30 April 2010.

1.5 Systemic problems within the State's health system

> *What is clear is that incremental reform is no longer the pathway to a financially sustainable vision for Western Australia. A fundamental reprioritisation of the public health system is needed….*[12]

In its recent report card on the nation's hospitals, the Australian Medical Association argued that the Western Australian hospital system "continues to decline despite the State Government's attempt to convince the public otherwise."[13] The Australian Institute of Health and Welfare made similar comments in a 2009 report which found that Western Australians face some of the longest waiting times in the country to be treated in hospital Emergency Departments.[14] While Volume One of this Report lends support to these general assessments, Volume Two further argues that critical deficiencies are evident in most parts of the health system. Contributing to this parlous state of affairs are systemic flaws within the Department of Health and the Department of Treasury and Finance which are now discussed.

The Committee finds that the State's health system is 'destined to fail' because of the following:

- **Flaws in the management of the Department of Health**

(i) too many other responsibilities for the Health Minister.

(ii) revolving door for Directors General of Health.

(iii) current health structure.

(iv) who makes the decisions that matter?

(v) substandard IT systems.

- **Flaws in communication with the public**

(i) no formal process for public feedback on health services.

(ii) poor communication with the public.

---

12 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

13 Australian Medical Association, 'Public Hospital Report Card 2009', 14 October 2009. Available at: www.ama.com.au/system/files/node/5030/Public+Hospital+Report+Card+2009.pdf. Accessed on 23 March 2010.

14 Mr Andrew Tillett, 'Patients in WA face longest wait at hospital', *The West Australian*, 10 June 2009, p13.

- **Flaws in the funding of the State's health system**

(i) no real growth for the health budget.

(ii) higher future health costs due to using public private partnerships.

(iii) impact of funding for elective surgery.

(iv) inaccurate budget forecasts by the Department of Treasury and Finance.

(v) impact of the 3% efficiency dividend.

(vi) no representation for the health portfolio on the Expenditure Review Committee.

(a) Flaws in the management of the Department of Health

(i) Too many other responsibilities for Health Minister

The current Health Minister, Hon Dr Kim Hames, has a heavy load of portfolio responsibilities, as did his predecessor. Senior members of the current Government criticised the previous Health Minister for his additional responsibilities as Attorney General and Minister for Electoral Affairs.[15] When in Opposition, Mr Troy Buswell, MLA, called Hon Jim McGinty "the State's part-time Minister for Health, who … is distracted by his attending to matters other than those involving his portfolios."[16]

The current Health Minister is also the Deputy Premier and is responsible for the Indigenous Affairs portfolio. This latter policy area contains probably the greatest challenge to any government: trying to bridge a life expectancy gap between the Indigenous and non-Indigenous population that the United Nations recently found to be the worst in the world. The projected total cost of expenses for Western Australia's health budget for 2009-10 is $5.1 billion. This is greater than the total general government expenses of Tasmania ($4.3 billion)[17], the Northern Territory ($4.0 billion)[18] and the ACT ($3.6 billion).[19]

---

15 These roles required him to report to Parliament on the Health Department; Attorney General's Department; Commissioner for Equal Opportunity; Corruption and Crime Commission; Parliamentary Inspector of the Corruption and Crime Commission; Law Reform Commission of Western Australia; Office of the Director of Public Prosecutions; Commissioner for Children and Young People; Office of the Information Commissioner; and the Western Australian Electoral Commission.

16 Mr Troy Buswell, MLA, Shadow Treasurer, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 2 April 2008, p1684.

17 Parliament of Tasmania, 'Budget Paper No 1', 11 June 2009. Available at: www.budget.tas.gov.au/media/pdf/publications/2009-10_BP1.pdf, p1.3. Accessed on 26 March 2010.

18 Northern Territory Government, 'Budget Paper No.2 Fiscal and Economic Outlook', www.budget.nt.gov.au/bp2.shtml. Available at: www.budget.nt.gov.au/bp2.shtml, p21. Accessed on 26 March 2010.

In March 2010, the Health Minister twice had to correct earlier information that he had given Parliament about the Health portfolio, and said in regard to departmental advice "What happens is that I get a question on notice from a member, I read it and I assume the answer is correct, because I have no way of knowing any different".[20]

The Government has appointed a separate Minster for Mental Health, and Hon Terry Waldron is Minister Assisting the Health Minister. Minister Waldron's main focus has been on Indigenous health issues, particularly the alcohol programs in the Kimberley. Given the size and range of responsibilities in the health portfolio, the Government should consider alternative arrangements, such as a Minister Assisting the Health Minister having responsibility for the Department's capital works program, or a Minister Assisting for specific programs, such as cancer (as does NSW).[21]

Finding 1

Given the challenges of health, future Ministers should have this portfolio as their only responsibility.

(ii) Revolving door for Directors General of Health- the 'poisoned chalice'

Mr Kim Snowball, the Acting Director General of Health, is the fifth person since the release of the Reid Report in 2004 to fill the State's most senior health role, overseeing the 37,000 employees of the Department of Health. This high turn-over of departmental heads can not be conducive to ensuring that the changes recommended in the Reid Report and the *Clinical Services Framework 2010-2020* are implemented. The pressures of filling this role dealing with the media to discuss problems with the State's health system, such as the death of Mr Kieran Watmore in the Albany Hospital.[22] All comments on the Federal health portfolio are made by either the Health Minister or the Prime Minister. In a similar fashion, most media comments in other jurisdictions are made by the relevant Health Minister, not the public servant leading the department. In Western Australia, almost no media comments are made by Directors General of the State's other departments, while in health it seems to be the standard procedure for the Director General to appear to explain shortcomings in the health system.

---

19 Australian Capital Territory Government, 'Budget Paper 3: Budget Overview', 5 May 2009. Available at: www.treasury.act.gov.au/budget/budget_2009/files/paper3/04finpro.pdf, p25. Accessed on 26 March 2010.

20 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 17 March 2010, p780 and 18 March 2010, p908. The Minister also provided an earlier correction, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 March 2010, p468.

21 Government of NSW, 'Ministers (by Seniority)', nd. Available at: www.parliament.nsw.gov.au/prod/parlment/members.nsf/V3ListCurrentMinisters. Accessed on Accessed on 26 March 2010.

22 ABC News, 'Coroner's findings into Albany hospital death', 30 September 2009. Available at: www.abc.net.au/news/stories/2009/09/30/2701158.htm. Accessed on 12 January 2010.

Dr Flett, the former Director General of Health, referred to the role as a 'poisoned chalice', despite the position being the highest-paid public service position in Australia. In a period when the State is attempting unprecedented health reform Dr Flett conceded that:

> *the biggest challenge that I found was the balance between managing the health, which was fine, and managing the politics. That combination is the challenge.*[23]

A key argument of this Report is that the political processes external to DOH that Dr Flett referred to (such as the decision to retain Royal Perth Hospital as a tertiary facility) impede the optimal distribution of health services in Western Australia to meet population needs.

Finding 2

Five different individuals have held the position of Western Australian Director General of Health in the past decade. The high turnover rate has hindered the efficient administration of public health in this State during a period of significant reform.

The recent extraordinary situation of the then-Treasurer publicly rebuking the former Director General of Health, Dr Flett, for giving honest evidence to a Parliamentary Committee is not in the interest of public administration in Western Australia, or in encouraging suitable people to lead the State's largest and most important department. The Committee was disappointed that neither the Premier nor the Minister for Health was able to convince Dr Flett to remain in his position for the remainder of his five-year term to see through the changes he had commenced.[24]

Recommendation 1

The Director General of Health's public comments should be restricted to administrative matters and all other issues should be addressed by the Premier, Minister for Health or Minister for Mental Health.

(iii) Current health structure

The Western Australian health system is made up of four area health services:

- North Metropolitan Area Health Service (NMAHS);
- South Metropolitan Area Health Service (SMAHS);

[23] ABC Stateline, 'Running the WA Health Service…is it Mission Impossible?', 12 February 2010. Available at: www.abc.net.au/news/video/2010/02/12/2820247.htm. Accessed on 26 March 2010.

[24] Mr Anthony Deceglie, 'Health boss reveals why he quit', *The Sunday Times*, 20 December 2009, p10.

- WA Country Health Service (WACHS); and
- Child and Adolescent Health Service (CAHS).

Table 1.1 shows the population covered by the NMAHS, SMAHS and WACHS. This structure has been distorted by the allocation of the Royal Perth Hospital to the SMAHS in 2006 in preparation for many of its services and staff to transfer to the new Fiona Stanley Hospital in 2011 (as outlined in CSF 2005). Under the current Government RPH will stay in the SMAHS as a second tertiary hospital, but will also offer its services to residents in the northern suburbs of Perth in lieu of a new tertiary hospital at Joondalup (as outlined in the CSF 2005).[25]

The decision to retain RPH as a tertiary hospital and place it in the SMAHS is a major departure from the Reid Report's recommendation to have one major tertiary facility in both northern and southern Perth. The Committee does not believe a major tertiary facility will successfully offer its services in one area health service region while being managed from another. Such an arrangement could support an initiative to merge both the SMAHS and NMAHS into one Metropolitan Area Health Service. Some area health services in jurisdictions such as NSW offer services to a population about the size of Perth.

Table 1.1- Population growth in Western Australia's area health services, 2003-07

Health Service	2003	2004	2005	2006	2007
NMAHS	801,298	814,979	826,268	851,321	871,666 (41%)
SMAHS	701,296	716,633	729,105	742,839	760,580 (36%)
WACHS	449,644	450,592	454,740	464,885	473,873 (22%)
TOTAL	**1,952,238**	**1,982,204**	**2,010,113**	**2,059,045**	**2,106,119**

DOH gave evidence that it had not undertaken any modelling or planning as to how the State 's hospitals might be grouped into Local Hospital Networks under the Federal Government's plans being considered by COAG. It has also not undertaken any modelling or planning as to whether there are efficiencies to be gained by altering the current area health service arrangements in Western Australia, such as combining the NMAHS and SMAHS into one service.[26]

The CAHS and PathWest Laboratory Medicine WA already offer a State-wide service. There are also a number of programs allocated to the NMAHS that offer State-wide services:

- Women's and Newborn Health Service;

---

25 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, p4.

26 Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p1.

- Community Midwifery Service — located in Public Health & Ambulatory Care;
- Tuberculosis Service and Hansen's Disease Service — located in Public Health & Ambulatory Care;
- WoundsWest — located in Public Health & Ambulatory Care;
- Aboriginal Healing Program and African Wellness Program — located in Public Health & Ambulatory Care; and
- Dental Health Services — located in Public Health & Ambulatory Care.

Finding 3

The geographical basis to the current area health service model, as recommended in the Reid Report, has been undermined with the retention of Royal Perth Hospital within the South Metropolitan Area Health Service.

The Department of Health has not undertaken any modelling or planning as to how the State's hospitals might be grouped into alternative area health services or 'local hospital networks'.

Recommendation 2

The Government combine the North Metropolitan Area Health Service and South Metropolitan Area Health Service into one Metropolitan Area Health Service. Administrative savings arising from this could be allocated to services that the Committee feels are currently under-funded, such as community and preventative health care programs.

Along with this centralisation of metropolitan area health services, the Minister should establish local hospital boards.

(iv) Who makes the decisions that matter?

There is a wide-spread perception in the health sector that clinicians make key decisions about the direction of the State's health system, and that they make them in their own, and not the public's, interest.

For example, Commissioner Garling noted in his report on acute care services in NSW public hospitals:

> *During the course of this inquiry, I have identified one impediment to good, safe care which infects the whole public hospital system. I liken it to the Great Schism of 1054. It is*

> *the breakdown of good working relations between clinicians and management which is very detrimental to patients. It is alienating the most skilled in the medical workforce from service in the public system.*[27]

In terms of Western Australia, ex-Director General of Health Professor Daube told the Committee "The reality of the system is that doctors are enormously powerful."[28] Putting it another way, Professor D'Arcy Holman said that:

> *The reactive* [hospital] *health services will always command the resources, the attention and the spotlight to the detriment of the need for the more proactive* [community health] *side.*[29]

In a paper arguing for more public input into the State's health system from Western Australians, Professor Gavin Mooney claims:

> *Currently the WA health service is provider driven; it is largely the values of clinicians that determine how resources are spent. It is with the clinicians that the power over resource allocation and deployment currently lies. Since that is the case, it is not at all surprising even if worrying that the cost of the health care sector continues to escalate in what is an unsustainable way. And that is before all the extra planned beds are opened and the running costs of these fall on the system.*[30]

This question of power relations within the Western Australian health system is critical when considering key policy decisions such as the retention of RPH as a tertiary facility. This decision is discussed in greater detail in Chapters 4, 6 and 7, as are the far-reaching and costly impacts it will have on the metropolitan health system.

Finding 4

The Department of Health has not provided details of the consultation process that was used, and the participants involved, to determine what services would be retained at Royal Perth Hospital, as outlined in the *Clinical Services Framework 2010-20*.

---

27 Cited in National Health and Hospitals Reform Commission, 'A healthier future for all Australians - Final Report', June 2009. Available at: www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/1AFDEAF1FB76A1D8CA257600000B5BE2/$File/CHAPTER%201.pdf, p52. Accessed on 26 March 2010.

28 Professor Mike Daube, Professor of Health Policy, Public Health Advocacy Institute of Western Australia, *Transcript of Evidence*, 14 October 2009, p5.

29 Professor D'Arcy Holman, Chair in Public Health, University of Western Australia, *Transcript of Evidence*, 26 August 2009, p3.

30 Professor Gavin Mooney, 'People, Power and Politics in the WA Health Service', nd. Available at: http://wapolicyforum.org.au/files/papers/WAPF_WA_Health_Service.pdf. Accessed on 29 March 2010.

(v) Substandard Information Technology systems

The Committee is aware that DOH is struggling in many areas of its Information Technology systems. This Report highlights flaws with the Department's web site and in Chapter 16 focuses on the lack of a computer-based system at the School Dental Service to make bookings for about 250,000 dental appointments per annum. The Committee was told by the then-Director General that 11 of the Reid Report's reform projects were delayed beyond the original HRIT workplan, mostly due to IT delays.[31]

One of the most serious IT issues seems to be problems with the financial system used by the Health Corporate Network (HCN) to pay Departmental staff. The Committee heard that the HCN was established to support the hospitals by replacing each of their own human resource divisions overseeing the wages and salaries of hospital staff. The Australian Medical Association told the Committee that the HCN "has been an unmitigated disaster" and:

> *It has been going on now for years and years and years, and it is way past the time when you can say it is just teething problems—because up to a certain point clearly such a big change was going to have teething problems. We have situation now where—this has been highlighted at my hospital just in this past week or so—junior doctors have literally just not been paid. They have been in the system for a long time—years—and they have got their records there, and they just have not been paid. Some of them do not know about it until their bank is calling them to tell them they are overdrawn and so on.*[32]

Finding 5

The Department of Health, through the Health Corporate Network, has difficulties in paying its staff in an efficient and timely manner.

Recommendation 3

The Auditor General report to Parliament on the current efficiency and effectiveness of the Health Corporate Network systems.

---

31 Submission No. 8 from Department of Health, 25 June 2009, p1.

32 Professor Gary Geelhoed, President, Australian Medical Association (WA), *Transcript of Evidence*, 25 August 2009, p5.

(b) Flaws in communication with the public

(i) No formal process for public feedback on health services

The Gallop Government's first Health Minister, Hon Bob Kucera, abolished local health boards. There is now no formal or systematic mechanism for the Department of Health to gain feedback from key stakeholders and the public on the operation of the health system, other than for them to go to the media with complaints. Some public comment on the State's health system is provided by the Health Consumers Council[33], but this does not make up for the loss of the formal provision of feedback following the demise of the health boards.

The Reid Report specifically stated (in Recommendation 67) that "Community advisory committees should be established in the metropolitan and South West Area Health Services to enable local communities to contribute to decisions about service priorities and plans."[34] The Department told the Committee that this recommendation had been completed but the Committee can find no evidence on the Department's web site of such committees.[35]

The WA Country Health Service (WACHS) Community and Consumer Engagement approach is centred on 24 District Health Advisory Councils (DHACs) located around the State.[36] The Committee heard that in some places the DHACs are not working as planned, and have created community disquiet when advice they have offered is ignored by WACHS. For example, the Shire President of Merredin said:

> *I know the members of the Local Health Advisory Group* [LHAG] *are feeling like there is very little purpose in sitting. The District Health Advisory Committee, which two of the CEOs from surrounding shires sit on it with other committee members, feel like they are just about a waste of time—the meetings and the input they can have—and they expressed that again at the zone meeting a week or so ago.*
>
> *Basically they* [the LHAG] *are there to rubber-stamp what is happening. The frustration, especially of a couple of the CEOs from around us that are putting a heck of a lot of time in, is they are there basically to rubber-stamp. If they raise issues that they* [WACHS] *are not in agreement with, then it is brushed over.*[37]

---

33 Health Consumers' Council, 'About Us', August 2007. Available at: www.hconc.org.au/. Accessed on date 26 March 2010.

34 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p98.

35 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, Attachment A, p6.

36 WA Country Health Service, 'Community and Consumer Engagement', 2006. Available at: www.wacountry.health.wa.gov.au/default.asp?documentid=540. Accessed on 26 March 2010.

37 Councillor Ken Hooper, Shire President, Shire of Merredin, *Transcript of Evidence*, 7 September 2009, p6.

Another participant in the Wheatbelt DHAC identified the problem as a lack of resources and purpose:

> *The difficulty is that they* [District Health Advisory Council] *have not been given a purpose; they have not been given a budget; they have not been given a resource. Consequently, they do not know what they are doing, and sometimes the staff do not know what they are doing either.*[38]

It is difficult for the Committee to determine the effectiveness of the LHAG and DHAC structure, as the WACHS material about these groups on its web site was last updated in 2006. However, the dissatisfaction with the current structure needs to be borne in mind when any new local management structure is put in place by the State and Federal governments under any COAG agreement.

A key plank of Federal proposals is to have local health networks run by boards which include representatives of the public and health professionals, to provide input into the running of the State's health system. In discussions on the Federal plans, the Western Australian Premier suggested that if the plan went ahead there might be four hospital boards in the State, two for Perth and two for country Western Australia.[39]

Finding 6

There is no formal mechanism for the Department of Health to gain feedback from the Western Australian public on issues to do with the operation of the State's health system.

Recommendation 4

The Department of Health develop a strategy for systematically gaining public feedback from Western Australians on the State's health system and include new mechanisms for providing information to the community on its web site.

38 Mr Frank Ludovico, Chief Executive Officer, Shire of Merredin, *Transcript of Evidence*, 7 September 2009, p6.

39 Mr Robert Taylor, 'Rudd in hospital plan hard sell to Barnett', *The West Australian*, 25 March 2010, p9.

Recommendation 5

The Government implement the recommendation of the Reid Report to establish community advisory committees or boards to provide feedback to the Department of Health for the:

- proposed Metropolitan Area Health Service;
- WA Country Health Service; and
- Child and Adolescent Health Service.

(ii) Poor communication with the public

The Committee's *Healthy Child — Healthy State* report tabled in May 2009 recommended that the Department of Health make improvements to its web site to make it more effective for the public to find relevant information.[40] The Government supported this recommendation. A year later this critical form of official communication with the public remains deficient.
For example:

- the web site has a large section on the Health Reform Implementation Steering Committee (HRISC) which the Committee heard from the Director General has not met for over 18 months;[41]
- the Dental Health Services section does not seem to have been updated since February 2004;[42]
- the DOH annual reports for 2008-09 were posted on the web site in late 2009 with incorrect links;[43]
- many web pages on the site have no date for when they were last updated (eg WA Mental Health);[44]
- previous quarterly performance reports have been removed from the web site, only the current one has been retained;[45] and

40 Education and Health Standing Committee, 2009, *Healthy Child - Healthy State: Improving Western Australia's Child Health Screening Programs*, Parliament of Western Australia, Perth, p3.

41 See www.health.wa.gov.au/hrit/home/index.cfm, accessed 22 January 2010.

42 See www.health.wa.gov.au/services/detail.cfm?Unit_ID=39, accessed 22 January 2010.

43 See www.health.wa.gov.au/publications/annual_reports_2009.cfm, accessed 12 January 2010.

44 See www.health.wa.gov.au/mentalhealth/home/, accessed 12 January 2010.

45 See www.health.wa.gov.au/publications/subject_index/p/performance.cfm, accessed 12 January 2010.

- the web site makes no mention of important departmental events, such as the resignation of the then-Director General, Dr Peter Flett, nor any notice of the appointment of the Acting Director General, Mr Kim Snowball.[46]

It seems that there is little direct communication between the Department and people who are either patients or are employed in the health system. Much of the communication on health issues is between the Director General, the Minister for Health and the Opposition Spokesperson on health via the media. Other jurisdictions place a greater emphasis on ensuring an up-to-date and easy to navigate health web site that includes information on the currency of data.[47] A well-functioning web site would improve the transparency with which the Department operates as well as provide the public with timely and important health information.

The Committee acknowledges some useful initiatives developed by DOH over the past year to improve the information flowing to the public. However, while the web site does contain some useful information, it is difficult to locate. For example, the daily activity of Emergency Departments is added at 9.30.a.m. every weekday (excluding public holidays) and gives the public an indication of specific ED waiting times.[48] However, this material is lost among the Department's large amount of administrative data. The Committee believes that DOH should consider developing a strategic web communication plan that includes a separate portal for Western Australians to access health information of direct use to them. This could be similar to the Federal approach in establishing the *yourHealth* web site to communicate more directly to Australians about possible health reform initiatives.[49]

In the United Kingdom a web site provides the British public with a great deal of information on how the health system is operating, including recent statistics from about 160 hospitals and health facilities run by the NHS primary care trusts. Data on the site includes:

- inpatient waiting lists, including the number of patients and their waiting times;
- outpatient waiting lists;
- monthly diagnostic waiting times and activity;
- waiting times of patients with suspected cancer and those subsequently diagnosed with cancer;
- patient progress under the '18 Weeks Referral to Treatment' program;
- the total number of attendances for all accident and emergency types; and

46 See www.health.wa.gov.au/press/, accessed 12 January 2010.

47 See Victoria- www.health.vic.gov.au/doh/ and Queensland- www.health.qld.gov.au/ as two exemplars, accessed 23 March 2010.

48 See www.health.wa.gov.au/emergencyactivity/daily/attendances.cfm, accessed 12 January 2010.

49 See www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/home, accessed 12 January 2010.

- information on cancelled operations.[50]

A new health portal for Western Australian patients could include such data, as well as:

- an updated version of the existing consumer health services directory with easier to find directions (with a map interface) to the nearest hospital, child care centre or GP;
- an updated version of the existing daily activity of ED services;
- Australian Early Development Index information for children by location;
- data from DOH's Community Development Information System on waiting lists for community child care services;
- information on how to make complaints about the State's health system;
- links to other health service providers such as private hospitals, the Royal Flying Doctor Service and St Johns Ambulance; and
- the latest updates on critical health information, such as influenza epidemics.

Finding 7

Compared to other jurisdictions, the Western Australian Department of Health's web site does not provide easy access to relevant and up-to-date health information.

Recommendation 6

The Department of Health should develop a strategic web communication plan by the end of 2010 that includes a separate health portal for Western Australians to more easily access health information of direct use to them. This new portal should include important performance data to assist Western Australians using their health system.

50 Department of Health, United Kingdom, 'Healthcare Statistics, Guidance and Performance Indicators', 2010. Available at: www.dh.gov.uk/en/Publicationsandstatistics/Statistics/Performancedataandstatistics/index.htm. Accessed on 12 April 2010.

(c) Flaws in the funding of the State's health system

(i) No real growth for the health budget

Governments in Australia under pressure over health issues have regularly created the impression that the health budget is growing so rapidly that it will consume the whole of a jurisdiction's budget.[51] For example, the Federal Treasurer claimed that health budgets would consume "the totality of state budgets sometime after 2035"[52] if no health reform was implemented. In a similar fashion, the State's then-Treasurer told Parliament:

> *Last year the rate of expense growth in the health department was over 12%; the year before, the rate of expense growth in the health department was over 12%. If we do not rein in the rate of growth of spending in the health department, in six or seven years we will have to double every state tax just to keep the health department in cash.* [53]

However, the situation is entirely different to this scenario painted by both the Federal and State Treasurers. While Western Australia has had the highest population growth of all states, the 2009-10 Budget papers show that DOH's expenses grew only 9.6% from the previous year (and its government appropriation by 8.7%). The DOH-generated income grew by 11.6% over the same period, with DOH reporting to the Committee on 28 February 2010 that this self-generated income comprised:

- Sale of goods and services- $124.2 million (budget- $197.4 million);
- Grants and subsidies- $241.5 million (budget- $371.1 million);
- Health fees and recoveries- $82.9 million (budget- $100.4 million); and
- Other revenue- $34.8 million (budget- $75.2 million).[54]

Over the past 20 years the proportion of the total general government appropriations spent on the State's health budget has remained at or below 25-26%. In 2007-08, the Commonwealth Grants Commission found that Western Australia's health spending was around the average for all Australian jurisdictions. The health budget has grown in size by more than three times between 1990-2009, but this was in line with the tripling of government income, as Table 1.2 indicates.

---

51 The latest such claim was made by the NSW Premier, Ms Kristina Keneally. See: Ms Louise Hall, 'Keneally calls on other states to support reform', 5 March 2010. Available at: www.smh.com.au/nsw/keneally-calls-on-other-states-to-support-reform-20100304-plsl.html. Accessed on 5 March 2010.

52 Hon Mr Wayne Swan, Federal Treasurer, 'Joint Doorstop Interview with the Hon Jenny Macklin MP', 25 March 2010. Available at: www.treasurer.gov.au/DisplayDocs.aspx?doc=transcripts/2010/025.htm&pageID=004&min=wms&Year=&DocType=2. Accessed on 29 March 2010.

53 Hon Mr Troy Buswell, Treasurer, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 23 February 2010, p9.

54 Data as at 28 February 2010. Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p5.

Table 1.2- Western Australia's health budget as a proportion of total government appropriations[55]

Year	Total general government recurrent appropriation ($billion)	Total health recurrent appropriation ($billion)	Health budget as proportion of general government appropriation
1990-91	4.94	1.25	**25.2%**
2000-01	7.79	1.88	**24.1%**
2008-09	15.29	4.08	**26.7%**

The financial years with the lowest proportion of the State's Budget spent on health were in 1993-94 and 1996-97 (22.5%). Health expenditure represented the highest proportion of the State's Budget in 2007-08 (27.0%). This is not to understate the difficulty in managing the growth in health demand and costs, but the rise in the health budget has been in line with the general increase in government income.

Finding 8

The Western Australian health budget between 1990 and 2009 has risen at a similar rate to the increase in Government's income and has remained at about 25-26% of the general government appropriations.

In the 2009-10, the State's income was forecast to rise by 5.2% while the health budget was appropriated an additional 5.9%, after a 3% efficiency dividend payment of $126.2 million was taken. The Health Minister explained the budget over-run in health expenses in 2009 as not due to any sudden increase in demand, but as "the result of commitments made by the previous government that were not funded; funding was not provided for a range of services that were introduced, and those things just had to be funded."[56]

55 Department of Treasury and Finance, *Reply to Questions on Notice*, 21 December 2009, p2.

56 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 8 September 2009, p6465.

Table 1.3- Annual health budgets since 2004 (the year of the Reid Report)

Financial year	Original appropriation ($000)	Actual appropriation ($000)	Surplus/deficit ($000)	Actual appropriation Increase over previous year
2004-05	2,856,866	2,926,341	(647)	**11.3%**
2005-06	3,101,334	2,987,242	(20,049)	**2.1%**
2006-07	3,282,298	3,318,974	9,433	**11.1%**
2007-08	3,600,465	3,762,557	(33,807)	**13.4%**
2008-09	4,088,561	4,239,710#	131,453#	**12.7%**
2009-10	4,590,003			**8.3%***

Estimated actual figures. Estimated surplus due to accounting treatment of COAG funds.
* Based on original 2009-10 budget allocation.

(ii) Higher future health costs due to using public private partnerships

The Western Australian Government recently announced that private companies could be involved in projects using public private partnerships (PPPs) where hospitals are 'changing or being built', such as the new Midland Health Campus and the Princess Margaret Hospital at the QEII site.[57] A recent report describes the experience in England's National Health Service (NHS), where 101 out of 133 new hospitals between 1997-2008 were built in this way. While keeping the Government debt levels looking artificially low (the costs of a PPP are not reported as government debt), the actual cost to the NHS for a hospital was between 1.8 and 2.1 times higher than if the government had borrowed the funds and built the hospital itself.[58] The authors of the report quote a Price Waterhouse study which showed:

> *returns to PFI* [Private Finance Initiative] *shareholders are around 2.4% above what would be expected. Rates of return to the consortia may be even higher after 'refinancing', a process in which the original PFI debts are repaid early and new loans taken out at*

57 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 11 March 2010, p634.

58 Mr Moritz Liebe and Professor Allyson Pollock, Centre for International Public Health Policy, 'Four Lessons for Western Australia: The Experience of Public-Private Partnerships/Private Finance Initiative in the UK's National Health Service', August 2009. Available at: http://wapolicyforum.org.au/files/papers/WAPF_PPP_PFI_Briefing_09_Aug_09.pdf, pp4-7. Accessed on 29 March 2010.

> *lower rates of interest. … For example, investors of the Norfolk and Norwich PFI hospital increased their rate of return from 16% to 60% through refinancing.*[59]

The procedure for increasing returns from a PPP was described as "the unacceptable face of capitalism"[60] by Edward Leigh, the chairman of the House of Commons Public Accounts Committee. The evidence of 'excess returns' to private finance investors contradicts the claim that the higher cost of private finance is simply a function of the risks taken on by private shareholders. Instead it represents a significant element of bad value for the public sector. The on-going costs to repay developers will ensure a continuing higher drain on health funds for generations of Western Australians than if the funds had been borrowed by the Government itself.

The Committee believes it is also possible that services being delivered at PPP-built hospitals in Western Australia will be more expensive or of poorer quality than government-provided services, if the decade-long experience in the UK is used as a guide. An unpublished review by the UK's National Audit Office using information provided by the Healthcare Commission compared the quality and cost of security services, linen and laundry services, portering services and cleaning services of the first round of NHS PPP projects with data from with non-PPP hospitals, and found:

- PPP security services had a higher average cost of £3.13 (AUD 6.30) per square meter compared with £3.03 (AUD 6.10) at non-PFI hospitals;
- the cost of linen and laundry services was significantly higher at PFI hospitals with costs of £1,204 (AUD 2,422) per occupied bed compared with £1,067 (AUD 2,146) at non-PPP hospitals;
- portering services at PPP hospitals also came at an average higher cost of £147 (AUD 295.75) per occupied bed but did not – according to the judgment of ward managers – perform better;
- average cleaning costs per square meter exceeded the average cleaning costs in non-PPP hospitals by £2.30 (AUD 4.63); and

---

59 Mr Moritz Liebe and Professor Allyson Pollock, Centre for International Public Health Policy, 'Four Lessons for Western Australia: The Experience of Public-Private Partnerships/Private Finance Initiative in the UK's National Health Service', August 2009. Available at: http://wapolicyforum.org.au/files/papers/WAPF_PPP_PFI_Briefing_09_Aug_09.pdf, pp6-7. Accessed on 29 March 2010.

60 Cited in Mr Moritz Liebe and Professor Allyson Pollock, Centre for International Public Health Policy, 'Four Lessons for Western Australia: The Experience of Public-Private Partnerships/Private Finance Initiative in the UK's National Health Service', August 2009. Available at: http://wapolicyforum.org.au/files/papers/WAPF_PPP_PFI_Briefing_09_Aug_09.pdf, p8. Accessed on 29 March 2010.

- the majority of PPP hospitals performed below the NHS average on the quality of their cleaning.[61]

Finding 9

Future services delivered at hospitals in Western Australia that have been built using Public Private Partnerships may prove to be more expensive or of poorer quality than government-provided services.

Recommendation 7

The Western Australian Government include in each annual health budget an outline of the cost of services to be provided at public private partnership health facilities and a comparison with the cost of these services provided at government-provided facilities.

(iii) Impact of funding for elective surgery

The size of the waiting lists for elective surgery in our public hospitals is a highly emotive issue. Opposition political parties have used examples of patients waiting extended periods for surgery to attack the government of the day. A recent example was that of a woman who had waited for almost a year to have a burst lap-band repaired and have her gall bladder removed.[62] Western Australia has 14,477 patients waiting for surgery at the end of December 2009 — up 10.4% on the December 2008 figure. Patients on the list were waiting about nine weeks on average for their surgery.[63] The Parliament was told that:

> *the waiting list has not continued to go down as it had been doing previously. The main reason behind that is that since about October last year we have had 500 additional patients a month over historical levels coming on the list. That is where the variation has*

61 Mr Moritz Liebe and Professor Allyson Pollock, Centre for International Public Health Policy, 'Four Lessons for Western Australia: The Experience of Public-Private Partnerships/Private Finance Initiative in the UK's National Health Service', August 2009. Available at: http://wapolicyforum.org.au/files/papers/WAPF_PPP_PFI_Briefing_09_Aug_09.pdf, p8. Accessed on 29 March 2010.

62 Mr Nick Butterly, 'Painful wait for those in surgery queue', *The West Australian*, 4 March 2010, p7.

63 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', December 2009. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, pi. Accessed on 15 April 2010.

been. It is not actually in the level of activity being undertaken, it is in patients being added to the list.[64]

Table 1.4- Elective acute hospital separations, 2008-09[65]

	2008	2009	Difference
Metropolitan hospitals	196,654	192,379	**-2.2%**
Country hospitals	48,518	49,433	**+1.9%**
Total	**245,172**	**241,812**	**-1.4%**

Western Australian governments have relied on special Federal funding to lower the State's elective surgery waiting lists but in 2008-09 an additional $10 million and in 2009-10 another $20 million in State funds were appropriated to reduce the waiting lists. These additional funds target patients who wait longer than the clinically indicated time to access elective surgery procedures. The Federal Government's 'Elective Surgery Blitz' program provided an additional $15.4 million to Western Australia during 2008 for these 'over-boundary' patients. This initiative will total $400 million over four years and in 2008-09 resulted in an additional 3,727 Western Australian patients accessing elective surgery - 1,007 patients more than the program's target. This program has been successful. The Health Minister told Parliament:

The number of patients outside boundary, particularly those on the waitlist for longer than 365 days, is down from 301 to 136. The number of patients waiting more than 500 days is now at 33, which is 60 fewer cases than was the situation at the same time last year.[66]

Western Australia has also been allocated $13.3 million by the Federal Government to enhance infrastructure for elective surgery capacity under Stage 2 of the 'Blitz' program and will receive a further share of the $300 million Stage 3 funds for 2009-10 and 2010-11. Stage 3 is an incentive-based program based on the State meeting targets set by the Federal Government. In January 2009, the Elective Wait List Advocate Committee was appointed. It is responsible for monitoring elective surgery wait lists and for providing elective surgery policy advice to the Minister for

64 Dr Robyn Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, Western Australian, Legislative Council, *Parliamentary Debates* (Hansard), 18 June 2009, pE666b-681a.

65 Department of Health, 'WA Health Performance Report- October to December 2009 Quarter', December 2009. Available at: www.health.wa.gov.au/publications/documents/WA_Health_Performance_Report_Oct-Dec09_Quarter.pdf, p3. Accessed on 15 April 2010.

66 Hon Dr Kim Hames, Minister for Health, Western Australian, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 May 2009, pE570.

Health and the Director General of Health.[67] The State Government has not allocated additional funds for lowering elective surgery wait lists in the 2009-10 Budget's out-years.

Finding 10

The State Government has not added to Federal funding aimed at lowering elective surgery wait lists in the Budget's out-years.

Recommendation 8

The State Government should allocate an additional $10 million in funds in 2010-11 and 2011-12, in addition to any Federal funds, to lower the State's elective surgery wait lists.

In April 2010 the Federal Government announced a new proposal to provide State governments with "$650 million over four years to reach a target of 95% of elective surgeries within clinically recommended times, together with a guarantee of free rapid treatment in a public or private hospital if patients wait longer than is recommended."[68] This initiative was offered to encourage states to join the proposed national hospital plan and because "Australia's rates of hospital admission are above the OECD average and significantly higher than comparable countries such as the United States, New Zealand, and Canada."[69]

In the United Kingdom, the average waiting time for elective surgery is about 8 weeks and the UK Department of Health set a standard from 2008 where no patient should wait for more than 18 weeks to receive surgery after being referred by a GP. If the NHS fails to meet this target for a patient it will be obliged to provide the treatment from a private hospital.[70]

---

67 Department of Treasury and Finance, '2009-10 Budget: Health', 9 May 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/part03_01_wa_health.pdf?n=6463, p161. Accessed on 15 April 2010

68 Commonwealth of Australia, 'A National Health and Hospitals Network: Further Investments in Australia's Health', 12 April 2010. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/B5E2F0FD961B3F65CA257703001981AE/$File/NHHN%20Report%20two.pdf, p4. Accessed on 15 April 2010.

69 Commonwealth of Australia, 'A National Health and Hospitals Network: Further Investments in Australia's Health', 12 April 2010. Available at: www.health.gov.au/internet/main/publishing.nsf/Content/B5E2F0FD961B3F65CA257703001981AE/$File/NHHN%20Report%20two.pdf, p8. Accessed on 15 April 2010.

70 Department of Health, United Kingdom, 'About the programme', nd. Available at: www.18weeks.nhs.uk/Content.aspx?path=/What-is-18-weeks/About-the-programme/. Accessed on 15 April 2010.

The Committee supports the Federal Government's proposal for a 'National Access Guarantee' to utilise private hospital capacity to provide elective surgery when patients have waited longer than is clinically appropriate. There is also clear potential to use private hospital facilities to reduce the current burden facing Emergency Departments in the State's public hospitals.[71]

Western Australia has a large private hospital system that already provides about 35% of Perth's hospital services (see Appendix Eight for a full list of these hospitals). Many of the metropolitan public hospitals are co-located with a private hospital (eg Sir Charles Gairdner and Hollywood hospitals) while the new Fiona Stanley Hospital will be co-located with St John of God Murdoch.

Other States have implemented a system where senior staff are located in Emergency Departments to liaise with appropriate patients to assist them in receiving their services in an adjacent private hospital, if they so choose. In 2008-09 there were 168,000 bed-days provided in public hospitals for private patients in Western Australia.[72] Using the Reid Report's 2004 figure of an average of $1,100 per tertiary bed-day, this has cost the State Government as much as $185 million in 2008-09, of which only $42.2 million was recouped from health insurance companies.

With Perth's metropolitan hospitals consistently operating at around 95% capacity, adjacent private hospitals offer an ideal synergy that should be utilised by DOH while demand for public services remains at the current high levels.

(iv) Inaccurate budget forecasts by the Department of Treasury and Finance

This section looks at the financial pressures on DOH that flow from the estimates of the State's finances made each year by the Department of Treasury and Finance (DTF). These estimates are based on DTF's economic projections for the State and national economies.

The health budget accounts for about a quarter of the State's expenditure, and any errors in DTF's economic projections that lead to government decisions to cut departmental budgets have a significantly larger impact on DOH than other departments. The Under Treasurer was asked about the accuracy of DTF's forecasts and replied "…you have asked what the probability is associated with getting the forecasts right: I can give you full assurance that there is 100% probability that they are the best forecasts we can do."[73] Table 1.5 below summarises how accurate the DTF forecast have been over the past four years. It compares the original forecast made the year before a particular financial year, the estimate contained in the financial year's budget and the actual figure provided by DTF after the year in question.

---

71 Australian Government, 'Expanding Elective Surgery Capacity in Our Public Hospitals', 20 April 2010. Available at: www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr10-nr-nr073.htm. Accessed on 4 May 2010.

72 Dr Peter Flett, Director General, Department of Health, *Response to Questions on Notice*, 10 November 2009, p5.

73 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p9.

Table 1.5- Comparison of Department of Treasury and Finance forecasts, 2005-09

	2005-06 Budget Year ($million)	**2006-07 Budget Year ($million)**	**2007-08 Budget Year ($million)**	**2008-09 Budget Year ($million)**
Forecast Revenue **in the prior Budget**	13,056	14,520	16,414	18,008
FY Budget Forecast Revenue	14,218	16,510	17,593	19,872
Actual FY Revenue	16,207	17,573	19,345	19,435
Difference: 2-yr forecast & actual	**3,151** (+19.4%)	**+3,053** (+21.0%)	**+2,931** (+17.9%)	**+1,427** (+7.9%)
Forecast Expenditure **in the prior Budget**	12,832	14,405	15,528	16,561
FY Budget Expenditure **Forecast**	13,697	15,234	16,141	18,017
Actual FY Expenditure	13,942	15,320	16,837	19,117
Difference: 2-yr forecast & actual	**+1,110** (+8.7%)	**+915** (+6.4%)	**+1,309** (+8.4%)	**+2,556** (+15.4%)
Forecast Surplus*** in the prior Budget**	224	435	889	1,447
FY Budget forecast Surplus	521	1,275	1,453	1,855
Actual FY Surplus	2,265	2,254	2,507	318
Difference: 2-yr forecast & actual	**+2,041** (+911.2%)	**+1,819** (+418.2%)	**+1,418** (+159.5%)	**-1,129** (-78.0%)

* Net Operating Balance.

It seems that the Department of Treasury and Finance's estimates for revenue have recently become more accurate, while those for expenditure have got worse, and those for the surplus (or net operating balance) are hardly credible. The evidence from the Under Treasurer on the difficulty of making budget forecasts is supported by information from the US that showed over the past 30 years, more than 80% of the national budget surplus forecasts were too positive.[74]

Impact on the health sector of inaccurate forecasting

A clear example of the hardship created in the health sector by poor DTF forecasts are the deep cuts made to the mental health sector in 2003 by then-Health Minister, Hon Jim McGinty. The 2003-04 State Budget was framed in an environment of international uncertainty with forecast real declines in State revenues, and continuing cost and demand pressures in key areas such as the health budget. DTF forecast a surplus of just $83 million for the year.[75] The first round of cuts was announced in Parliament on 16th September 2003. Losses to mental health were wide spread and included cuts to the mental health budget for Aboriginal, youth, gender-specific and multicultural services, consumer advocacy and carer advocacy services.

In the non-government sector, cuts were made to services including Derbarl Yerrigan's Community Support Service for Aborigines. The Health Consumer's Councils Consumer Advocacy Service and the WA Community Advocacy Group on Mental Health were all axed. The most widespread cut to non-government organisations was the 2.5% indexation increase promised to all agencies in the first half of 2003.[76]

The final budget position for the State's finances in 2003-04 was actually a $799 million surplus, with revenues $1.7 billion higher than originally forecast by DTF just a year earlier.[77]

Comparisons with other jurisdictions

The official government forecasting experience in Western Australia over the past four years also seems to compare poorly to that of similar-sized jurisdictions such as South Australia and Queensland, as Table 1.6 shows. For the 2008-09 financial year, Western Australia's actual Government revenue was $19.4 billion compared to SA's $13.5 billion and Queensland's $37.0 billion. Western Australia's forecasts seem to be consistently more inaccurate than SA's over the

---

74 Ms Amanda Cox, 'Budget Forecasts, Compared With Reality', 2 February 2010. Available at: www.nytimes.com/interactive/2010/02/02/us/politics/20100201-budget-porcupine-graphic.html. Accessed on 5 February 2010.

75 Department of Treasury and Finance, '2003-04 Budget: Economic and Fiscal Outlook', 8 May 2003. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2003_04/bp3.pdf?n=7765, p9. Accessed on 26 March 2010.

76 WA Association for Mental Health, 'Mental Health Matters', 27 September 2004. Available at: www.waamh.org.au/saveourservices/. Accessed on 26 March 2010.

77 Department of Treasury and Finance, '2005-06 Budget: Economic and Fiscal Outlook', 26 May 2005. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/BUdget_2005_-_2006/bp_3.pdf?n=7228, p2. Accessed on 26 March 2010.

four-year period, and similar in accuracy to Queensland for estimates of expenditure and surplus, but worse for revenue estimates.

Table 1.6- Comparison of budget forecasting in Western Australia, South Australia and Queensland, 2005-09

REVENUE	2005-06 FY		2006-07 FY		2007-08 FY		2008-09 FY	
	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast
WA	+14.0%	+24.1%	+6.4%	+21.0%	+10.0%	+17.9%	-2.2%	+7.9%
SA	+4.9%	+10.6%	+4.4%	+7.2%	+6.1%	+10.7%	+2.1%	+8.3%
QLD	+13.1%	+21.5%	+10.0%	+15.1%	-3.4%	+3.8%	+1.2%	+11.1%

EXPENDITURE	2005-06 FY		2006-07 FY		2007-08 FY		2008-09 FY	
	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast
WA	+1.8%	+8.6%	+0.6%	+6.4%	+4.3%	+8.4%	+6.1%	+15.4%
SA	+3.4%	+9.8%	+3.3%	+6.0%	+2.5%	+8.2%	+5.1%	+12.0%
QLD	+2.7%	+8.5%	+4.5%	+10.8%	+2.2%	+9.9%	+3.4%	+11.9%

SURPLUS	2005-06 FY		2006-07 FY		2007-08 FY		2008-09 FY	
	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast	Error in Budget forecast	Error in 2-year forecast
WA	+334.7%	+911.2%	+76.8%	+418.2%	+72.5%	+182.0%	-82.9%	-78.0%
SA	+296.1%	+71.2%	+129.7%	+167.9%	+1,446.7%	+186.4%	-245.6%	-213.7%
QLD	+297.6%	+718.1%	+657.6%	+215.6%	-681.7%	-731.2%	-95.7%	-86.1%

This recent data for three jurisdictions show that estimates made in any budget for the following year have large errors, and those made in the actual financial year budget may also have large errors. DTF recognised the poor quality of its estimates and undertook a review of one core element — forecasting the $US/$AUS exchange rate. After comparing different models, it found that the best performed model was the long run average (or LRA) model, which simply assumes that the exchange rate reverts to its average value in a linear fashion over the course of the forward estimates period (i.e. four years). This new model was used in preparing the Mid-year Economic Review in December 2009.[78]

The Committee believes that the State Government should acknowledge the difficulty in forecasting the State's revenues, expenditures and surpluses (even just one year forward from the delivery of its Budget) and the impact such errors have on large agencies providing critical services such as DOH. This would require DTF to provide a strategy for developing a more accurate budget modelling process to alleviate the problems associated with funding large agencies.

One approach might be to include in the Budget probability figures for its estimates on important inputs to its modelling, such as population growth, exchange rates and inflation forecasts. This type of reporting of financial information is presently carried out in the broader financial markets. During the mid-year economic forecasting process, budgets for large agencies delivering critical services could be held steady if the economy matches the forecasts, or deteriorates, but could be increased if the State's budget is in a better position than originally forecast.

78 Department of Treasury and Finance, 'Exchange Rate Forecasting Review', October 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/_Treasury/Publications/exchange_rate_forecasting_review.pdf, pp1-2. Accessed on 5 February 2010.

Finding 11

The Department of Treasury and Finance's recent budget estimates for the State's expenditure and revenue has not been as accurate as other similarly-sized jurisdictions, especially for prior-year estimates.

Recommendation 9

The Government should develop a strategy for managing the impact of inaccurate economic forecasts provided by the Department of Treasury and Finance. This would assist the Department of Health to maintain the State's critical health infrastructure and programs.

(v) Impact of the 3% efficiency dividend

The Committee believes that public health is too important to have the health system's effectiveness placed at risk to meet blunt demands for efficiency dividends (ie budget cuts). The key aim of the Reid Report's recommendations was to generate a 2% decrease in the rate of growth of health expenditure. A reform program was recommended for Government that, unlike the 3% efficiency dividend, was designed to save funds and generate an increase in revenue without compromising the health and well being of Western Australians. As outlined later in this Report, Governments since 2004 have not shown faith in fully implementing the Reid Report's recommendations.

The Committee sees nothing wrong with governments borrowing to finance critical infrastructure, such as new hospitals, that will benefit many generations. The Royal Perth Hospital has provided important health services to Western Australians for the past 155 years and it is likely that the new Fiona Stanley Hospital will serve the State for a similar period.[79] The current 3% efficiency dividend will strip about $127 million from the DOH for the 2009-10 financial year, and about $660 million over five years — the equivalent of 4-5 regional hospitals. A full list of DOH's capital works projects that have been deleted, reduced or deferred resulting from the Department of Treasury and Finance's Capital Works Audit is provided in Appendix Seven.

The Under Treasurer told the Committee that the Government had allocated $48 million to the Public Sector Commission to fund staff redundancy payments associated with any severances made by DOH in the process of meeting its dividend savings.[80] These redundancies will pay for experienced and knowledgeable staff, including front line nursing staff, to leave the State's health

79 Royal Perth Hospital, 'A Brief History', 2006. Available at: www.rph.wa.gov.au/history.html. Accessed on 12 January 2010.

80 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p9.

service and take their skills with them. The size of this fund for staff redundancies is about what the Government will spend in 2009-10 on upgrading either the Port Hedland or Joondalup hospitals.

In terms of the State's commitment to maintain a surplus, evidence from the Under Treasurer indicates, firstly, that rating agencies would not necessarily reduce the State's investment rating just because the Budget went into deficit for a short period due to broader economic influences (such as the Global Financial Crisis):

> *I think probably the more significant issue around credit ratings is that they are a signal of the degree of confidence in the State's financial management more broadly to the community, in the state, nationally and internationally.*[81]

Secondly, the cost to the State Government of any downgrading from the current Triple-A to an AA+ using the Standard and Poor's credit ratings, or AA1 in terms of Moody's Investor Services would be small in terms of the size of the State's overall budget:

> *What happens depends on the state of the markets at that point in time. It could mean a difference of anywhere between 0.02 per cent to 0.08 of a percentage point on our debt cost.*[82]

Even at the top end of the range suggested by the Under Treasurer, this would amount to an additional $5-7 million per annum for the estimated total public sector net debt of $7.0 billion at 30 June 2009.[83]

The Committee's *Invest Now or Pay Later* report in March 2010 found that Western Australia's health system has been operating in an environment of fiscal restraint as a result of the global financial crisis. However, the State appears to have emerged from the economic downturn with a number of commentators predicting strong growth over the coming years:

> *2010 looks set to mark the beginning of a new wave of growth and prosperity for the State. … the WA economy is expected to grow by 4¼% in 2010-11, 5% in 2011-12 and 6% by 2012-13. A return to growth in the world's major economies is expected to boost the State's export returns, and provide the impetus for the State's investment cycle.*[84]

---

81 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p8.

82 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p8.

83 Department of Treasury and Finance, '2009–10 Economic and Fiscal Outlook- Budget Paper No. 3', 14 May 2009. Available at: http://www.dtf.wa.gov.au/cms/uploadedFiles/State_Budget/Budget_2009_2010/2009-10_budget_paper_3.pdf, p10. Accessed on 12 January 2010.

84 CCIWA, 2009, *WA Economic Compass Outlook - December Quarter 2009*, Chamber of Commerce and Industry Western Australia, Perth, pp3-6.

> *The resource boom years of 2006 to 2008 seen in the State would pale in comparison to the next round of prosperity.*[85]

While the Department of Treasury and Finance originally forecast a contraction of 1.25% in the State's economy for 2009-10, this has been revised to predicted growth of 2.25%.[86] The mid-year financial projections also paint a positive picture for the State's economy over the next few years and there is now a projected growth of 2.75% in 2010-11, increasing to 4.0% in 2011-12 and 4.75% in 2012-13.[87] Based on the State's 2008-09 Gross State Product of $156.6 billion,[88] this projected growth would equate to an additional $3.52 billion in 2009-10; $4.4 billion in 2010-11; and $6.58 billion in 2011-12.[89]

In preparing for the 2010-11 State Budget, the then-Treasurer confirmed that the State's economy was doing better than expected, when he predicted that the growth for 2009-10 will be 3.75% (compared to DTF's original prediction of a contraction of 1.25%), and 4.5% growth in 2010-11.[90] Based on this evidence, the State is well positioned financially to respond to the demonstrated need for additional resources to be allocated to the health system.

Finding 12

The Government's 3% efficiency dividend has been a crude and untargeted strategy to cut government expenses and has placed a substantial burden on staff to continue to provide the same level of front-line services. These pressures have been exacerbated by an unexpected growth in demand for services by the State's rapidly increasing population.

85 Access Economics, 2009, *Business Outlook December 2009 - The Recovery: Mild Not Wild*, Access Economics, Canberra, p107.

86 Department of Treasury and Finance, 2009, *2009-10 Government Mid-year Financial Projections Statement*, Government of Western Australia, Perth, p43.

87 Department of Treasury and Finance, 2009, *2009-10 Government Mid-year Financial Projections Statement*, Government of Western Australia, Perth, p44.

88 ABS, 2009, *5220.0- Australian National Accounts: State Accounts 2008-09*, Australian Bureau of Statistics, Canberra. Available at www.abs.gov.au/AusStats/ABS@.nsf/Latestproducts/5220.0Main%20Features22008-09%20(Reissue)?opendocument&tabname=Summary&prodno=5220.0&issue=2008-09%20(Reissue)&num=&view=, p12. Accessed on 26 February 2010.

89 Actual figures based on compounding of projected Gross State Product.

90 Mr Daniel Emerson, 'Forget about any tax cuts: Buswell', *The West Australian*, 13 April 2010, p7.

Finding 13

Western Australia's economy has emerged from the economic downturn with strong growth predicted over the coming years. Western Australia can clearly afford the additional resources required for a properly funded health service.

Recommendation 10

In light of the deteriorating performance of an already under-resourced State health service and the likely rebound in the State's economy, the Government's 3% efficiency dividend should not continue to be applied to the Department of Health.

(vi) No representation for the health portfolio on the Expenditure Review Committee

Under the previous government, the Health Minister was on the Expenditure Review Committee (ERC). One of the roles of the ERC is to develop the State's annual budget. Given the health portfolio's services represents about 25% of all Government expenditure and their services are key to the health of Western Australians, this arrangement made sense. Under the current Government, the Health Minister is not on the ERC. This situation is particularly problematic since the demise of the Health Reform Implementation Steering Committee that was chaired by the Director General of Health and the Under Treasurer. The ERC is now likely to be less well informed on health issues than in the past government.

Finding 14

The health portfolio represents about 25% of all Government expenditure and yet the Minister for Health is not a member of the Western Australian Government's Expenditure Review Committee.

Recommendation 11

The Premier should immediately include the Health Minister as a member of the Expenditure Review Committee.

CHAPTER 2 A HEALTHY FUTURE FOR WESTERN AUSTRALIANS – THE REID REPORT

2.1 Origins of the Reid Report

In March 2003 the Gallop Government established the Health Reform Committee (HRC). The HRC conducted a review with terms of reference to "develop a vision for the Western Australian health system while ensuring that the growth of the health budget was sustainable."[91] One year later, the Health Reform Committee completed its report, entitled *A Healthy Future for Western Australians*. This document has become known as the Reid Report, named after the HRC's Chairman, Professor Michael Reid.

The Reid Report was prompted by concerns over the future viability of the health system, as well as the efficiency and accessibility of its services. Financial concerns were paramount. The HRC was asked to devise a strategy that would "manage costs in the system to ensure sustainable growth in the health budget."[92] Underpinning this call was the comparatively expensive cost of local health services. At that time DOH's annual growth in expenditure was averaging 8.5% against a national average of 6%. In addition, during the preceding five years, DOH had exceeded its budget by an average of $60 million per year—a situation aptly described by the HRC as 'unsustainable'.[93] A major contributing factor was the excessive demand for tertiary hospital beds, the servicing of which cost $380 more per bed-day than a general hospital.

The undue requirements placed on tertiary facilities were seen as a reflection of systemic inefficiencies within the health sector. The HRC described pressure on EDs as, "One of the most immediate issues facing the system."[94] This outcome was due to a variety of causes. Prominent among these was a shortage of Community Health Services and General Practitioners (GPs). GP services had suffered due to a "decline in bulk-billing and after-hours service provision and, in some cases, closure of GP's books to new patients."[95] This produced a flow-on effect throughout the system. More people were presenting to EDs with conditions requiring only primary care.[96]

---

91 Reid Report–*see* Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

92 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p127.

93 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp45,113.

94 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p29.

95 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth.

96 In 2004-05 Emergency Department services were offered in the following tertiary hospitals (RPH, Fremantle and Sir Charles Gairdner) and general hospitals (Armadale-Kelmscott Memorial, Joondalup, Rockingham-Kwinana and Swan District).

The ensuing pressure was ultimately absorbed by tertiary hospitals where 80% of admissions were for patients requiring treatment that would normally be dispensed by GPs or in general hospitals.[97]

Demographic factors also weighed on the operational capacity of hospital services. Health administrators were confronted with an ageing population and an increasing incidence of chronic and complex conditions such as asthma, heart disease and diabetes, which "tend to have a high utilisation of Emergency Department services" and could be treated within a community health setting.[98] Similarly, a significant rise in mental health conditions had seen psychiatric services exert a greater demand for hospital bed-days. Compounding the gravity of the situation was an ongoing shortfall in the number of required health workers, from nurses through to specialist clinicians and surgeons.[99]

A final factor impeding the effectiveness of health services was a history of incremental and ad hoc reform initiatives, especially involving the allocation of new hospital resources. This process had produced expensive capital additions resulting in "a compromised facility that does not operate at ideal efficiency."[100] Of particular concern was the close proximity of the flagship tertiary facilities at Royal Perth (RPH) and Sir Charles Gairdner (SCGH) hospitals, where clinicians contributing to the review generally agreed that there was "some unnecessary duplication of services and some unproductive rivalry".[101]

Importantly, the Reid Report expressed concern about the issue of access to services. Notable was the Report's finding of "a mismatch between the distribution of hospital beds and the areas of major population growth".[102] Moreover, the current configuration of major metropolitan hospitals no longer reflected the geographical spread of Perth's population. Perth's ongoing urban development was producing significant population shifts along the northern and southern coastal corridor. Yet 33% of hospital beds were still located in the four city-based hospitals situated within a four kilometre radius (RPH; SCGH; Princess Margaret Hospital (PMH); and King Edward Memorial Hospital (KEMH)). This development had produced service disparities such as the scenario in Rockingham which, at that time, had a 67-bed facility serving a population of 90,000.[103]

---

97 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp16,45.

98 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

99 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp5,15.

100 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p79.

101 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

102 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

103 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp5,15.

It was also found that access to quality health care appeared, to some degree, to be socially determined with evidence suggesting "that the gap in health status between the healthiest and least-healthiest is substantial and widening."[104] Aboriginal communities, the mentally ill, and people from lower socio-economic backgrounds were cited as particularly illustrative of this trend of Western Australians with the worst access to public health services.[105]

Finding 15

The key outcome of the Reid Report was for the State's health services to be developed to overcome the mismatch between the existing distribution of hospital beds and the areas of major population growth.

2.2 Objectives of the Health Reform Committee

The Health Reform Committee (HRC) acknowledged that Western Australia "has sustained a high quality, safe health system". Nonetheless, "the need for change is very clear."[106] Without sweeping reforms, multi-day bed demands were expected to grow by 2.6% per annum, which would exacerbate the ongoing difficulties regarding timely access to treatments, particularly in the State's hospitals.[107] The Reid Report advocated a number of important reform goals. A key objective involved providing care in the most appropriate setting, ideally closer to people's homes.[108] A number of inter-related strategies were designed towards this end:

- Concentrate the use of tertiary services to focus on specialist treatment;
- Shift outpatient services, where possible, towards clinician's rooms and an expanded general hospital network; and
- Enlarge the primary care sector to reduce the demand for inpatient services.[109]

---

104 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p16.

105 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p16.

106 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p5.

107 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp13,29.

108 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p19.

109 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp19,21,68-69.

The aims of the reforms offered by the Report were clear. The "overall thrust" was intended to promote increasing reliance on the use of primary health services.[110] Proposed efficiency gains would help provide budget relief by an average 2% reduction in annual health expenditure over the next five years.[111] Equally important was ensuring that the provisioning of future health services catered appropriately for the State's growing and ageing population.[112]

2.3 Structure of the Reid Report

The Reid Report is the most comprehensive review of the Western Australian public health system ever undertaken. It contains 86 recommendations grouped over 10 chapters. This section summarises the key recommendations from the Report.

(a) Chapter One - the need for change

The first chapter confirmed that the local health system was facing similar challenges to its counterparts throughout the Western world. Namely, maintaining a high quality service in the face of increasing demand. A single recommendation offered eight underlying objectives to underpin the reform agenda. These objectives reinforced working towards a system that was patient-centred, equitable, and sustainable. Another aim was to encourage greater input from non-government and private providers to enhance the efficiency of the sector.[113]

(b) Chapter Two - population health, primary and community care

Professor Mike Daube was the Director General of the Department of Health in 2004 and collaborated on the Reid Report. Appearing before the Committee, Professor Daube observed that, "…the first focus of that report was on prevention and health promotion. It was the first of its priorities."[114] The Reid Report stressed that substantial investment in this area was "warranted and necessary."[115] This sentiment was supported with 16 recommendations directed towards Population Health, Primary and Community Care.

The primary health care sector employs GPs, pharmacists, and community health nurses as part of its workforce and is, for most people, the first port of call with the health system. The Reid Report

---

110 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p19.

111 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvii.

112 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p41.

113 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp18-20.

114 Professor Mike Daube, Professor of Health Policy, *Transcript of Evidence*, 14 October 2009, p2.

115 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

described this sector as "very fragmented" and requiring a greater emphasis on health promotion.[116] A range of recommendations were offered to alleviate this situation. Nine recommendations targeted health promotion, prevention and early intervention for vulnerable groups within the population. The HRC cited significant evidence within Australia and internationally to argue that investment in this area would "reduce health costs and improve health status in the long term."[117] It recommended that a "major, coordinated, long term health program which has an integrated lifestyle approach"[118] be established for the management of chronic conditions such as diabetes and cardiovascular disease.

Strategies were also offered to reduce the demands that aged-care services were placing on acute hospital beds. The HRC called for a fall prevention program and an increase in post-acute home care packages or transitional care options for those awaiting placement in aged-care facilities.[119]

Mental health was another area of attention for the HRC as mental illness accounted "for around 20% of the total health care costs in Australia".[120] The Report called for a coordinated, multi-sectoral approach, including non-government services and the broader community. As part of this approach, greater attention was needed on improving awareness, prevention and early intervention programs, and supportive accommodation services within the community.[121]

(i) Indigenous health

Finally, Aboriginal health required urgent redress with the existing inequities in health status and in access to health care for Indigenous Western Australians described as 'untenable'.[122] A primary care strategy involving "the informed preferences of the communities themselves"[123] was called for in particular to address chronic disease management and unsafe lifestyle factors. From a

---

116 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp21-22.

117 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p23.

118 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p24.

119 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp23-24,30-31.

120 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p32.

121 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp33-34.

122 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p34.

123 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p35.

preventative aspect, a new inter-agency approach to maternal health from conception onwards was endorsed to improve the health outcomes of future generations.[124]

(ii) Better integration between sectors

The remaining seven recommendations in this chapter focused on developing the interaction between all sectors of the health care system. Primary care and community health practitioners were called on to refine the manner in which they worked together. Improved integration of these services could help deliver a coordinated screening, general practice treatment, and home care service model. This whole-of-life approach to care was espoused as a credible way of improving community health and well-being.[125]

Likewise a community sector interface with the hospital system was promoted. The Western Australian Health Call Centre should become a conduit for hospitals developing "stronger links with GPs and other community-based providers."[126] An enhanced role for GPs was seen as a way of reducing the current burden on hospital EDs. This could be facilitated by:

- Streamlining the delivery of hospital discharge processes to GPs;
- Expanding the early discharge procedures "which organise self-management, home care, and community health support programs";[127]
- Establishing "comprehensive GP services at, or adjacent to, hospital sites in the metropolitan area";[128] and
- Developing a 'system-wide' clinical database, which would facilitate "an easy exchange of relevant information between the community and hospital systems."[129]

This extensive suite of recommendations would strengthen primary services and better integrate them within the broader health care sector. Ultimately, the Reid Report proposed that this would

---

124 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp36-37.

125 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp24-25.

126 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p27.

127 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p29.

128 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p30.

129 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp38-39.

reduce the excessive future demands for inpatient (hospital) care that were inhibiting the financial and operational efficiency of the health system.[130]

Finding 16

Actions by the Western Australian Government to strengthen primary health services and better integrate them within the broader health care sector (not necessarily more hospital beds) were seen as the key to improving the future efficiency and productivity of the State's health system.

(c) Chapter Three - improving access to hospital services

(i) Metropolitan hospitals

The 14 recommendations in Chapter Three have been the major focus of subsequent political debate and media interest. This is not surprising given the significant proportion of the DOH budget that is allocated to hospital services.[131] The HRC stressed that the future planning of health services had to reflect the fact that most Western Australians "who need hospital services require secondary level care as distinct from high cost teaching hospital tertiary care."[132] Furthermore, this secondary level care "needs to be accessible and closer to home".[133]

In order to provide care in a more "appropriate setting", problems then plaguing the hospital system needed correcting. Most pressing was the need to reduce the number of inappropriate presentations at tertiary hospitals. Moreover, the unproductive rivalry between Royal Perth and Sir Charles Gairdner hospitals had to be resolved.[134] The HRC advocated a revised configuration of hospital and community-based services "based on integrated models of care for both north and south of the river."[135] The Area Health Service structure was also to follow this 'north-south

130 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p21.

131 Based on the 2009-10 Budget, 55% of the total cost of health services was spent on 'admitted patients'. See, Department of Treasury and Finance, 2009, *2009-10 Budget Statements: Budget Paper No.2 Volume 1*, Government Printer: Perth, p163.

132 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p41.

133 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p41.

134 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp41,50.

135 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

model'[136] with clinical staff appointments within the respective areas to be conjoined across tertiary and general hospitals.[137]

As for the metropolitan hospital system, the recommended reconfiguration comprised the following four major components that were seen as crucial to improving appropriate access and controlling health expenditures.

1 The designation of two tertiary hospitals, with one north and one south of the river[138]

This recommendation was reached after considering a significant amount of clinical opinion and weighing various options, "including the status quo."[139] Ultimately, the north-south model was considered to be more representative of "the geography of the metropolitan area,…[and] responsive to population growth". It was also "a sufficiently large population to enable comprehensive planning and provision of health services."[140]

The existing 'southern' tertiary hospital, at Fremantle, was described as "badly set-up as a result of unplanned growth over previous decades"[141] and not suitable for expansion. It was recommended that Fremantle retain its tertiary status until a new southern tertiary hospital was built. The suburb of Murdoch was the preferred location of this facility, which would "incorporate the tertiary clinical services of Fremantle Hospital together with designated clinical groups from Royal Perth and Sir Charles Gairdner hospitals."[142] Planning for the new hospital "should commence immediately."[143] As for the other hospitals that were part of the Fremantle campus, it was recommended that the 20 obstetric beds at Woodside be closed and offered at one of the four

136 At the time of the Reid Report there were five area health services covering Perth: East Metropolitan; North Metropolitan; South Metropolitan; Women's and Children's; and Dental. The Reid Report instead proposed a three-part structure incorporating North Metropolitan, South Metropolitan and a Women and Children's Health Service. See, Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p99.

137 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp45-46.

138 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvi.

139 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth., p48.

140 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p44.

141 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

142 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

143 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

proposed 'general' hospitals (see below). Alternatively, Kaleeya should be redeveloped to focus on sub-acute care, aged-care, rehabilitation and day procedures".[144]

For the 'northern' tertiary hospital, two options were canvassed:

(i) one tertiary hospital across the two sites of Royal Perth and Sir Charles Gairdner hospitals; or

(ii) select either the Royal Perth Hospital or Sir Charles Gairdner Hospital (Queen Elizabeth II Medical Centre) site as the preferred location.[145]

As part of this recommendation, the HRC expressed its preference for a single facility situated at the QEII site. However, a "focussed and time limited community and consultative process should occur and a detailed business case developed by September 2004, before the final decision is made."[146] If this proposal was supported, the RPH site should retain an "inner city see and treat centre".[147] This recommendation endorsed a single management and clinical staffing structure across both the RPH and SCGH sites. Importantly, the HRC thought there would be a future need for a second northern tertiary hospital in "the long term (the next 20 years), a third adult teaching hospital will probably be justified in the northern corridor of the metropolitan area."[148]

Finding 17

The Reid Report clearly articulated the case for just one tertiary hospital to service the needs of Perth's northern suburbs, and one to service the southern suburbs. However, a third tertiary hospital would need to be built within 20 years in Perth's northern suburbs to cater for its rapidly growing population.

2 Rockingham-Kwinana District, Joondalup Health Campus, Swan District and Armadale-Kelmscott Memorial hospitals should be expanded to approximately 300 beds each.[149]

The proposed 'ring' of four key general hospitals would support the tertiary facilities, and "provide a comprehensive range of core clinical services and be staffed by appropriately skilled

144 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p47.

145 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p50.

146 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p51.

147 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp50-51.

148 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p51.

149 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvi.

clinicians."[150] Underlying this strategy was the need to "improve access to hospital care in high-growth metropolitan areas and reduce demands on tertiary hospitals for general care",[151] while lowering the unnecessary demands in tertiary facilities. General and 'sub-specialist' procedures undertaken in other hospitals (such as Bentley and Osborne Park) would be transferred to the general hospitals, allowing these smaller facilities to concentrate on specialist services.

3. Other metropolitan hospitals should specialise in rehabilitation, mental health and aged-care services.[152]

The Reid Report noted that mental health, aged-care, and rehabilitation services would place a 'significant' demand on future health care.[153] The Western Australian health system needed to prepare for this to ensure patients on both sides of the Swan River were appropriately catered for. In response, the HRC proposed that Bentley, Osborne Park and a reconfigured Fremantle hospital increase their capacity to offer these services. For mental health services, Graylands Hospital would remain the State's premier provider of acute care. However, services would be expanded at the 'specialist' hospitals to relieve the growing demand Graylands was facing. The four general hospitals would also provide mental health care services.[154] For rehabilitation services, it was suggested that the RPH Rehabilitation Hospital at Shenton Park be closed. This would occur after a purpose-built centre was provided at the Northern Tertiary hospital. Additional rehabilitation services would be located in Bentley, Fremantle and Osborne Park hospitals.[155]

Finding 18

The Reid Report proposed that the two tertiary hospitals in metropolitan Perth be supported by four general hospitals offering a comprehensive range of core clinical services for populations to the north, south, east and south east of the Central Business District. These general hospitals would be supported by others provided specialist mental health, aged-care, and rehabilitation services.

150 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp45-46.

151 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp45-46.

152 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvi.

153 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p46.

154 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp47,68. The Reid Report made no further mention of Hawthorn Hospital, which has since been converted to a 'step-down' facility for people at the post-acute stage of a mental illness.

155 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p47.

4. The women's and children's hospitals should be co-located with an adult tertiary hospital.[156]

Recommendation 31 stated that the King Edward Memorial and Princess Margaret hospitals should be rebuilt and co-located with an adult tertiary hospital to gain significant clinical benefits "through integrating women's and children's services".[157] Both hospitals were in need of significant capital investment to upgrade their facilities.[158] The HRC argued that this money would be better spent on the construction of a co-located purpose-built centre of excellence. No particular location was endorsed. Instead, "further consultation with the community and clinicians should occur before a decision is made".[159] KEMH was to be relocated in the medium term, with PMH (including the Telethon Institute) moved in the longer-term as part of a 'second phase'.[160]

The focus on hospital services concluded with a mapping of the current and future metropolitan hospital structure, including bed allocations,[161] (see Figures 2.1 and 2.2 below).

156 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvi.

157 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp52-53.

158 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

159 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

160 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

161 No specific completion date for this hospital reconfiguration was offered in the Reid Report. See, Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, ppvii,55-56.

Figure 2.1 - WA public hospital system as at 2004 (with bed numbers)

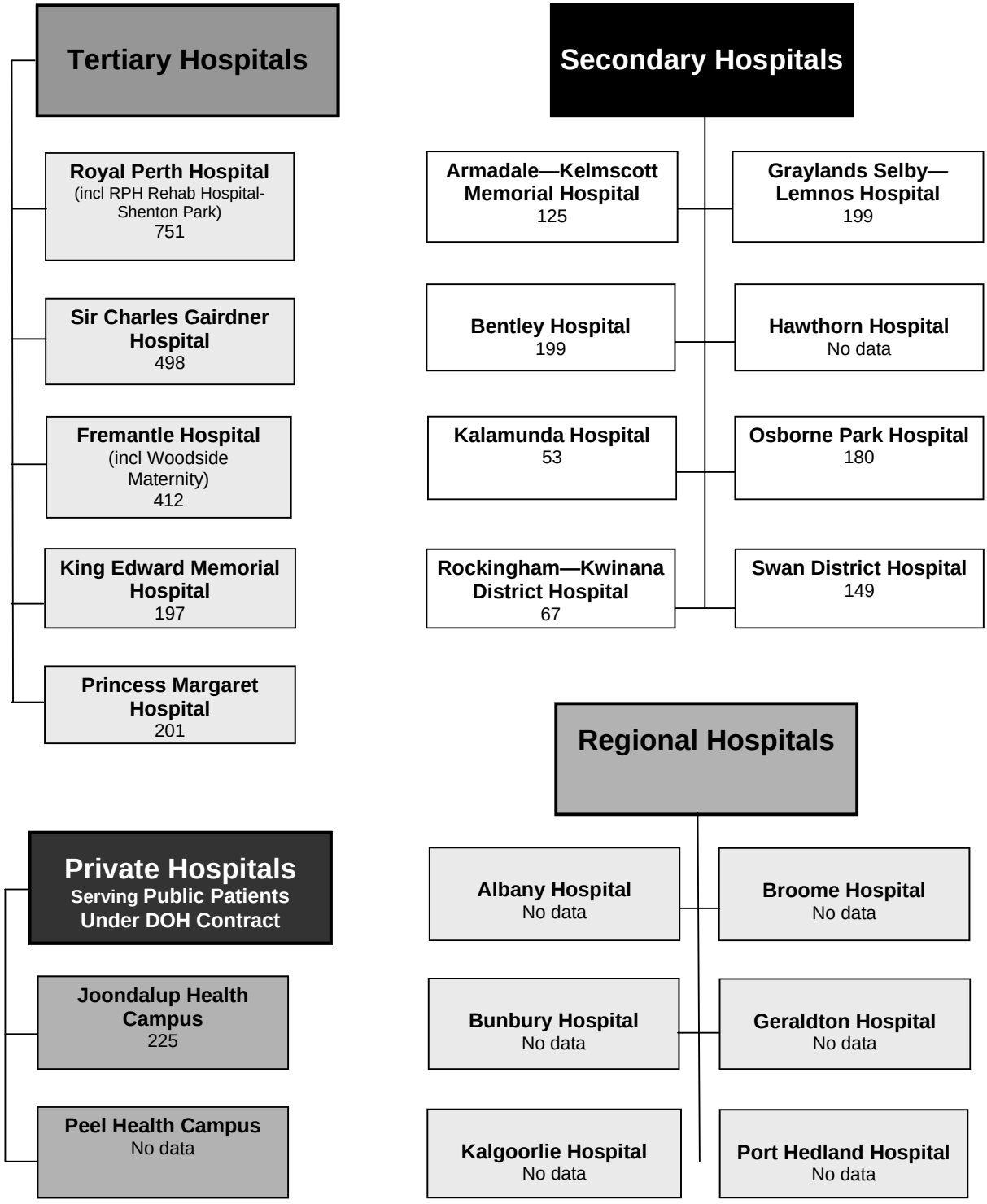
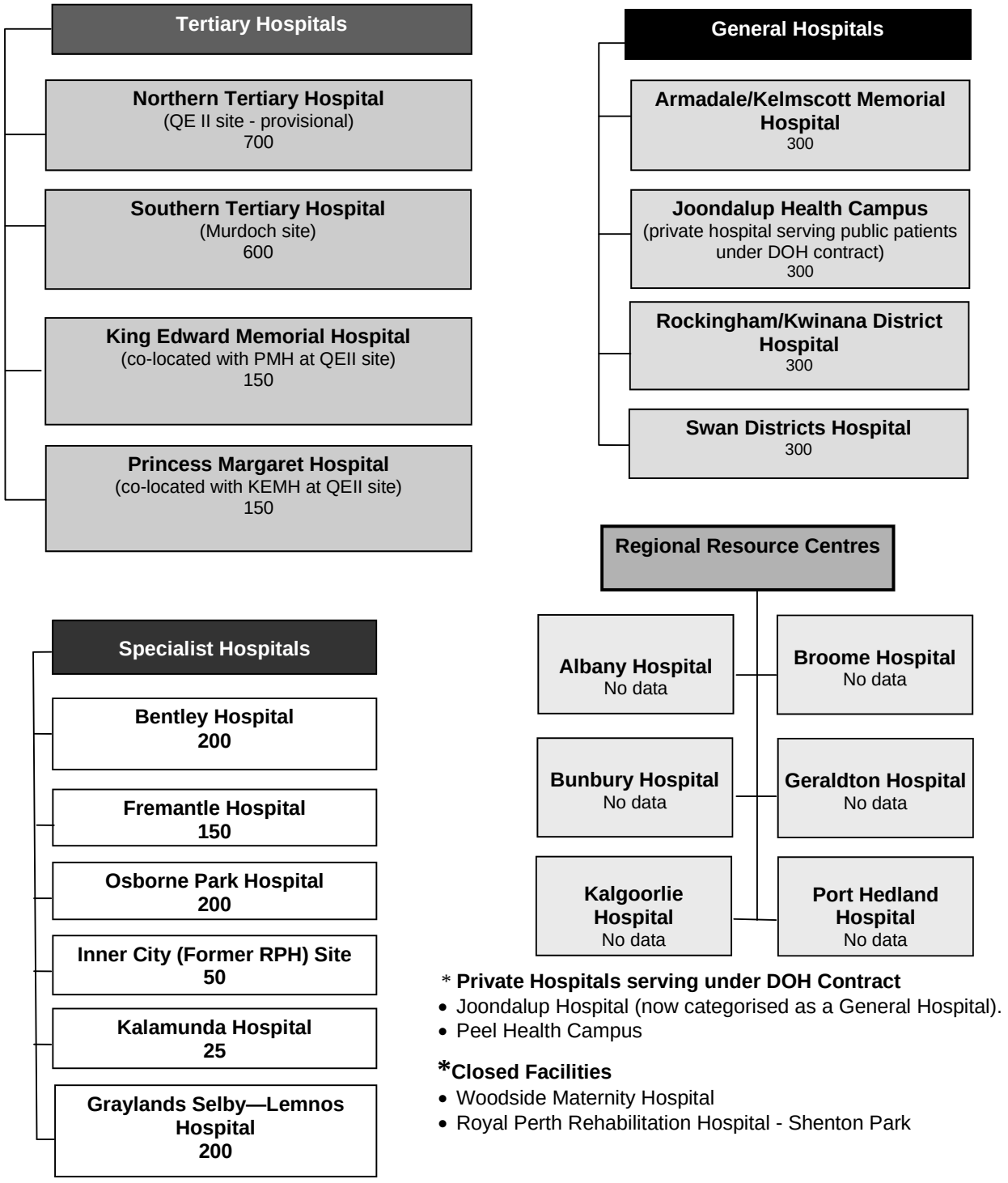


Figure 2.2- Proposed 'future' public hospital configuration (with bed numbers)



* **Private Hospitals serving under DOH Contract**

- Joondalup Hospital (now categorised as a General Hospital).
- Peel Health Campus

***Closed Facilities**

- Woodside Maternity Hospital
- Royal Perth Rehabilitation Hospital - Shenton Park

(ii) Regional hospitals

The metropolitan facilities were the chief focus of the Reid Report's consideration for hospital reform in Western Australia given over 75% of the State's population lived there. Only four recommendations addressed rural and regional hospital services. A key aim of these was to limit, as much as clinically appropriate, the need for patient transfers to Perth for reasons other than tertiary level care.[162] Several initiatives of the Western Australian Country Health Services (WACHS) were endorsed. These included the vision that was articulated in the WACHS *Country Health Services Review* published in 2003. This document proposed a range of future directions to improve service delivery in country areas.

A major proposal was the integration of regional hospital services under a Regional Network Model by 2008. This model comprised five elements of service provision with Regional Resource Centres (RRCs) at its apex. These RRCs would be "developed to retain as much secondary level acute care activity within the regions as possible".[163] Accordingly, the RRCs would be based in the hospitals of Albany, Broome, Geraldton, Kalgoorlie, and Port Hedland, with an additional facility suggested for the Pilbara.

The subsequent levels of care below RRCs included Integrated District Health Services (IDHS) offering primary services and 24-hour emergency cover to towns with populations of 4,000 to 12,000. Below the IDHS were Health Services for Small Towns (for populations up to 4,000) and Small Communities (for populations up to 1,000) which would then offer a progressively reduced suite of care options.[164]

In its endorsement of the *Country Health Services Review*, the Reid Report supported the conversion of the Bunbury Hospital into an additional Regional Resource Centre. These RRCs were described as "part of a 'hub and spoke' model where smaller regional hospitals fed into the designated regional centres."[165] Support was also given for increasing the number Multi Purpose Services that were then being established in regional Western Australia.[166] The Report also encouraged Perth-based clinicians to support the growth of telemedicine to better serve the State's rural populations.[167]

---

162 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p42.

163 Department of Health, 2003, *The Country Health Services Review*, Perth, p33.

164 Department of Health, 2003, *The Country Health Services Review*, Perth, pp42-43.

165 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p43.

166 A Multi-Purpose Service (MPS) "is a health facility that, through the pooling of State and Commonwealth funds allows a hospital to provide a range of health, aged-care and other community services to small rural communities." See, Department of Health, 2007, *Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010*, Perth, p90.

167 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp42-43.

Finding 19

The Reid Report endorsed WA Country Health Service's 'hub and spoke' proposal for providing secondary health services in regional areas, with patients requiring tertiary services to be transported to one of the two tertiary hospitals in Perth.

(d) Chapter Four - specific clinical services

The fourth chapter of the Reid Report considered the provision of clinical services. An earlier discussion paper on this topic drafted by a group of 'respected' external clinicians found:

> *a degree of unnecessary clinical duplication across three of the adult tertiary hospital sites, and that alternative arrangements were recommended for reasons of safety, quality, workforce sustainability and/or efficiency.*[168]

The thirteen recommendations in this chapter articulated these alternative arrangements across the various specialist health services. In several areas—including standard elective orthopaedic surgery and Emergency Department services— it was proposed that the capacity of the four general hospitals be expanded. This would reduce inappropriate workload demands being placed on tertiary facilities and provide care nearer to home for most patients.[169] The expansion of the general hospitals should be further utilised to construct adjoining palliative care facilities. This would offer patients appropriate end-of-life care that was close to acute facilities while again reducing the current demands made on tertiary beds.[170]

The expanded general hospitals could also be used to progressively decrease the 70% of outpatient treatments that tertiary hospitals were currently providing. This initiative would be complemented by the earlier recommendation to establish comprehensive GP services close to these tertiary hospitals.[171] Tertiary hospitals would specialise in more complex elective procedures and the treatment of major trauma. For trauma patients, it was recommended that one adult centre and one paediatric centre dealing with major trauma should be "located as close as possible to the 'centre'

168 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p57.

169 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp59,69.

170 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp65-66.

171 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp30,68-69.

of the population they serve."[172] The 'northern tertiary' hospital and Princess Margaret Hospital were the Reid Report's preferred locations for these trauma centres.

The HRC also endorsed a Department of Health (DOH) proposal to establish a single neurology service and move away from the current system that offered services at both Royal Perth and Sir Charles Gairdner hospitals. The HRC refrained from nominating a preferred location for neurology services, but endorsed the continuation of paediatric neurology at Princess Margaret Hospital.[173] Alternatively, it suggested that adult cardiothoracic services could be offered at the Northern and Southern tertiary hospitals, but utilising a single management structure.[174]

In a range of other clinical fields, the Reid Report urged the maintenance or development of Centres of Excellence. Situated within a tertiary hospital, these centres would coordinate the State-wide delivery of their respective specialties. Haemodialysis would be based at the 'southern tertiary' hospital, obstetrics would be located at King Edward Memorial Hospital, while support was given to Sir Charles Gairdner Hospital as the home of the State Cancer Centre.[175]

(e) Chapter Five - creating a more efficient system

The six recommendations in Chapter Five of the Reid Report addressed where "significant efficiency gains could be made in the future."[176] The dominant, but not exclusive, focus here was on reducing the costs of clinical practices. Proposals to reduce expenditure included shortening the time that people were staying in hospitals. The HRC called for the development of strategies to reduce the Average Length of Stay (ALOS) without compromising clinical outcomes. DOH was also encouraged to formalise targets for increasing patient admissions on the actual day of surgery, rather than the day before procedures.[177]

Further scrutiny was directed by the HRC towards the financial management of pathology, pharmacy and hospital food services. The HRC conducted reviews of these areas prior to compiling their final report. The findings of these reviews were endorsed and specific calls were made for a single pathology service by 2005. From an IT viewpoint, a standardised drug-coding formula for pharmacy processes was recommended, as was a computerised food service system

---

172 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p58. In 2004, three hospitals—Royal Perth, Sir Charles Gairdner, and Fremantle—were providing adult major trauma services. This remains the case in 2010.

173 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p61.

174 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp59-60.

175 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp61-66.

176 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p71.

177 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp70-74.

for hospital caterers.[178] It was suggested that an initial $11 million spend in these three areas may yield annual savings of $17 million.[179] With DOH comprising the largest share of State government purchases, procurement reform was another efficiency area targeted in the Reid Report. The consolidation by DOH in 2002 of five procurement arms into HealthSupply WA was commended. Nevertheless, a recommendation called for a dedicated group within HealthSupply WA to drive further procurement reform.[180]

(f) Chapter Six - developing a sustainable workforce

The HRC confirmed that there would "be a critical shortage of doctors, nurses and allied health staff in critical areas over the next 10 years."[181] Nine recommendations in Chapter Six were aimed at countering this trend. Improving workforce morale—through encouraging a sense of ownership in the reform process—was seen as critical to retaining valued employees. DOH was called on to directly involve its staff in the implementation of the strategies advocated in the Reid Report. Innovative reform ideas from staff should be recognised by way of research grants and awards. Greater input in future planning should also be welcomed from collaborative leadership groups comprising a cross-section of senior clinicians.[182]

DOH was further advised to enhance its workforce planning. Existing methods had "resulted in some severe shortages in several health occupational categories."[183] Future planning required, at a minimum, a uniform human resource management system across the whole of the department. Staff attraction and retention were considered crucial. The HRC acknowledged the establishment of earlier campaigns designed to retrain former nursing staff and to attract more students into the wider medical workforce. The latter had been made possible after the Federal government had increased the number of funded undergraduate and post-graduate medical places. While this would bolster the health workforce in the near future, the practical training of this impending cohort would create significant time pressures in the State's tertiary hospitals. In response, the Reid Report recommended that this convention be unwound and that greater use be made of non-tertiary public hospitals, private hospitals and the private sector in the training of graduates.[184]

---

178 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp77-78.

179 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp76-77.

180 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp79-81.

181 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p85.

182 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth., pp83-84,88-90.

183 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p85.

184 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp85-87.

A similar focus was urged on the attraction and retention of allied health professionals. So too, on the Aboriginal health workforce, where more needed to be done to ensure a larger number of Indigenous employees were recruited.[185] Finally, the provision of a supportive research environment to retain talented clinical staff was endorsed.[186]

(g) Chapter Seven - organisational structure

The Reid Report conceded that the smooth delivery of the proposed reform process would rest upon continual refinements to the operations of DOH, and its on-going interaction with federally-funded health services. It was acknowledged that considerable progress had been made since 2001 in restructuring DOH's operations. Six area health services had replaced the previously unwieldy 47 hospital boards that had acted independently throughout the State. Even so, further refinements were needed.

Firstly, greater clarity was required concerning the responsibilities of the new health services and the DOH head office in Royal Street. It was recommended that Royal Street remain accountable for "system-wide policy and planning, allocating resources, managing the system's regulatory framework",[187] and ensuring compliance with State government operational requirements. Alternatively, the Area Health Services (AHS) should assume as much responsibility as possible for "the service delivery component of population health, aged-care, dental health, mental health and Aboriginal health programs".[188] The added burden this would place on the Chief Executives of the Area Health Services was recognised. To compensate, it was suggested that these officers should be relieved of their role as managers of the tertiary hospitals in which they were based. This would allow their full energies to be directed towards the management of all health services in their respective catchments.[189]

Secondly, strong links between country and metropolitan area health services were considered "essential to ensure that country patients have timely access to tertiary health care and up-to-date professional expertise."[190] This called for the establishment of formal links between regions and particular area health services, as listed in Table 2.1.

---

185 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p88.

186 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp88-89.

187 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p94.

188 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p94.

189 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp94-95.

190 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p96.

Table 2.1- Relationship between metropolitan area health services and WACHS regions

Metropolitan area health service	WA Country Health Service region
Northern Metropolitan Health Service	Midwest and Murchison Goldfields Pilbara Kimberley
Southern Metropolitan Health Service	South West Great Southern Wheatbelt
Women's and Children's Health Service	All regions for paediatrics and obstetrics

The HRC added that the metropolitan area Chief Executives' performance measurement should be partly based on the successful consolidation of these linkages.[191]

The Reid Report also called for a further streamlining of the metropolitan area health service structure towards a North/South model. This modification should occur as soon as possible. North and South Metropolitan would then be responsible for their respective "population health, community health and community-based mental health services."[192] The remit for the Women's and Children's Health Service would be State-wide. These recommendations were accompanied by a call for greater community input into to the local requirements of the area health services to ensure that population needs were met. Two initiatives would underpin the integrity of this process:

1 the establishment of community-based advisory committees; and

2 regular assessments of the performance of the health system from the Health Consumers' Council (WA).[193]

The HRC concluded its consideration of appropriate organisational structures with a brief examination of how to improve the outcomes generated by the division of responsibility for health between the Federal and State Governments. With the former mostly responsible for primary and aged-care, and the latter for hospital, community and public health services, chronic operational problems were evident across the broader system. Examples included: gaps and duplication of

191 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p97.

192 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p99.

193 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp97-98.

services, a stifled approach to planning and innovation, and a prevailing mentality of cost-shifting across jurisdictions.[194] The blunt advice from the HRC to DOH was to "improve joint Australian/State Government integrated models of care and pooled funding."[195]

(h) Chapter Eight - accountability, resource allocation and governance

The HRC assessment in Chapter Eight was direct:

> *Current accountability arrangements, mechanisms for resource allocation and clinical governance within the Department of Health are deficient and need to be addressed as a matter of priority.*[196]

Among the concerns cited by the HRC were increasingly frequent budget overruns and a fixed funding model to health services that unwittingly rewarded inefficient operators. Opaque performance measures made public and parliamentary scrutiny difficult and resource allocation was skewed towards tertiary services.[197] To counter these deficiencies, the Reid Report called for "a robust accountability and performance management framework."[198]

The Report recommended that by 2005-06 a funding model that supported the area health services be implemented. Under this model, resource allocations should be output-based for hospitals and population-based for community health services.[199] In addition, performance agreements for spending and service delivery should be established between the Director General and Area Health Service Chief Executives. These accords would align with the Departmental objectives agreed to each year by the Director-General with the Health Minister and the Treasurer.

The Reid Report was also concerned with maintaining consumer faith in the service capabilities of DOH. To ensure quality of patient care was safeguarded, it was proposed that a State-wide Clinical Governance Framework be established within two years. To further foster community confidence, a culture of transparency should be promoted via published performance reports. Ideally, "Department of Health should produce a quarterly report card…[with] easy access to key

194 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp100-101.

195 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p102.

196 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p103.

197 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p103.

198 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p104.

199 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp105-106.

statistics on health system performance."[200] Yet to guarantee the veracity of such reports, the data collection process would need to be revisited. As a consequence of multiple data owners and systems within DOH, "Data reliability, integrity and consistency are major concerns within the system." Therefore, as a matter of priority, DOH data and information needed to be "consolidated in a central repository".[201]

(i) Chapter Nine - costs and benefits of reform

The penultimate chapter of the Reid Report reinforced the importance of finding ways to control the unsustainable rise in DOH expenditures that were evident in the preceding five years.[202] The HRC reiterated the value of the recommended reform strategies aimed at demand reduction via health prevention and promotion, refined clinical practices, and streamlined hospital services. If embraced, these strategies would generate an estimated saving of 355,000 bed-days in 2008-09—if current demand levels remained constant.[203]

The Department of Health was also urged to revisit revenue raising opportunities as another way of improving its balance sheet. The Reid Report showed that the annual revenue stream from public hospital operations was $50 million lower than the national average. Increases in patient co-payments were 'not recommended'. However, DOH was encouraged to increase the number of health insurance holders opting for treatment as private inpatients in the public system.[204]

Capital requirements were the final area given consideration in this chapter. It was confirmed that a significant capital investment would be required for the infrastructure component of the reform program. This would total $1.5 billion above current budgeted expenditure. The HRC calculated that this investment, while sizeable, would enable its recommended demand management strategies to generate $535 million in annual savings by 2013-14. The HRC proposed that robust business cases be developed to support the required infrastructure reform projects.[205]

---

200 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p110.

201 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p111.

202 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p113.

203 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p115.

204 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p117.

205 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp115,118-119.

(j) Chapter Ten - implementation and change management

The four recommendations in the final chapter emanated from the need to ensure that momentum for reform was maintained. It was acknowledged that "scepticism, and sometimes cynicism"[206] had developed among the health workforce due to the failure to institute changes promoted in earlier reviews. To avoid a repeat of this outcome, the HRC endorsed the creation of an Action Plan to outline the reform timetable. A Communication Strategy would then provide ongoing status reports for the Minister and the Expenditure Review Committee of Cabinet.[207] Monitoring of the reform program could be undertaken by an 'external reference group'. It too would report to the Minister, as well as the Treasurer.[208]

Within DOH, overall management of the process should rest with a 'Health Reform Implementation Coordination Unit' reporting to the Director General. This unit would assume responsibility for overseeing 'designated implementation teams' with the Clinical Senate[209] acting in an advisory capacity to make certain that patient outcomes were not compromised.

206 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p121.

207 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp121-122.

208 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p123.

209 Established in 2003, the Clinical Senate meets regularly and "provides a means for medical practitioners, nurses and allied health professionals to assume a leadership role in advising and leading clinical and system wide reform." See, Department of Health, (n.d.), "About the Clinical Senate", Available www.clinicalsenate.health.wa.gov.au/about/index.cfm. Accessed on 4 December 2009.

CHAPTER 3 WA HEALTH'S FIRST CLINICAL SERVICES FRAMEWORK

3.1 Clinical Services Framework 2005-2015

Within six months of the Reid Report being published in March 2004, a Clinical Services Plan Steering Group was established within the Department of Health to "drive the implementation of Reid's clinical recommendations."[210] Under this group's supervision the *WA Health Clinical Services Framework 2005-2015* (CSF 2005) was developed and released on 21 September 2005.

Then-Director General of Health, Dr Neale Fong, described the document as a strategic overview for the advancement of clinical services. Dr Fong added that the CSF 2005 was "finalised following a period of intense consultation". This process "engaged a large number of clinical stakeholders, staff and community in deliberation about the options and implications for implementation."[211] This initial input was collected into a public document to spark discussion on the changes required after the Reid Report. The *Clinical Services Consultation 2005* report was lauded by Dr Fong as a valuable influence "in the decision-making process for this framework".[212]

The CSF 2005 provides a "strategic direction for the delivery of clinical services throughout Western Australia".[213] It was designed to support the realisation of several long-term objectives. These include:

- providing a financially sustainable system;
- improving access to services;
- reducing inequality on health status;
- optimising public and private services; and
- improving the balance of preventative, primary and acute care.[214]

The Clinical Services Framework 2005 recognised the Reid Report's increasing emphasis on preventative health and the need to create a model of care "that invests more in keeping people

---

210 Department of Health, 2005, *Clinical Services Consultation 2005*, Department of Health, Perth, p2.

211 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pi.

212 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, ppi,38.

213 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p38.

214 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p1.

well and at home and accessing appropriate hospital services for the right reasons."[215] Like the HRC's call for a 'fundamental reprioritisation', the CSF 2005 agreed that a significant reconfiguration of health services was now warranted to achieve these goals.[216] A key feature of the framework was its outline for restructuring the metropolitan hospital system.

3.2 Report structure

(a) Metropolitan hospital services

The CSF 2005 introduced a Clinical Services Role Delineation matrix which defined the services, clinical level of care,[217] and requisite bed numbers for each metropolitan hospital. The distribution of services was based on the twin principles of:

- offering care nearer to people's homes; and
- reducing the duplication evident in metropolitan health services.[218]

At a macro level, the plan was to consolidate the 'North/South' Area Health Service model recommended in the Reid Report. A major priority was to ensure that neither population group within the metropolitan area health services was disadvantaged in terms of access to a continuum of care, "from the primary care sector…[through to] specialty clinical services, provided by a tertiary care hospital."[219] Within the North Metropolitan Area Health Service (NMAHS), hospital bed capacity was to remain fairly constant, albeit with a redistribution of services to reduce the travel demands for residents of the far northern suburbs. This would be achieved with most of Royal Perth Hospital's (RPH) beds being transferred to the 'central tertiary' hospital at Sir Charles Gairdner and an expanded facility at Joondalup Health Campus.

Whereas the Reid Report had only speculated on the future status of Joondalup Health Campus, the CSF 2005 advised that population growth had necessitated the need to plan for the conversion of this hospital to a 'fully-fledged' tertiary facility by 2015-16.[220]

---

215 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp1,4.

216 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p4.

217 A 'Level of Care' is applicable to a wide variety of public health services ranging from Surgical and Medical, through to Primary Care, Prevention and Promotion. It is based on a scale of 1 to 6, with Level 1 representing the most basic, through to Level 6 which includes the most sophisticated and specialist treatments.

218 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p7.

219 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p15.

220 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p8.

Alternatively, 'significant development' was scheduled for the South Metropolitan Area Health Service (SMAHS) catchment (predominantly the construction of Fiona Stanley Hospital and the expansion of Rockingham-Kwinana District Hospital), which had historically suffered from a relative shortage of beds.[221]

CSF 2005 endorsed the continuation of King Edward Memorial and Princess Margaret hospitals as tertiary care facilities under the State-wide Women's and Children's Health Service. The Reid Report recommendation to co-locate these hospitals at an adult tertiary site to resolve the operational difficulties each was currently facing was acknowledged in CSF 2005 as the preferred solution. Even so, CSF 2005 advised that PMH should be re-located to the North Block of RPH once that precinct was vacated. Conversely, King Edward was to be relocated to a new site. The CSF 2005 was non-committal on the location, suggesting that 'footprints' for the structure be maintained at the North Block of Royal Perth, the Fiona Stanley Hospital site and at Sir Charles Gairdner "with a final decision to be made closer to a move date."[222]

(b) Metropolitan bed strategy

The plan for hospitals within the metropolitan area health services was augmented by a Metropolitan Bed Strategy that determined the appropriate number of beds for each facility. The final results were derived using a 'complex' and 'dynamic' mathematical process called "demand modelling".[223] Modelling of this type has been used in several other states and underpinned the projections made in the Reid Report.[224] According to DOH, this process is not just about bed numbers. More important is the ability to accurately determine future activity levels taking into account a range of variables including the reforms advocated by the Reid Report, population growth, and efficiency gains in health care attributable to advances in medical technologies.[225] From this 'vital data platform', parameters are updated in order to predict the capacity of the health system and the required number and optimal location, of same-day and inpatient beds.[226] The proposed bed numbers for each metropolitan hospital are contained in a table at the end of the Clinical Services Delineation matrix in CSF 2005 and are listed in Table 3.1 against the original proposals contained in the Reid Report for each hospital.

---

221 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp16-17.

222 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p21.

223 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p13.

224 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p2.

225 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p21. See also, Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p13.

226 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p13.

Table 3.1- Demand modelling – comparative bed projections for the Reid Report versus Clinical Services Framework 2005[227]

Metropolitan hospital	April 2005	Reid Report (2014)+	CSF 2005 (2010-11)	CSF 2005 (2015-16)
Fiona Stanley	11++	600	610	1,058
Sir Charles Gairdner	645	700	986	1,046
RPH	708	50	64	72
Princess Margaret	256	150	256	178
King Edward Memorial	276	150	229	212
Graylands	263	200	210	136
Shenton Park [RPH Rehab]	236	Nil [closed]	122	0
Armadale-Kelmscott	207	300	274	276
Joondalup	235	300	494	623
Swan District	206	300	326	334
Rockingham	85	300	239	306
Bentley	235	200	196	200
Fremantle [incl Woodside]	541	150	252	217
Osborne Park	209	200	214	273
Kalamunda	71	25	50	50
TOTAL	**4,184**	**3,625**	**4,522**	**4,981**

+ The Reid Report's figures were based on an unclarified future timeframe. However 2014 is a reasonable estimate, as the Report called for the reconfiguration to occur within 10 years.

++ Palliative care beds provided under contract by St John of God Murdoch Hospice.

The marked difference between the bed numbers recommended in the Reid Report and the CSF 2005 demonstrates the dynamic nature of the demand modelling method. Chapter 5 will examine the veracity of DOH's demand modelling and its pitfalls. The significance of the modelling cannot be underestimated, as the results it produced were set to 'inform' the Infrastructure Development Plan that would ultimately direct the capital works program for the hospital system.[228] Chapter 6

227 Unlike the Reid Report, the CSF 2005 figures included same-day beds for 2010-11 (351 beds) and 2015-16 (394 beds).

228 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p13.

examines the status of the major hospitals in the overall reform process and discusses the issues that contributed to the varying projections contained in the Reid Report and the CSF 2005.

(c) Rural and regional health services

References to rural and regional health services in CSF 2005 are limited. The framework advised that the Western Australian Country Health Services (WACHS) and the South West Area Health Services (SWAHS) had commissioned their own clinical services plans for regional WA. For the SWAHS, this refers to the *Bunbury Health Task Force Report* while the *Country Health Services Review 2003* addressed the future planning needs for WACHS.[229] The CSF 2005 repeated the description provided in the Reid Report for the proposed Regional Network Model for WACHS. Without providing further detail, CSF 2005 confirmed that a capital and infrastructure plan for regional health services had been articulated. This would improve the capacity of regional facilities, patient transport services and staff retention strategies.[230]

(d) Mental health services

The CSF 2005 conceded that the State's mental health services were struggling to cope with the increasing incidence of mental illness in the community. To combat this $173 million had already been committed over three years as part of the Mental Health Strategy 2004-2007. Under this plan, 113 adult inpatient beds would be added across the metropolitan area and Bunbury. In addition, 420 beds would be established in 'community supported accommodation services' in a bid to assist those recovering from acute mental health episodes.[231] The CSF 2005 service delineation matrix recommended that over 750 mental health beds should be operating by 2015-16.[232] The overarching objective was to reduce the demand for acute mental health care, which was compromising the hospital Emergency Department services through inappropriate admissions.

(e) Organisational structure

The final section of the CSF 2005 lacked the detail that was evident in its description of the clinical service needs of the metropolitan hospital sector. Offered instead was a broad overview of the required direction for human resource management and systemic change that would ensure successful implementation of the health reform program. Regarding the structure of WA Health, the CSF 2005 repeated the position of the Reid Report, namely that several major organisational

---

229 Western Australian Country Health Services, 2003, *Country Health Services Review 2003*, Department of Health, Perth, p2,7.

230 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p24.

231 Department of Health, *Health Reform Implementation Taskforce: Western Australia's Mental Health Strategy 2004-2007*, 14 October 2004, Perth, n.p. Available at: www.health.wa.gov.au/hrit/publications/docs/Mental_Health_Strategy_2004-2007.pdf. Accessed on 25 January 2010.

232 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp, 11(d),27-28.

changes were required. Prominent among these were the "strengthening" of the recommended Area Health Services model and the establishment of State-wide clinical networks incorporating the input of public and private health providers, leading academics, carers and health consumers.[233]

(f) Workforce management

Without providing specific data, the CSF 2005 reported that the projections for future health workforce requirements in Western Australia had been developed.[234] However, confirmation was given that these calculations incorporated the Reid Report's recommendations regarding efficiency improvements. The CSF 2005 said productivity gains would be achieved through the following workforce developments:

- provision of administrative and clerical support to medical staff;
- expanding the prescribing rights of Nurse Practitioners; and
- developing multi-skilled health workers, particularly in rural areas, to perform the roles currently delivered by various individuals.

To increase the supply of workers, several strategies were being developed including:

- doubling the number of places for medical students between 2005-10;
- mapping the current and future requirements of the surgical workforce;
- continuing to increase the number of nurses in training, and retraining, programs; and
- continuing to source overseas labour where short-term demands are most acute.

Also under development were measures aimed at improving retention rates amongst existing staff.[235]

(g) Infrastructure development

The CSF 2005 agreed that to maintain and improve current facilities in line with proposed reforms, "significant investment in health care infrastructure was required."[236] DOH established an

---

233 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p29.

234 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p30.

235 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp31-32.

236 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p33.

Infrastructure Development Framework (IDF) to develop, manage, and monitor the program in liaison with the Government. The IDF is prepared with reference to the requirements arising from the demand modelling process and included in the CSF's Clinical Services Delineation matrix. A timeframe for the redevelopment program across each metropolitan hospital was included in the CSF 2005, although it was stressed that these schedules were subject to variation as planning details were further refined. The Health Infrastructure Steering Group (HISG) would be the lead entity within DOH overseeing the IDF. The HISG would work as a collaborative body incorporating the input of Area Health Service Chief Executives and the Department's Health Finance and Licensing Unit.[237]

(h) Information and communications technology

To support the CSF 2005, an Information and Communications Technology (ICT) framework was to be established. Following the national push towards 'e-Health' solutions, the ICT would feature a clinical information system available to all branches of the health system, including private hospitals and community health and primary care sectors. The ICT framework was to be implemented incrementally across the State and include "electronic patient records, single patient identifiers and provider identification".[238]

3.3 Political responses to the Reid Report and CSF 2005

The Gallop Government welcomed the Reid Report and the CSF 2005 and the then-Health Minister, Hon Jim McGinty, told Parliament that the Government accepted all recommendations except for the proposed relocation of Princess Margaret Hospital.[239] He said the plan to merge the administration of Royal Perth and Sir Charles Gairdner hospitals would "do away with duplication, waste and chewing up of the scarce health dollar, which has occurred through having these two large tertiary hospitals within three kilometres of each other in the city area."[240] Having acknowledged the HRC's preference for the SCGH site, Mr McGinty added that the Government would meet the recommendation that there be one northern tertiary hospital in the short to medium term.

Similarly, the then-Health Minister lauded the CSF 2005 as a 'bold vision'. He added that the accompanying investment in hospital redevelopment:

---

237 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp33-37.

238 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p35.

239 Recommendation No 31. By 2006, the Carpenter Government confirmed it would revert back to the original Reid recommendation to co-locate PMH and King Edward Memorial on the Sir Charles Gairdner site. See, Hon Mr Jim McGinty, Health Minister, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 24 May 2006, pE312. For the initial response see, Hon Mr Jim McGinty, Health Minister, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard) , 30 March 2004, pp1164-1165.

240 Hon Mr Jim McGinty, Health Minister, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 22 June 2004, pp4024-4025.

> *will give Western Australians the finest health care system in the nation, if not the world, and will deliver health care closer to where people live.*[241]

The 2006-07 State Budget announced a Metropolitan Infrastructure Development Plan (MIDP), developed in conjunction with the CSF 2005, to provide an initial analysis of the infrastructure implications that will likely flow from the updated reform program.[242] By this time, the Labor Government had altered its position on the future of Princess Margaret Hospital and now agreed with the CSF 2005's call to construct PMH anew on the North Block of the Royal Perth Hospital site and allocated $222 million towards this project.[243]

Then-Opposition leader, Hon Colin Barnett, offered the Liberal Party's support for the majority of the recommendations in the Reid Report, but described the report as "fundamentally flawed because it is a centre-south model and ignores the northern suburbs."[244]

Importantly, he was also concerned about the lack of consideration given to private sector facilities, arguing that:

> *35% of hospital beds in Western Australia are part of the private hospital system.…They are an integral part of our health delivery system, yet that is ignored in the Reid Report.*[245]

The Opposition supported all but two of the Reid Report's recommendations. The changes planned for Osborne Park Hospital, which would result in the loss of its obstetric service, drew heated criticism. Then-Opposition Health Spokesman, Hon Dr Kim Hames, branded the decision as 'ridiculous'.[246] For Dr Hames, the cancellation of the 1,500 births performed at Osborne Park each year would place unwanted pressures on an already struggling obstetric department at King Edward Memorial Hospital.[247] Similarly, a Legislative Council Select Committee on Public

---

241 Hon Mr Jim McGinty, Health Minister, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 September 2005, pp5759-5760.

242 WA Department of Health, 'WA Health Infrastructure Development', nd. Available at: www.health.wa.gov.au/hrit/infrastructure/home/index.cfm. Accessed on 20 January 2010. See also, Department of Treasury and Finance, 2006, *2006 Budget Statements: Budget Paper No.2 Volume 2*, Department of Treasury and Finance, Perth, p531.

243 Hon Mr Jim McGinty, Health Minister, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 September 2005, p5759.

244 Hon Mr Colin Barnett, Opposition Leader, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 August 2004, p5605.

245 Hon Colin Barnett, Opposition Leader, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 August 2004, p5605.

246 In a later debate about Osborne Park Hospital, Dr Hames indicated some personal knowledge of its operations, "Osborne Park Hospital's maternity service will definitely stay at that hospital. That hospital provides a fantastic service to that region; in fact, it is a hospital at which I have delivered numerous babies in the past."- see Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates Committee B*, 28 May 2009, pE268.

247 Mr Anthony Deceglie, 'KEMH Staff Tackle Emergency Record', *Sunday Times*, 23 March 2008, p5.

Obstetric Services chaired by Hon Helen Morton, was established after the tabling of the CSF 2005. Ms Morton expressed concern that the realignment of obstetric services involved the closure of some community-based maternity units, thereby restricting the choice of service for expectant mothers and their families.[248]

However, the main issue of contention concerned the arrangement of the State's tertiary hospitals. Both major parties agreed to the establishment of the 'southern tertiary' hospital at Murdoch and the $1.76 billion commitment made to fund the newly-named Fiona Stanley Hospital. However, the proposal surrounding the 'northern tertiary' hospital was problematic. The Liberal Party proposed that Royal Perth Hospital should retain its tertiary status and not be targeted for closure via a merge with SCGH.[249] Mr Barnett argued that the hospital "employs 5,000 people, it serves and sees thousands of patients every year….[Thus] we will retain RPH as one of our two major tertiary hospitals".[250]

Speaking after the CSF 2005 was published, Dr Hames reiterated the Liberal Party's opposition to the closure of RPH. Among his arguments was that the proposal will severely disadvantage patients living in Perth's 'eastern corridor'. He added that the flow-on of Emergency Department presentations to SCGH would be impossible for that hospital to meet, notwithstanding the proposed increase in its size.[251] Dr Hames presented petitions containing over 40,000 signatures to Parliament opposing the closure of Royal Perth Hospital. He claimed that the closure was not practical and would not generate any savings.[252] The 16 petitions presented to Parliament opposed the closure of Royal Perth Hospital and requested that the name remain, but did not call for it to be maintained as a tertiary hospital facility.[253]

The fate of RPH became a source of continuing debate during the 37th Parliament [2005-08] and featured during the 2008 election campaign. The Liberal Party took to the 2008 election a policy to retain RPH as a tertiary hospital. Since its election victory in 2008—which Dr Hames partly credited to the Liberal Party's stand on RPH— the Barnett Government has sought to guarantee the RPH's future as a tertiary institution via the Royal Perth Hospital Protection Bill 2008, which is currently before Parliament (see Chapter 7 below). This election commitment necessitated a major revision of the CSF 2010 process, as the next chapter outlines.

---

248 Select Committee into Public Obstetric Services, 2007, *Report*, Parliament of Western Australia, Perth, p3.

249 *Building for the Future: Perth's Hospitals*, paper presented at the Liberal Party State Conference, 2004.

250 Mr Robert Taylor, 'Barnett Pledges to Keep RPH', *The West Australian*, 2 August 2004.

251 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 22 September 2005, pp5904-5906.

252 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 March 2007, pp 851-852.

253 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), *Parliamentary Debates* (Hansard), 16 August 2006, p4733; 13 September 2006, p5855; 31 October 2006, p7883; 29 November 2006, p8924; 8 May 2007, p1751; 13 May 2008, p2851; and 2 December 2008, p733.

Finding 20

The Gallop Government in 2004 agreed to all but one of the Reid Report's recommendations for reforming the State's health system. Its opposition to the co-location of Princess Margaret Hospital with the King Edward Memorial Hospital was later reversed.

Finding 21

The Liberal Party agreed with all but two of the Reid Report's recommendations for reforming the State's health system. It opposed the plan to close Royal Perth Hospital and Osborne Park Hospital's obstetric service.

Finding 22

Public petitions opposed the closure of Royal Perth Hospital and requested the Government to retain its name. The Liberal Party's election commitment was to maintain Royal Perth Hospital as a tertiary hospital.

CHAPTER 4 CLINICAL SERVICES FRAMEWORK 2010-2020

4.1 Policy climate preceding publication of CSF 2010

The *WA Health Clinical Services Framework 2010-2020* (CSF 2010) was released on 3 December 2009. By then, despite the Department of Health's assurances to this Committee that "the overall reform program is largely completed or in the process of implementation",[254] disquiet over the current status of the health system was evident from comments by both the public and professional health staff.

As will be shown in later chapters, the pace of the proposed infrastructure redevelopments has slowed since 2005. This has hampered the realisation of the Reid Report's forecast of a reform-driven "average two-percentage points per annum reduction in the growth of health expenditure" [255] over the five years to 2009. In fact, DOH has continued to exceed its operating budget. In late 2009 DOH revealed that it was already about $200 million over budget for the current financial year and had accessed $49.8 million dollars from special purpose trust accounts to meet its year-end budget shortfall for 2008-09. These financial difficulties were likely to continue with DOH also subject to an additional 3% spending cut via the Government's 'Efficiency Dividend' process.

Meanwhile, local newspapers regularly report on operational deficiencies within the health system, including ambulance and Emergency Department delays, bed shortages and a rise in stress-induced compensation claims from health staff.[256] Assessing this environment, one commentator described the State's health system as 'permanently ill' and likely to endure a "death by a thousand cuts….as slowly but surely services are left with less money and fewer staff."[257] The financial impact of the decision to retain RPH was also drawing criticism. Mr Paul Murray termed DOH a 'house of cards' about to fall over after the Department of Treasury and Finance advised that the decision to retain Royal Perth Hospital as a tertiary facility would have significant recurrent cost implications.[258]

In the week leading up to the release of CSF 2010, the Labor Opposition went further in its attack on the Liberal commitment to retain RPH as a tertiary hospital. Opposition Leader, Hon Eric Ripper, MLA, argued that the entire "Reid review reform program has degenerated into a hospital

---

254 Submission No. 8 from Department of Health, 19 June 2009, p2.

255 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pvii.

256 See for instance, Mr Anthony Deceglie, 'Waiting for 40 Hours at RPH', *The Sunday Times*, 29 November 2009, p27; Ms Kate Tarala, 'RPH at Gridlock Brings Winter Struggle Warning', *The West Australian*, 10 June 2009, p13; Ms Cathy O'Leary, 'Emergency Waiting Time Worst in Nation', *The West Australian*, 22 July 2009, p1; Mr Anthony Deceglie, 'Ramping Chronic', *The Sunday Times*, 19 April 2009, p20; Mr Anthony Deceglie, 'Hospital Compo Claims Soaring', *The Sunday Times*, 19 April 2009, p12.

257 Ms Cathy O'Leary, 'Face It, Health Has a High Price', *The West Australian*, 1 December 2009, p21.

258 Mr Paul Murray, 'Health House of Cards About to Fall Over', *The West Australian*, 20 June 2009, p30.

building program that is without genuine reform and lacks rationality."[259] In response, Health Minister Dr Hames maintained that the Government is "following the Reid recommendations more than the former government did."[260] He added that the CSF 2010 would demonstrate this.

Finding 23

The Reid Report's prediction of a reform-driven average 2% per annum reduction in the growth of health expenditure over 2004-09 has not been realised.

4.2 Background to CSF 2010

Several factors drove the need for an updated Clinical Services Framework. One was procedural, as DOH explained in the CSF 2010:

> *The CSF is reviewed and updated periodically to ensure it remains responsive to the principles of health reform and reflects changes in the health care environment.*[261]

However, the impact of the Government's policy change was also highlighted:

> *The CSF 2010 takes into account policy decisions made since the publication of the previous clinical services framework.... For example, the decision to retain Royal Perth Hospital has necessitated a major adjustment in the clinical planning process.*[262]

Finding 24

The decision to retain Royal Perth Hospital necessitated a major adjustment to the timing of the clinical planning process of the Department of Health for the *Clinical Services Framework 2010-20*.

---

259 Hon Eric Ripper, Opposition Leader, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 24 November 2009, p9605.

260 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 24 November 2009, p9608.

261 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p2.

262 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp2-3.

DOH said that the consultation process for CSF 2010 was as thorough as that for the earlier reform documents.[263] However, it cautioned that the reform process was impacted by further policy changes and budgetary restraint:

> *…it is important to note first that much of the planning is based on projections, and projections become less exact the further they reach into the future. Secondly, the successful delivery of services specified within CSF 2010 is contingent on the correct alignment of circumstances (political, economic, etc.) and resources (workforce, funding, etc.). Many of these factors are beyond the control of this CSF.*[264]

This prudent tone is further evident throughout later sections of CSF 2010. For example:

> *WA Health works within the constraints of policy and available resources to provide a range of health services.*[265]

And:

> *With finite resources, WA Health is working to manage demand and to reduce inefficiencies.*[266]

CSF 2010, in comparison to its predecessor, is far more circumspect in its approach to outlining the longer term vision for health in Western Australia. For example, the Health Service Development Timeframe, which was included in the original CSF as a provisional timetable for the redevelopment of the metropolitan hospital network, does not appear in CSF 2010.

4.3 Structure of CSF 2010

The CSF 2010's introduction is followed by several chapters outlining what is new and what has been revised. CSF 2010 is described as "the first document published in WA that encompasses clinical planning across the entire State public sector and across all facets of hospital care."[267] This is made possible through an expanded demand modelling process and role delineation matrix that now included:

---

263 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p3.

264 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p4.

265 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p10.

266 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p27.

267 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p3.

- a breakdown of required bed numbers and services at metropolitan and country hospitals (incorporating Regional Resource Centre and Integrated District Health Service facilities);
- recommended levels of care for hospital services in Regional Resource Centres and Integrated District Health Services; and
- a level of care matrix for various 'non-hospital services' throughout the State including public health, community mental health, primary and ambulatory care.

The updated framework also advised of new developments regarding infrastructure and workforce initiatives. The WA Country Health Services (WACHS) workforce were now integrated into a State-wide planning process. Also, a State Health Infrastructure Plan (SHIP) was nearing completion. SHIP would expand upon the original Metropolitan Infrastructure Development Plan of 2005 and would provide a 10 year capital assets program for health across the State.[268]

(a) Metropolitan hospital network – bed distribution

The critical feature of the CSF 2010 is the revised Clinical Services Framework Matrix, which includes the configuration of the major hospital network in light of the policy change surrounding the retention of Royal Perth Hospital. Health Minister Dr Hames said that CSF 2010 allowed for an increase of 574 beds across the health system by 2015.[269] This appears to produce a total metropolitan bed figure that is close to the number projected in CSF 2005.[270] However, as Table 4.1 below illustrates, the revised projections actually result in 171 **fewer** beds (4,801 versus 4,981) in 2015 across the metropolitan hospital network, compared to the original CSF 2005 projections.

When questioned by the Committee about this anomaly, Ms Jodie South offered the following response:

> *In the previous CSF it was not in the published document. There were no bed numbers put against Peel. It was not because there was a belief that Peel would shut or anything like that; it was purely the case that the Premier decided that it was out of scope for the 2005 CSF*.[271]

---

268 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp14-15.

269 Hon Dr Kim Hames, Minister for Health, '10-year blueprint for WA Health Services', 3 December 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132878&minister=Hames&admin=Barnett. Accessed on 15 March 2010.

270 Comparisons with corresponding time periods are not possible between CSF 2005 and CSF 2010 given the different base years and timeframes used in each document. The closest possible comparison that can be made is between the CSF 2005 10-year timeframe for 2015-16 and CSF 2010's 5-year forecast for 2014-15.

271 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 16 February 2010, p2.

The Committee was assured that:

> *If we include the planned number of beds* [including Peel] *under the old CSF compared with the new CSF, there are marginally less* [sic] *beds in the metropolitan system planned under the current CSF.*[272]

The Committee does not accept this analysis. Working in reverse, by removing the Peel Health Campus and Murray District Hospitals' bed numbers from CSF 2010 projections to gain an accurate comparison with CSF 2005, the following changes across the metropolitan network is evident for 2015:

- Tertiary hospitals – 73 fewer beds;
- General hospitals – 249 fewer beds; and
- Specialist/Other hospitals – 151 more beds (primarily obstetrics and neonatal).

Finding 25

The Clinical Services Framework 2010-20 projections for 2015 show 171 fewer beds across the metropolitan hospital network compared to the projections in the original Clinical Services Framework 2005-15.

[272] Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence,* 16 February 2010, p3.

Table 4.1- Public metropolitan bed projections for 2015: CSF 2005 compared to CSF 2010[273]

Metropolitan hospital clinical services matrix	CSF 2005 beds (2015-16)	CSF 2010 beds (2014-15)
Tertiary Hospitals		
Fiona Stanley	1,058	658
State Rehab Centre (at Fiona Stanley)	n/a	140
Sir Charles Gairdner	1,046	616
RPH	72	470
Princess Margaret	178	279
King Edward Memorial	212	271
Graylands	136	195
Shenton Park - [RPH Rehabilitation]	[Closed]	[Closed]
Total Tertiary Hospital Beds	**2,702**	**2,629**
General Hospitals		
Armadale-Kelmscott	276	270
Joondalup	623	471
Swan District	334	327
Rockingham	306	222
Total General Hospital Beds	**1,539**	**1,290**
Specialist and Other Hospitals		
Bentley	200	219
Fremantle - [including Woodside]	217	362
Osborne Park	273	267
Kalamunda	50	43
Total Specialist and Other Hospital Beds	**740**	**891**
COMBINED SUB-TOTAL	**4,981**	**4,810**
Peel Health Campus – [Included as a General Hospital]	n/a	140*
Murray District - [Included in Rockingham numbers]	n/a	20*
TOTAL METROPOLITAN BEDS	**4,981**	**4,970**

273 Bed numbers for the Peel Health Campus and Murray District Hospital were not included in the CSF 2005 matrix for metropolitan hospitals. These 160 beds are now included in the General Hospital allocation for CSF 2010. The bed figure for Murray District is based on its current capacity, as no projected figure was provided in CSF 2010. Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp11a-11d,14. See also, Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp21-26.

The CSF 2010 projections for 2015 also show a marked redistribution of bed numbers across the metropolitan area health services. This reallocation clearly works to the detriment of North Metropolitan Area Health Service (NMAHS), as Table 4.2 illustrates. The main reason for this is the transfer of the management of Royal Perth Hospital to the South Metro Area Health Service (SMAHS) that occurred in January 2006.[274]

In recent correspondence from Mr Kim Snowball, Acting Director General of Health, it was confirmed that RPH will continue to service people living in the Perth's northern suburbs covered by the NMAHS while being administered by the SMAHS:

> *people living in the northern suburbs of Perth can continue to receive adult tertiary services from all tertiary facilities but particularly, RPH and SCGH.*[275]

Table 4.2- Changes to tertiary bed allocations, by metropolitan area health service[276]

Hospital	CSF 2005 (beds in 2015-16)	CSF 2010 (beds in 2014-15)	Difference
North Metro AHS			
Sir Charles Gairdner	1,046	616	-430
Royal Perth Hospital	0	n/a	0
TOTAL NMAHS	**1,046**	**616**	**-430**
South Metro AHS			
Fiona Stanley Hospital	1,058	658	-400
Royal Perth Hospital	n/a	470	+470
TOTAL SMAHS	**1,058**	**1,128**	**+70**

The redistribution of tertiary beds across the metropolitan area health services in CSF 2010 is inconsistent with the intent of the Reid Report and original CSF 2005, which said that bed capacity would be based on population needs. CSF 2005 also said that the NMAHS bed capacity would remain 'relatively constant' and would "improve access and reduce the distance travelled

274 Royal Perth Hospital, 'About Us', 2006. Available at: www.rph.wa.gov.au/about.html. Accessed on 15 March 2010.

275 Mr Kim Snowball, Acting Director General of Health, *Response to Questions on Notice,* 16 February 2010, p3.

276 Figures in this Table do not include the other tertiary hospitals (PMH, KEMH, Graylands and RPH Shenton Park Rehabilitation Hospital), as they are listed in CSF 2010 as State-wide services.

for services".[277] This transfer of beds to the SMAHS contained in CSF 2010 also belies the earlier criticism made by the Premier, Hon Colin Barnett, when Opposition Leader, that the Reid Report was "fundamentally flawed because it is a centre-south model and ignores the northern suburbs."[278] The original move of RPH to the SMAHS in 2006 was in preparation for its staff to move to Fiona Stanley Hospital when it opened.

Despite the response from the Acting Director General, there does not seem to be any reason to continue with the location of the administration of RPH to the SMAHS unless its services were to be offered to people in Perth's southern suburbs, and to make up for the reduction in beds at the Fiona Stanley Hospital in 2015-16. Whatever the justification, the retention of such a large number of tertiary beds in central Perth is poor health planning. It denies people living in the southern and northern suburbs (where very high population growth rates are evident) the right to convenient tertiary-level hospital care.

Finding 26

The proposed redistribution of tertiary beds in CSF 2010 works to the clear detriment of people living in both Perth's northern and southern suburbs. This redistribution is inconsistent with the intent of the Reid Report and the original Clinical Services Framework 2005-15.

Table 4.3 below shows the five and eleven-year bed number projections from CSF 2010 for the metropolitan tertiary and general hospitals.

277 Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp16-17.

278 Hon Mr Colin Barnett, Opposition Leader, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 August 2004, p5605.

Table 4.3- CSF 2010 metropolitan bed projections for 2014-15 and 2020-21[279]

Metropolitan Hospital Clinical Services Matrix	CSF 2010 beds (2014-15)	CSF 2010 beds (2020-21)
Tertiary Hospitals		
Fiona Stanley	658	658
State Rehabilitation Centre (Fiona Stanley)	140	180
Sir Charles Gairdner	616	616
RPH	470	494
Princess Margaret	279	247
King Edward Memorial	271	286
Graylands	195	195
Total Tertiary Hospital Beds	**2,629**	**2,676**
General Hospitals		
Armadale-Kelmscott	270	437
Joondalup	471	594
Swan District	327	496
Rockingham[#]	242	356
Peel Health Campus	140	210
Total General Hospital Beds	**1,450**	**2,093**
Specialist and Other Hospitals		
Bentley	219	219
Fremantle - [including Woodside]	362	382
Osborne Park	267	279
Kalamunda	43	43
Total Specialist and Other Hospital Beds	**891**	**923**
TOTAL METROPOLITAN BEDS	**4,970**	**5,692**

Includes bed numbers for Murray District Hospital, currently a 20 bed facility.

The Stage 2 projections in CSF 2010 add 643 beds to the outer metropolitan general hospitals by 2020-21. While this is an important recognition of the unprecedented population growth occurring in these localities, the Committee has several reservations about its timing. Firstly, the proposed increase in capacity is not guaranteed. CSF 2010 confirms that these bed numbers

> *assume additional built capacity by 2020/2021. The exact timing of these developments will be outlined in Health's updated 10 year capital plan.*[280]

279 Bed numbers in this Table include contracted beds.

Secondly, the decision to reduce the capacity from what was originally proposed for 2015 creates further difficulties for these hospitals, which are already struggling to cater for the population growth witnessed since 2001. The importance of this point is demonstrated in Chapter 6 in the profile of the Joondalup Hospital.

(b) Metropolitan hospital system – configuration and services

(i) Tertiary hospital sector[281]

A comparison of the proposed configuration of the tertiary hospital sector presented in CSF 2005 with that of CSF 2010 demonstrates a lack of progress with key aspects of the health reform program. The original Clinical Services Framework said that by 2011:

- Fiona Stanley Hospital (FSH) would be operational;
- as a consequence, Fremantle Hospital would no longer operate as a tertiary facility; and
- tertiary services at Royal Perth Hospital would have been relocated to Fiona Stanley Hospital.

In addition, the provisional CSF 2005 timeframe suggested that the process of relocating Princess Margaret Hospital to the North Block at RPH would commence by 2013. However, by the time CSF 2010 was released in December 2009, the revised scheduling indicated that:

- FSH was now expected to become operational by 2014;
- Fremantle Hospital would continue to offer tertiary services while FSH remained under construction;
- RPH would be retained as an additional tertiary facility; and
- Princess Margaret Hospital would now be relocated to the QEII site of Sir Charles Gairdner Hospital with a completion date of 2015.

CSF 2010 also departed considerably from CSF 2005 in the allocation of some expensive tertiary clinical services. Prior to the Reid Report, Level 6 medical, surgical and clinical services were available across three metropolitan sites (Royal Perth, Sir Charles Gairdner and Fremantle hospitals). Both the Reid Report and CSF 2005 recommended the ultimate removal of tertiary facilities from RPH to overcome 'unnecessary duplication' of such services between it and Sir Charles Gairdner Hospital (just 3 km from RPH).

---

280 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p22.

281 For bed numbers in this section, see, Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, pp8,11a-11d,20-21. See also, Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp17-19,21-26.

The Reid Report argued that "a cardiac surgical unit is likely to be most safe, effective and sustainable when it manages around 800 cases a year."[282] Current demand for this expensive surgery is for just over what one unit could provide, but distributed over three hospitals. Forecast demand data provided by DOH through to 2014-15 indicates that cardiothoracic surgery activity will still only be at a level well less than two units should offer, but will still be distributed over three hospitals (see Table 4.4).

Table 4.4- Projected cardiothoracic surgery separations by hospital, 2011-15[283]

Hospital	2011-12	2012-13	2013-14	2014-15
Royal Perth Hospital	390	396	402	376
Sir Charles Gairdner Hospital	460	466	473	413
Fremantle/Fiona Stanley Hospital	279	284	286	410
TOTAL	**1,129**	**1,146**	**1,161**	**1,199**

Despite this, the retention of Royal Perth Hospital as a tertiary facility ensures the status quo will be maintained across this, and other expensive Level 6 clinical services, including:

- adult neurosurgery;
- adult orthopaedic surgery; and
- Emergency Department.

RPH will also retain the State's heart and lung transplant service which, under CSF 2005, was to be transferred to the new Fiona Stanley Hospital. Another area where the decision to retain RPH as a tertiary hospital continues service duplication is mental health. CSF 2010 maintains adult Mental Health Inpatient services at RPH (others include Fiona Stanley, Sir Charles Gairdner and King Edward Memorial hospitals), taking the number of such facilities to four by 2015 from the current three.

282 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p60.

283 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Questions on Notice*, 9 March 2010, p1.

Finding 27

Despite acknowledgement in the Reid Report that there was some 'unnecessary duplication' of services north of the Swan River between Royal Perth Hospital and Sir Charles Gairdner Hospital, the CSF 2010 restores the status quo (and in-built duplication) in high-cost areas including adult neurosurgery, cardiothoracic surgery, orthopaedic surgery and Emergency Department services.

Finding 28

Retention of high-cost tertiary services at Royal Perth Hospital has left them based where staff currently work, rather than in the northern and southern suburbs where population growth has created a high demand for health services.

Recommendation 12

The Minister for Health provide to Parliament within three months of this report being tabled the number of cardiac surgical procedures carried out at Royal Perth Hospital, Sir Charles Gairdner Hospital, the Mount Hospital and Fremantle Hospital for 2007-08, 2008-09 and 2009-10; and the average annual cost of these procedures for each of the four hospitals.

(ii) General hospital sector

In CSF 2010 the Armadale-Kelmscott Memorial Hospital, Swan District Hospital (to become Midland Health Campus), Rockingham General Hospital, and Joondalup Health Campus maintain their status as general hospitals. The Peel Health Campus is added to this configuration in CSF 2010. Some other notable changes to general hospitals are evident in this document. The first is the reduction in their projected bed capacity. Collectively the four general hospitals, based at locations described in the Reid Report as 'high-growth metropolitan areas', have 249 fewer beds allocated to them by 2015. Importantly, the CSF 2005 had advocated instead expanding these hospitals as part of its strategy of providing 'care in the most appropriate setting', and thus reducing the burden on central tertiary hospitals.[284] For example, Rockingham Hospital, after removing the 20 Murray District Hospital beds included in its CSF 2010 total, has 84 fewer beds allocated for 2010-15. To compensate, a further 114 beds are projected to be added by 2020-21.

[284] Department of Health, 2005, *WA Health Clinical Services Framework 2005–2015*, Department of Health, Perth, p5.

Joondalup Health Campus is where the effect of the revision in general hospital beds within the CSF 2010 is most pronounced. The CSF 2005 projection of 623 beds for 2015 is reduced to 471 beds in CSF 2010. Even the 2020-21 allocation of 594 beds is lower than CSF 2005 figure for 2015. Moreover, the plan to upgrade Joondalup to a tertiary facility by 2015 has been deferred indefinitely. DOH advise in CSF 2010 that Joondalup Health Campus "will remain a general hospital within the scope of this iteration of the CSF".[285]

Despite this reclassification, Joondalup is scheduled to be upgraded to a Level of Care rating of 5 (from 4) across most of its clinical services by 2014-15.[286] Joondalup's services for dealing with disaster preparedness increase from Level 4 to Level 6 by 2014-15. The revised projections in CSF 2010 for Joondalup Health Campus offer the starkest example of the relative health service disadvantage suffered by people living in Perth's northern suburbs.

Finding 29

The projected 2015 bed allocation in CSF 2010 removes 249 beds across the following general hospitals: Armadale-Kelmscott Memorial, Joondalup Health Campus, Rockingham and Swan District. This represents a significant departure from the CSF 2005 strategy of providing 'care in the most appropriate setting' to patients.

Recommendation 13

The CSF 2010 be amended to ensure that tertiary services are provided according to population needs.

Current population projections indicate a need for tertiary services at the Joondalup Health Campus and the Government should upgrade the Joondalup Health Campus to a tertiary facility by 2020.

(iii) Specialist hospital sector

Osborne Park, Fremantle and Bentley hospitals remain scheduled to become specialist hospitals focussing on providing mental health, aged-care and rehabilitation services. Even so, some differences are evident between CSF 2005 and CSF 2010:

---

285 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p17.

286 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp-21-27.

- obstetric services at Osborne Park Hospital are retained, albeit with a reduced capacity of 25 beds (down from 35);[287]
- Fremantle and Osborne Park hospitals are to retain a surgical facility for "high volume, low complexity surgery", including same-day procedures; and[288]
- the date at which these specialist hospitals were to become operational had been extended from 2011 to 2014 due to the delays in completing work at other hospitals, notably the construction of the Fiona Stanley Hospital.

(iv) Rural and regional hospital system

CSF 2010 is notable for its inclusion for the first time of WACHS hospitals into its Clinical Services Delineation Matrix. This allows the display of the required bed numbers across the six Regional Resource Centres (RRCs) and 15 Integrated District Health Services (IDHS).[289] Table 4.5 below contains the CSF 2010 projections for these hospitals, some of which will be examined further in Chapter 6. The biggest increases in the 10-year time frame are for beds in the RRCs at Broome and Bunbury, while the largest increase for an IDHS is at Busselton.

---

287 This development is consistent with the Liberal Party's opposition to the proposed closure of these services before the 2008 State election, and is another of the policy changes contained in CSF 2010.

288 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, pp18,22.

289 In December 2005 the South West Area Health Service (containing one Regional Resource Centre and four Integrated District Health Services) was incorporated into WACHS. See, WA Country Health Services, 'Organisational Structure', 2006. Available at: www.wacountry.health.wa.gov.au/default.asp?documentid=396. Accessed on 28 January 2010.

Table 4.5- WA Country Hospital Services hospital bed numbers – current versus CSF 2010[290]

Hospital	Current beds (2007-08)	CSF 2010 (2014-15)	CSF 2010 (2020-21)	Change 2007 to 2021
Regional Resource Centres				
Kalgoorlie	116	131	140	+21%
Broome	45	79	87	+93%
Port Hedland	58	63	72	+24%
Albany	124	126	134	+8%
Geraldton	93	96	117	+26%
Bunbury	160	170	245	+53%
Total RRC Beds	**596**	**665**	**795**	**+33%**
Integrated District Health Services total beds numbers#				
Esperance	39	39	39	-
Derby	47	53	58	+23%
Kununurra	42 (10)	46 (10)	50 (10)	+19%
Newman	12	12	12	-
Nickol Bay	40	40	40	-
Katanning	48 (19)	48 (19)	48 (19)	-
Carnarvon	41 (15)	41 (15)	42 (15)	+2%
Busselton	59	76	82	+39%
Margaret River	24	24	25	+4%
Collie	36	36	36	-
Warren	30	30	30	-
Northam	48	48	48	-
Merredin	30	30	30	-

290 Figures in this Table include contracted beds. Bed numbers in brackets are reported aged-care beds.

Narrogin	51	51	51	-
Moora	23 (8)	23 (8)	23 (8)	-
Total IDHS Beds	**570 (52)**	**597 (52)**	**614 (52)**	**+8%**
TOTAL	**1,166**	**1,262**	**1,409**	**121%**

(c) Current and future delivery of health services

The remaining sections of the CSF 2010 discuss in a general manner the strategies to be followed, and partnerships to be utilised, to improve the overall delivery of health care in the State. Several programs are identified as complementary to the quest of reducing hospital length of stays and Emergency Department presentations. These include:

- Hospital in the Home (HiTH);
- Rehabilitation in the Home (RiTH);
- Hospital in the Nursing Home;
- Friend in Need - Emergency (FINE) Scheme (a new program designed to develop and improve non-in-patient acute and complex care in the community); and
- After-hours GP Clinics.[291]

In addition, 18 'Health Networks' have been established since July 2006 to develop a State-wide clinical policy over a range of disciplines. Within these networks, clinicians and consumers have worked together to design evidence-based 'models of care' to improve the efficiency with which health care is delivered. This development advances a recommendation of the Reid Report and a reform initiative announced in the CSF 2005. Still, it is important to note that these models of care may not all be reflected in clinical practice. The DOH website states that models of care only 'outline a plan' and that collaboration continues with Health networks "to translate these models into improvements in service delivery."[292] Little detail is given in CSF 2010 regarding whether all these programs or plans have been fully costed, implemented and evaluated.

Other major initiatives identified in CSF 2010 include the Four Hour Rule program. Under this scheme, the roll-out of which has already commenced, hospitals have two years to devise

[291] Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p29.

[292] Department of Health, 'Improving Health Services – Model of Care Implementation', (nd). Available at: www.healthnetworks.health.wa.gov.au/modelsofcare/implementation.cfm. Accessed on 4 February 2010.

strategies and processes to ensure that "98% of patients arriving at EDs are seen and admitted, discharged or transferred within four hours".[293]

At the end of 2009, none of Perth's adult tertiary hospitals had reached 60% of patients being treated within four hours, the worst being SCGH with only 47% of ED patients being treated within this time. By contrast, PMH saw nearly 90% of its ED patients within four hours.[294] The Health Minister reported in late April 2010 that after a year of operation, 30% more patients were being seen, admitted, discharged or transferred within four hours of presenting at a Perth ED.[295]

Finding 30

The successful implementation of the Four Hour Rule program may help relieve pressures on Perth's tertiary hospitals.

Recommendation 14

The Department of Health report to Parliament by the end of 2010 on successful strategies used in other jurisdictions that can reduce avoidable admissions to Western Australian hospitals.

In terms of other parts of the health system, CSF 2010 mentions that the State Mental Health Policy is due for release later in 2010, and will be geared towards "promoting mental wellbeing and preventing illness."[296] The CSF 2010 also mentions the recently released reports of the National Hospital and Health Reform Commission (NHHRC) and National Preventative Health Taskforce (NPHT) and acknowledges that "future financial investment will focus on these areas."[297]

---

293 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p29.

294 Ms Cathy O'Leary, 'Hospitals set to miss key 4-hour target', *The West Australian*, 11 March 2010, p19.

295 Hon Dr Kim Hames, Minister for Health, 'State Government's four-hour target reduces patient waiting times', 17 April 2010. Available at: www.mediastatements.wa.gov.au/Pages/Results.aspx?ItemID=133358. Accessed on 22 April 2010.

296 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p28.

297 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p10.

Finally, the value of Federal/State joint initiatives is considered as part of 'The Way Forward' in delivering health care.[298] One example is the Federal plan to fund privately-run GP Super Clinics, which are designed to "improve coordination between GPs, public hospital and community services including allied health services and Commonwealth health services."[299] Once established, these clinics should provide a range of clinical services on one site and will allow a greater emphasis on prevention and chronic disease management, with the goal of reducing the current pressure on hospital Emergency Departments.

Given DOH's commitment to manage demand and to reduce inefficiencies, it is surprising the lack of comment in CSF 2010 surrounding the potential use of private hospital services to reduce pressures in the State's public hospitals. Despite the Reid Report and the CSF 2005's call for the optimisation of public and private services, the CSF 2010 includes just one paragraph discussing the merit of this strategy:

> *There is an emerging requirement for WA Health to explore further partnership opportunities with the private sector*….[These] *could relate to a single aspect or combination of aspects in the areas of asset investment or service operation.*[300]

4.4 Political responses to CSF 2010

Like his predecessor following the release of CSF 2005, the Health Minister was effusive in his praise of the potential of CSF 2010:

> *This plan positions the State to deliver high-quality health services for the entire WA community in the coming decade…. A key element of this blueprint for WA's health system is the State Government's decision to retain Royal Perth Hospital as an inner city, tertiary hospital with a major Emergency Department.*[301]

298 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p27.

299 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p31.

300 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, Perth, p33.

301 Hon Dr Kim Hames, Minister for Health, '10-Year Blueprint for WA Health Services', 3 December 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132878&minister=Hames&admin=Barnett. Accessed 29 January 2010.

However, it is difficult to accept the concept of the CSF 2010 as a 'blueprint' given Dr Hames comments to the media in response to questions regarding the costing of the new framework:

> *the job of the framework isn't to set in place what the Government will fund in terms of beds in the future…The requirement to do the sums is now a Treasury requirement.*[302]

The Under Treasurer, Mr Tim Marney, appearing before the Committee three weeks before CSF 2010 was released, gave no indication that full funding of the CSF 2010 proposals was a *fait accompli*:

> *Once the clinical services framework is approved by government, Health will plug into…* [their funding] *model and spit out a number at the end and we will digest on it or choke on it one way or another.*[303]

Dr Hames told the media that the CSF 2010 had been endorsed by Cabinet without locking the Government into every detail and added that:

> *If the Treasury and the Government feel that they are unable to fund the management of those beds, then that will be a decision of Government.*[304]

When pressed by the media as to whether the CSF 2010 was anything more than a wish-list, Dr Hames replied:

> *Call it a wish list if you want. This is the wish list that Western Australia needs to have to properly cater for the demands in the future of health in WA.*[305]

In response, the Labor Opposition maintained its long-standing criticism of the financial viability of maintaining Royal Perth Hospital as a tertiary facility. Speaking the week before CSF 2010 was released, Shadow Treasurer, Mr Ben Wyatt, said the health budget was unsustainable in its current form. He went on to claim that it would be difficult for the Government to maintain the State's AAA credit rating while concurrently operating RPH and Fiona Stanley Hospital.[306] Similarly,

---

302 Ms Philippa Perry and Ms Cathy O'Leary, 'Health Blueprint Only a "Wish List"', *The West Australian*, 3 December 2009. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/6544820/health-blueprint-only-a-wish-list. Accessed 29 January 2010.

303 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 11 November 2009, p12.

304 Ms Philippa Perry and Ms Cathy O'Leary, 'Health Blueprint Only a "Wish List"', *The West Australian*, 3 December 2009. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/6544820/health-blueprint-only-a-wish-list. Accessed 29 January 2010.

305 Ms Philippa Perry and Ms Cathy O'Leary, 'Health Blueprint Only a "Wish List"', *The West Australian*, 3 December 2009. Available at: http://au.news.yahoo.com/thewest/a/-/breaking/6544820/health-blueprint-only-a-wish-list. Accessed 29 January 2010.

306 Mr Ben Wyatt, Shadow Treasurer, 'Honest Update Needed on State's Finances', 27 November 2009. Available at: www.wa.alp.org.au/news/1109/27-01.php. Accessed 29 January 2010.

when the CSF 2010 was released the Shadow Minister for Health, Mr Roger Cook, stated "they've got no idea how these things are going to financed."[307]

Looking beyond the ongoing political debate over the path of health reform in Western Australia, it seems uncertain whether the latest strategic outline for reform as contained in the CSF 2010 will be fully funded in the current economic climate.

Finding 31

Uncertainty exists as to whether the entire 10-year plan for health reform as articulated in the *Clinical Services Framework 2010-20* will be fully funded by the Government.

4.5 Conclusion

The majority of recommendations in the Reid Report, which formed the basis for both of the Clinical Services Frameworks, were driven by the rapidly escalating cost of health. The subsequent planned rationalisation and redistribution of hospital beds and services towards the outlying centres of population were seen as crucial elements of the plan to control health expenditures. Yet if the most recent 'Statement of Risks' from the Department of Treasury and Finance's *Economic and Fiscal Outlook 2009-10* is correct, the planned reforms have yielded little improvement in slowing the growth in health costs. This document found that the DOH has:

- double-digit expense growth over recent years;
- escalating demands on emergency and hospital services; and
- a significant growth in costs while meeting this demand.[308]

DOH advised the Committee that the majority of the Reid Report's recommendations have been implemented during the past 4 years.[309] A complete list of the 86 recommendations and their progress in being implemented is included in Appendix Four.

However, this assurance was accompanied with the following qualification:

> *A small number of reform recommendations have not been progressed due to changes in policy direction. These changes include:*

307 Ms Alisha O'Flaherty, 'Costing Questioned', *ABC (WA) Television News*, 3 December 2009.

308 Department of Treasury and Finance, 2009, *2009-10 Budget, Economic and Fiscal Outlook, Budget Paper No. 3*, Perth, p43.

309 Submission No. 8 from Department of Health, 25 June 2009, p2.

1. *agreement to split KEMH and PMH;*

2. *agreement not to have a joint management structure between SCGH and RPH;*

3. *agreement to have the State Trauma Centre located at FSH not RPH, and*

4. *agreement to maintain RPH as a tertiary facility.*[310]

Given this information, several factors may explain the apparent difficulties in delivering health reform in Western Australia, despite the best efforts of those involved in preparing the Reid Report, CSF 2005 and CSF 2010. In particular:

- the assumptions made about the efficiency impact of the reform program advocated in the Reid Report were inaccurate;
- the inability to implement the reforms recommended by Reid Report in full—particularly the major policy change to retain RPH as a tertiary hospital— prevent the benefits from being realised;
- the failure of modelling assumptions underpinning the CSF 2005 and CSF 2010 to actively forecast future activity levels;
- the failure of both sides of politics, despite bipartisan agreement, to implement on time pivotal reforms recommended by the Reid Report; or
- a combination of these factors.

310 Submission No. 8 from Department of Health, 25 June 2009, p2.

CHAPTER 5 HEALTH SERVICES MODELLING

5.1 Introduction

The management of health care is an extremely complex process with service planning influenced by a range of highly variable and interlinked factors, including:

- the level of patient demand;
- efficiency improvements attributable to advances in clinical practices, information and communication technology; and
- budgetary, infrastructure and workforce constraints.

The inherent difficulty in collating these components to determine an optimal health system lends itself to the use of computer modelling and the creation of different scenarios for future demand for health services. As Fone *et al.* have argued, computer models:

> *provide an insight into the working of a system and can be used to predict the outcome of a change in strategy. This is particularly useful when the system is very complex and/or when experimentation is not possible.*[311]

While many approaches have been utilised in other jurisdictions, Western Australian health administrators have adopted a system known as 'demand and capacity' modelling to calculate local service requirements. This methodology underpinned the planning projections contained in the Reid Report and both Clinical Service Frameworks.[312]

5.2 Department of Health's demand and capacity modelling

(a) Significance of demand and capacity modelling

The Department of Health (DOH) uses computer modelling to predict future service or 'activity' demands. For DOH, much is contingent upon the accuracy of the model's forecast activity levels. Ms Jodie South, DOH's Senior Project Manager Infrastructure, confirmed that the final result of the modelling "flows through to our infrastructure planning, our recurrent cost planning and our workforce planning."[313] Of critical importance for DOH is the fact that this data forms the basis for the business case taken each year to Treasury for the Department's budget. Hence, erroneous

311 Dr David Fone *et al*., 2003, 'Systematic Review of the Use and Value of Computer Simulation Modelling in Population Health and Health Care Delivery', *Journal of Public Health and Medicine*, Vol. 25, No.4, p325.

312 See Department of Health Strategic Planning Directorate, 2004, *Projecting Demand for WA Hospital Inpatient Activity - Methodology*, Department of Health, p1; Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p15.

313 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p22.

estimates—or more specifically underestimates—can significantly affect the subsequent financial viability of the public health sector and has flow-on effects to the quantity and quality of services that DOH can offer. Significantly, the Under Treasurer has been critical of the results of DOH's forecasting and the impact this has had on the Department's financial performance:

> *While it was clearly apparent to me and my people 12 months ago that there was that disconnect, particularly between dollars and activity, it has taken us some time to convince the health system of that disconnect. The light bulb has finally flicked on in that regard.…Twelve months ago we were saying its activity levels were not consistent with the dollars that it was given so it had to fix something. Basically that was met with denial. The light has finally flicked on so it has finally recognised it has a problem.*[314]

Finding 32

Demand and capacity modelling predicts future activity levels for health services and influences the Department of Health's infrastructure, workforce and recurrent cost planning. A failure to accurately estimate future requirements can have a profound impact on the Department's financial viability and operational efficiency.

(b) Demand and capacity modelling explained

Demand and capacity modelling involves two steps, each with component parts. Firstly, 'demand modelling' is undertaken to provide a raw figure for estimated future activity levels. This is done by measuring five years of patient flow data from a base year. Clinicians are then consulted to see whether these trends remain accurate or whether efficiency gains, attributable to improvements in clinical practice, might reduce future demands. Once allowances are made for these advances, population projections supplied by the Australian Bureau of Statistics (ABS) are overlayed on the data. This produces a 'status quo' model, which indicates what demand will be if current trends in the State's activity, population growth and clinical practices are maintained. A State-wide estimate is calculated using these inputs and is then broken down into projected public and private sector utilisation levels.[315]

A 'scenario model' is then developed. Scenario models calculate projections in activity allowing for improvements in the delivery of health care that are planned as part of any reform process.

Among the targets of these scenarios are:

- a reduction in the Average Length of Stay (ALOS) for hospital patients;

314 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, pp11-12.

315 Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, pp3,9. See also Submission No. 33 from Department of Health, 18 August 2009, p2.

- a reduction in unnecessary hospital admissions; and
- the provision of care in the most appropriate settings.

Strategies that have been proposed in Western Australia for realising these goals include streamlined hospital check-in and check-out procedures, a greater reliance on community health services and a push towards treating more country patients in their local facility. Scenario modelling also attempts to factor in changed health policies instituted at a state or commonwealth level. Actual service planning tends to commence only after scenario modelling has been completed and a particular scenario agreed to by the Department of Health's Executive.[316]

The second major step is 'capacity modelling'. Here, the demand modelling results are extrapolated in order to determine the best way that services can be delivered in the future in the existing and planned facilities. Capacity modelling produces a 'capped' and an 'uncapped' number of recommended hospital beds across each DOH hospital site.

Uncapped models create an "optimal hospital bed map"[317], which assumes an environment where health planning is not subject to any budgetary or operational restrictions. This 'ideal' model or output reflects the reform principles of care closer to home, and provided in the most appropriate setting. It restricts tertiary hospitals to the provision of mostly tertiary care, with secondary care available only to that hospital's local catchment population. The majority of secondary level services are then redistributed to the outer metropolitan general hospitals.[318]

However, the model that DOH described as more realistic and the one that produces their final result is the 'capped' model:

> *The reality is we have constraints, They might be workforce they might be infrastructure….For these reasons, we actually put caps on our hospitals…we might say our outer metropolitan hospitals can only have 350 beds, and then the model is run to see what happens when you cap it.*[319]

DOH confirmed that the role delineation matrices contained in CSF 2005 and CSF 2010 present data according to capped modelling. The capped modelling process is also used to incorporate the constraints and additions imposed by the Government's electoral commitments. DOH stressed that they update their modelling annually to reflect changes in any of the model's variables and inputs

316 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p3,22. See also, Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, p3.

317 Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, p4.

318 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p16.

319 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p17.

it uses, and to remain abreast of the policy requirements of the Department.[320] The following sections show that any constraints imposed in the capped model, including government commitments, can detract from the optimal delivery of health services based on population needs.

Finding 33

The modelling process used by Department of Health caps the true projected activity levels in the State's hospitals to allow for operational constraints attributable to broader Government policy decisions and internal workforce, infrastructure and budgetary limitations.

(c) Evaluations of demand and capacity modelling

The modelling process used by DOH is also referred to as the Hardes' Model. This acknowledges Hardes and Associates, the company who have refined the model and regularly audit the results of DOH's internal calculations. South Australia, Tasmania, New South Wales, Queensland and the Australian Capital Territory all rely on Hardes' health modelling services. So too, do eight private providers throughout the country.[321] A 2005 internal review by NSW Health has found that "the [Hardes'] modelling approach is robust and that inpatient modelling undertaken in NSW is among the most sophisticated described in national and international literature."[322]

Despite this endorsement, and those implicit in the widespread use of the Hardes' Model throughout Australia, it is worth noting that the veracity of all health models remains open to debate. Dr Mark Mackay conducted an exhaustive study on this topic in 2007 and endorsed the potential of health care models as a resource for health administrators, but concluded that the effectiveness of such methodologies here and abroad was yet to be adequately evaluated. He added that, "There has been a failure of any one approach…to gain traction as a solution…to the hospital bed management problem."[323] Factors undermining the utility of computer modelling in this field include "continual changes arising from political cycles, inflexible funding, a preference to adhere to existing service models and a lack of understanding of modelling by decision-makers".[324]

320 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p13.

321 Submission No. 33 from Department of Health, 18 August 2009, p3.

322 Finding as cited in Submission No. 33 from Department of Health, 18 August 2009, p3.

323 Dr Mark Mackay, 2004, *Compartmental Flow Modelling of Acute Care Hospital Bed Occupancy for Strategic Decision-Making*, Doctoral Thesis, School of Psychology, University of Adelaide, pp20,65.

324 Dr Mark Mackay, 2004, *Compartmental Flow Modelling of Acute Care Hospital Bed Occupancy for Strategic Decision-Making*, Doctoral Thesis, School of Psychology, University of Adelaide, pp20-21.

While it was beyond the scope of this Inquiry to judge the robustness of DOH's demand and capacity model, it was important to establish whether these issues identified by Mackay detracted from the final output contained in CSF 2010 for delivering health services in Western Australia.

(d) Shortcomings in Western Australia's modelling

The complexity surrounding demand and capacity modelling has been acknowledged at the highest levels of health since the publication of the Reid Report in 2004. Then-Health Minister, Hon Jim McGinty, conceded that "there is a whole series of things, which I must say I also find confusing, with the way in which these counts take place."[325] McGinty's successor, and current Health Minister, Dr Kim Hames made a similar admission during the 2005 Budget Estimates hearings, declaring "I find the issue of bed numbers in our hospitals absolutely confusing."[326]

The acknowledgement by both Dr Hames and Mr McGinty confirm that policy makers often struggle to comprehend the intricacies of how beds in the health system are counted and included in DOH's complex modelling, for example, for the planning projections contained in the *Clinical Services Framework 2010-20*.

Finding 34

The effectiveness of demand and capacity modelling for determining the distribution of health services can be undermined by a general lack of understanding of the process by policy makers and resistance to change among health practitioners.

(i) Impact of decision to retain Royal Perth Hospital as a tertiary facility

As per its terms of reference, the Committee sought to determine what impact the decision to retain Royal Perth Hospital (RPH) as a 410-bed tertiary facility might have had on the most recent modelling process which produced the CSF 2010. Three issues emerged as problematic. Firstly, the RPH decision delayed the on-going health reform program while the model was revised to incorporate this change in policy from the previous government. In March 2009, DOH advised the Committee that the role delineation for the three proposed adult tertiary hospitals (Fiona Stanley, RPH and Sir Charles Gairdner) had to be confirmed before capacity modelling could be undertaken. The consultation required by this change in policy by the current Government was described as a "huge process".[327]

---

325 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates* (Hansard), 10 June 2005, pE483.

326 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Estimates* (Hansard), 10 June 2005, pE483.

327 Dr Philip Montgomery, Executive Director Planning, Royal Perth Hospital, *Transcript of Evidence*, 18 March 2009, p13.

The Committee was told that the updated modelling would be completed and available by June.[328] Ultimately, further delays were experienced and the Committee did not receive a copy of the new data until the CSF 2010 was released on 3 December 2009.[329] These delays also affected the work of this Committee, which had to put back the tabling date for this Inquiry by six months while it awaited the updated information contained in CSF 2010.

Finding 35

The decision to retain Royal Perth Hospital as a tertiary facility meant that the role delineation across the metropolitan hospital network had to be revised. This was a lengthy process, which delayed the preparation of the Clinical Services Framework 2010-20.

Secondly, the retention of RPH in the metropolitan network as a tertiary hospital has had a marked impact on the reconfiguration of hospital services. As demonstrated in Chapter 4 above, the revised modelling in CSF 2010 produced a net 171-bed decline in the total number of beds proposed just five years earlier in CSF 2005 for the metropolitan hospital network by 2015. Given the high population growth in Perth since CSF 2005, this represented a substantial departure from DOH's earlier evidence to the Committee that predicted an increase in CSF 2010 of "potentially about 160 beds by 2016".[330]

Several explanations for this 300-bed difference were offered by the Department of Health. Their answers confirmed that the RPH decision had contributed to major divergences from the original reform program in terms of both its timing and strategic direction. The projected bed-differential in the outer-metropolitan general hospitals—which will now receive 249 fewer beds by 2015 compared to CSF 2005 projections— was attributed by DOH to a delay in the original round of infrastructure building:

> *Under CSF 2005, we were planning to do the first stage of development of those peripheral hospitals in around 2011-2012, and stage 2 builds were supposed to be in 2015-2016. They have basically been delayed for a range of reasons in our capital program. We are only now just either completing or starting the first stage of builds. So if you look at what is planned in stage 1 development and stage 2, there are no fewer beds in our peripherals, but the timing has moved out from CSF 1* [CSF 2005].[331]

---

328 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, pp13,17.

329 Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, p12.

330 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, pp20-21.

331 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 16 February 2010, p3.

This argument is correct to the extent that, under CSF 2010, a further 560 beds are planned for the period between the end of the revised Stage 1 period [2014-15] and the revised Stage 2 period [2020-21].[332] Notwithstanding the proposed future building of beds in general hospitals after two further State elections, 171 fewer beds have now been scheduled for 2015 under the new framework—a situation attributable in part to delays in the infrastructure building program that began in 2005. Of added concern is that this reduced allocation has occurred despite Western Australia experiencing population growth rates that have exceeded the projections used by DOH in their own modelling. This situation will severely exacerbate the current difficulties the metropolitan hospital system has in meeting demands for service.

A second explanation was received from DOH that offers a different view as to whether the decision to keep Royal Perth Hospital as a 410-bed tertiary facility affected the optimal distribution of Perth's hospital beds:

> *The modelling for CSF 2010 indicated that the growth in population required the addition of approximately 400 beds to the system to meet increased demand. The retention of Royal Perth Hospital allows the system to meet this demand particularly for patients from some inner city suburbs.…The 400 bed* [sic] *RPH facility means that projected bed requirements can be met before consideration of a second stage for Health's infrastructure program.*[333]

This response contradicts an earlier statement by DOH in March 2009 that their planning was designed to build up hospitals in "outer metropolitan Perth…where the most growth is expected".[334] Recent population data from the ABS for 2008-09 supports DOH's forecasts that the Wanneroo, Swan and Rockingham Local Government Areas have the largest population growth rates.[335] The Government's decision to retain RPH as a tertiary hospital also belies the Reid Report's key recommendation to "improve access to hospital care in high-growth metropolitan areas and reduce demands on the tertiary hospitals for general care".[336]

The Reid Report confirmed that 80% of admissions into tertiary hospitals were for secondary-level care. Moreover, "many (but not all) of these patients could be treated in larger general hospitals".[337] Expanding the role of the general hospitals was considered "significant for the

---

332 Department of Health, 2009, *WA Health Clinical Services Framework 2010–2020*, Department of Health, p22.

333 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, p1.

334 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p19.

335 Australian Bureau of Statistics, '3218.0 – Regional Population Growth, Australia, 2008-09', 30 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2008-09~Main+Features~Western+Australia?OpenDocument. Accessed on 20 April 2010.

336 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

337 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

sustainability of the health system".[338] It was important to redirect services this way as it was then costing DOH $380 per day more to treat patients in tertiary beds than in general hospitals.[339]

The decision to retain 410 tertiary beds in the City's centre appears arbitrary in light of the facts presented by the Reid Report, and detrimental to the system-wide reform outcomes the Reid Report advocated. The then-Opposition did not support the recommendation of Reid to close RPH as a tertiary hospital. The Health Minister, Dr Kim Hames, recently said that, "we made a political decision, and I believe a very sensible decision to retain Royal Perth Hospital".[340] The Committee believes this demonstrates an apparent lack of understanding of the costly impact that such decisions can have when DOH's modelling relies on a 'capped' process.

Dr Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, confirmed that while the Reid Report had underpinned the development of the original CSF, there had since "been political decisions and government decisions around the structure [of health]."[341] When specifically asked whether, under the capped modelling used by DOH, the decision to retain RPH as a 410-bed tertiary facility would reduce the capacity ceiling placed on the outer metropolitan general hospitals, Dr Lawrence conceded:

> *Certainly the retention of any site in any capacity will do that. That site was not in the original capped model, so yes it has caused a change in the way patients flow. That is the simple answer.*[342]

The Acting Director General of Health, Mr Kim Snowball, implicitly acknowledged the impact of incorporating government decisions into the capped model:

> *I think that in terms of what we have put together as an agency, we have an obligation to implement government policy—the policy of the government of the day. In producing this document, we have been faithful to that and to our provision of advice in terms of what we see as clinically the best distribution of services and the best role delineation we can achieve for the health of the people in this state.*[343]

By its very nature, capped modelling provides a less than optimal delineation of hospital services. This is unavoidable given the financial, infrastructural and workforce constraints that Western

---

338 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

339 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

340 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Estimates* (Hansard), 28 May 2009, pE539.

341 Dr Robyn Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 16 February 2010, p4.

342 Dr Robyn Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 16 February 2010, p13.

343 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, p10.

Australian health administrators are faced with, and have to be accountable for. Despite DOH's efforts to advise on the most appropriate role delineation for the metropolitan hospitals, the need to retain Royal Perth Hospital within the capped model has led to:

- a reduction of 171 beds by 2015 on the projections contained in the CSF 2005;
- a reduction of hospital services from areas of acknowledged high population growth; and
- increased the financial burden on the State's health system by retaining an inappropriate balance of tertiary-level beds in Perth's CBD.

Finding 36

The retention of 410 tertiary beds at Royal Perth Hospital has produced a redistribution of beds away from hospitals in the outer metropolitan area where significant population growth is occurring.

Finding 37

The placement of 410 tertiary beds in the City's centre appears arbitrary in light of the recommendations based on population data presented by the Reid Report, and detrimental to the longer term reform outcomes the Report advocated.

(ii) The impact of using low population projections

During the broad public consultation process that occurred between the release of the Reid Report and the development of CSF 2005, DOH acknowledged that "some questions were posed regarding the accuracy of modelling projections and the assumptions made."[344] The Committee was interested in the veracity of the model's underlying assumptions in two major areas:

- population projections; and
- the inclusion of reform initiatives.

Population projections

During its demand modelling stage, DOH relies on population forecasts made by the Australian Bureau of Statistics (ABS) which are generated from the most recent national census. The forecasts are based on trends in variables including fertility, mortality, internal and overseas

344 Department of Health, 'Clinical Services Consultation 2005 Update', nd. Available at: www.health.gov.au/HRIT/csc/. Accessed on 8 July 2009.

migration, and provide a high, medium and low-growth population forecast known respectively as Series A, B and C. The standard practice for DOH has been to use the Series B or 'medium' projections, which assume current trends in the ABS variables will be maintained.

For the original CSF 2005, the population baseline and ongoing projections were drawn from the ABS 2003 Series B, which used the 2001 Census data.[345] These projections were subsequently refined with data supplied by the then-Department of Planning and Infrastructure (DPI). Both the ABS and DPI data sets underestimated the actual 2007 State population (see Table 5.1).

Table 5.1- Estimated Western Australian 2007 population versus actual population[346]

Source		Difference from actual
ABS 2003 Series B (Forecast)	2,059,092	-47,027 (-2.2%)
DPI 2005 (Forecast)	2,080,539	-25,580 (-1.2%)
ABS 2007 (Actual)	2,106,119	

Both the DPI forecast and the ABS Series B forecast produced a substantial under-estimate of the actual State's population within forecast periods of just two and four years. Such shortfalls may have significant budgetary implications, as DOH's acknowledged "Any change in population growth will affect the projected activity and in turn, the total cost of service delivery."[347]

CSF 2010 population figures

To prevent greater inaccuracies in future forecasts of demand for services, the baseline population from which its forecasts are made is adjusted by DOH as the actual figures become available. For example, the inpatient modelling contained in CSF 2010 that underpinned the projections to 2021 used the actual population figures for 30 June 2008 as a starting point.[348] While such 'rebasing' of population figures can reduce the error margin of projections for future demand, the Committee has serious concerns about the ongoing accuracy of DOH projections given a recent change in methodology by the Department.

The Committee is concerned by information provided to the Inquiry in March 2009 that the CSF 2010 activity projections now used the ABS Series C, or ***low-growth***, population forecasts released in 2008. The Committee challenged the Department's new approach and was advised that

345 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 Mar 2009, pp18-19.

346 Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, p6.

347 Mr Kim Snowball, Acting Director-General, Department of Health, *Response to Question on Notice*, 16 February 2010, p2.

348 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p17.

DOH had now factored in the large migration to the State that occurred in the period 2001-06 and had revised their population growth figures to a lower level in anticipation of the impact of the global economic slowdown.[349] This decision:

> *is very much based around a slowdown in the economy, and is very much based on not seeing that 20-45 age group immigrating to this State.*[350]

Yet just four months before this evidence, the Health Minister had told Parliament "the Department of Health has advised that there has been a significant increase in its future estimate of the population of this State."[351] After the release of CSF 2010, the Acting Director General confirmed:

> *if you bear in mind when this* [CSF 2010] *was actually developed, it was at a time when there was a much lower ebb in terms of the economy and so on, but we have not updated this to reflect a different level of predicted growth in population.*[352]

The Committee questions the prudence of this approach given the most recent population data demonstrate that the anticipated economic slowdown has not slowed Western Australia's population growth. Figure 5.1 below shows that year-end June 2008 and June 2009 population growth rates have actually exceeded even the ABS Series A (high growth) projections by more than 0.5%.

---

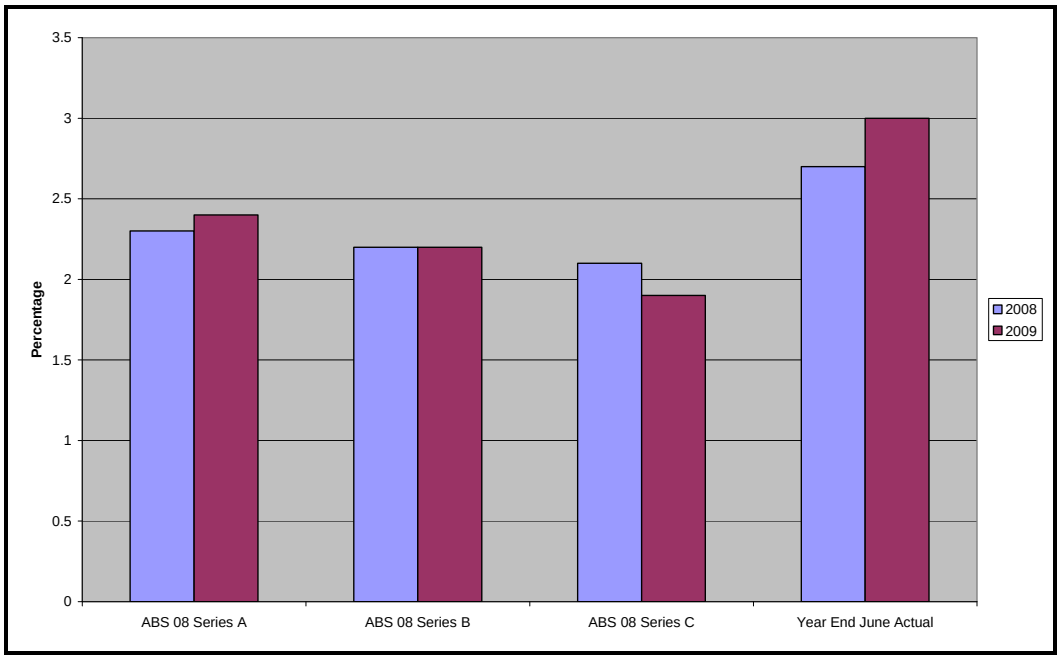
349 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p9.

350 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p18.

351 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, (Hansard), 12 November 2008, p179.

352 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, p7.

Figure 5.1- Projected Western Australian population growth versus actual rate, 2008-09[353]



More worrying is the fact that the ABS Series C predicts the population growth rate would fall from 2.1% in 2008 to 1.9% in 2009, and then plateau between 1.6-1.5% for the years to 2015.[354] Western Australia's population growth in 2008 was the highest since records commenced[355] and the highest of all jurisdictions, continuing a trend that has been evident since at least 2003. Additionally, the June 2009 actual population for WA of 2,237,000 people exceeded the 2009 ABS Series C (low-growth) projection by 45,697 people.[356] This was during the economic slowdown anticipated by the Department of Health.

---

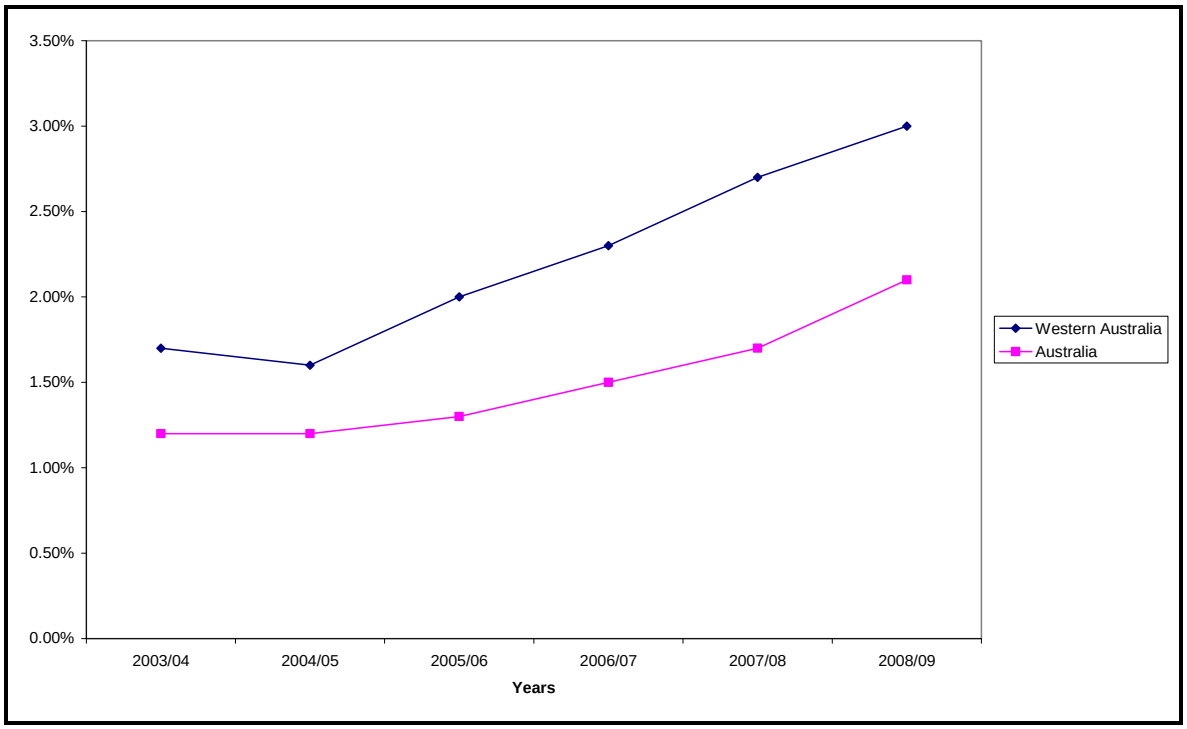
353 Actual data refers to ABS Estimated Residential Population figures. See Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Sep 2009*, 25 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0. Accessed on 20 April 2010; Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Jun 2008.* Available at: www.abs.gov.au/AUSSTATS/abs@.nsf/allprimarymainfeatures/A3D845ADEFAFBFA7CA25757C00137633?opendocument. Accessed on 3 March 2010; Australian Bureau of Statistics, *3222.0 – Population Projections Australia, 2006 to 2101.* Available at: www.abs.gov.au/AUSSTATS/subscriber.nsf/log?openagent&32220_2006 to 2101.pdf&3222.0&Publication&0E09CCC14E4C94F6CA2574B9001626FE&&2006 to 2101&04.09.2008&Latest, 4 September 2008, p85. Accessed on 3 March 2010.

354 Using tabled information supplied by Department of Health. See Ms Jodie South, Department of Health, *Supplementary Material*, 18 March 2009, p6.

355 Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Sep 2009*, 25 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0. Accessed on 20 April 2010.

356 Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Sep 2009*, 25 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0. Accessed on 20 April 2010; Ms Jodie South, Department of Health, Supplementary Material, 18 March 2009, p6.

Figure 5.2 Western Australia's population growth rate compared to Australia's[357]



Finding 38

Despite recent record population growth in Western Australia, the Department of Health has moved from using medium-growth projections provided by the Australian Bureau of Statistics to low-growth ones.

Future economic and population growth

Adding to the Committee's concerns are projections by economic forecasters of even higher economic activity and associated population growth for the State. Explaining the resilience of the Western Australian economy, Access Economics recently commented that "the momentum of work in the pipeline kept home fires burning, and now the upturn beckons. And what an upturn it

357 For yearly reports 2004-09) see, Australian Bureau of Statistics, *3101.0 – Australian Demographic Statistics, Sep 2009*, 25 March 2010. Available at: http://www.abs.gov.au/AUSSTATS/abs@.nsf/second+level+view?ReadForm&prodno=3101.0&viewtitle=Australian%20Demographic%20Statistics~Sep%202009~Latest~25/03/2010&&tabname=Past%20Future%20Issues&prodno=3101.0&issue=Sep%202009&num=&view=&. Accessed on 20 April 2010.

could be."[358] Similarly, the latest WA Chamber of Commerce and Industry quarterly outlook argued that "2010 looks set to mark the beginning of a new wave of growth and prosperity."[359] In response to what he sees as a looming skills shortage, then-Treasurer, Mr Troy Buswell, MLA, has consulted industry groups about the need to establish a State migration strategy "in the very near future."[360] In such a tight labour market it is difficult to see how more 20-45 year-olds will not enter the State in search of work, undermining the low-growth assumption made by DOH in its modelling.

The ramifications of any miscalculation are significant. DOH advised the Committee that if the medium growth population projections were realised, another 140 hospital beds (115 in metropolitan Perth and 25 in country WA) would be required across the State by 2016-17 in addition to the projections contained in CSF 2010. The number of extra beds would double to 280 (230 in metropolitan Perth and 50 in country WA) if the ABS high growth population projections are realised.[361] No estimates were provided by DOH for population figures that exceeded the ABS Series A (high growth) projection, as Western Australia had experienced in both 2008 and 2009.

The financial implications of this under-estimate of the State's population are harder to quantify, but equally as critical. DOH acknowledged that using the current low-growth population assumptions:

> *expenditure growth of 6%-7% over the preceding year's actual expenditure will be required to deliver activity levels consistent with the* Clinical Services Framework 2010-2020 *over the forward estimates period.*[362]

This unlikely scenario is concerning on a number of levels:

- it accepts an ongoing expenditure level in excess of the aspirational 5.5% benchmark that was advocated in the Reid Report;[363]
- these projections also exceed the budgeted expenditures accounted for in Treasury's 2009-10 Economic and Fiscal Outlook for the out-years to 2012-13;[364] and

---

358 Access Economics, 2009, *Business Outlook December 2009 – The Recovery: Mild Not Wild*, Access Economics, Canberra, p107.

359 Chamber of Commerce and Industry Western Australia, *WA Economic Compass: Outlook December Quarter 2009*, CCI Economics, Perth, p3.

360 Mr Robert Taylor, 'Job Ads Boom as Experts Warn of Skill Shortages', *The West Australian*, 12 January 2010, p1.

361 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, p2.

362 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, p2.

363 Department of Health, 'WA Health Infrastructure Development', nd. Available at: www.health.wa.gov.au/hrit/infrastructure/governance/index.cfm. Accessed on 3 March 2010.

- this year's actual expenditure total will be at least $250 million higher after the Barnett Government recently agreed to cover a projected DOH budget over-run.[365]

Mr Kim Snowball told the Committee that DOH was currently engaged with Treasury over the cost of implementing CSF 2010. He stressed that funding was not being sought for the life of CSF 2010 projections to 2020, and that future budget proposals could be adjusted for changes in predicted activity attributable to higher population growth. For now though, both parties are in the "process of agreeing to the modelling and essentially going through the assumptions that underpin the model."[366]

This could be a contentious negotiation as Treasury, in its recent Mid-Year Review, have already cited 'strong population growth' as a key risk to the Health budget.[367] Moreover, the Under Treasurer, Mr Tim Marney, told the Committee that higher service demand was:

> *the major reason why Health blew its budget in 2008-2009. It had allocated a level of activity through the health system…which was completely inconsistent with the money that was then allocated.*[368]

In evidence to the Committee, Mr Marney suggested that the Department of Health had acknowledged its problem in forecasting and budgeting the demand for its services. However, Mr Marney's comments for the 2008-09 'budget blow outs' refer to a period when DOH was using medium- growth population data, while it has now moved to a low-growth projection. Recent comments from the then-Treasurer confirm that projected DOH activity levels continue to be under-stated. In the recent debate over the Treasurer's Advance Authorisation Bill 2010, then-Treasurer Mr Troy Buswell, MLA, said that the additional $210 million required for the Health budget was partly attributable to an activity increase of 2.1% above original forecasts.[369]

The Committee has strong reservations about the current use of low-growth population projections by DOH in its demand modelling process. As this process underpins the costing of CSF 2010 and the recurrent expenditure of DOH through its Whole of Health Cost Model,[370] it is crucial that

---

364 Department of Treasury and Finance, 2009, *2009-2010 Budget Paper No. 3: Economic and Fiscal Outlook*, Government of Western Australia, Perth, p78.

365 Mr Peter Kerr, 'Barnett Gives Nod to $250m Health Blowout', *The West Australian*, 18 February 2010, p6.

366 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, pp7,19.

367 Department of Treasury and Finance, *Government Mid-Year Financial Projections Statement*, December 2009. Available at: www.dtf.wa.gov.au/cms/uploadedFiles/_Treasury/State_finances/myr_200910.pdf?n=3157, p33. Accessed on 3 March 2010.

368 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p11.

369 Hon Mr Troy Buswell, Treasurer, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 16 March 2010, p730.

370 Mr Kim Snowball, Acting Director-General, Department of Health, *Response to Question on Notice*, 16 February 2010, p2.

projected activity levels are as accurate as possible. Without this precision, the hospital network in Western Australia will continue to operate in excess of its budget and with a permanent shortage of beds and staff. The financial and operational difficulties this creates will flow-on to all areas of the State's public health system.

Finding 39

The Committee has received no evidence that, despite receiving regular briefings, the Department of Treasury and Finance recognise the structural flaws arising from the decision of the Department of Health to use low-growth population projections in its modelling.

Recommendation 15

The Department of Health must use at least the ABS Series A (high-growth) population projections in its demand modelling for its current planning for recurrent and reform-based funding requirements. This will present the Government with a more realistic account of the future operational and financial needs of the State's health system.

Recommendation 16

The Auditor General evaluate the veracity of the Department of Health's demand and capacity modelling process, with particular attention given to determining the cost of using a more accurate population projection.

(iii) Potential miscalculations – overestimated reform achievements

One of the factors that are built in to scenario modelling calculations is the potential for health to be 'doing business differently'. As noted earlier, this could be manifested by refined clinical practices or improvements attributable to reform initiatives. DOH confirmed that CSF 2010 modelling had incorporated some small changes in clinical trends, but these were "not huge".[371]

Consequently, the Committee was more interested in quantifying the likely impact of reform initiatives on the final modelling results. In its presentation to the Committee in March 2009, DOH advised that reform initiatives included improved performance in health resulting from:

[371] Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, pp16-17.

- reduction in the Average Length of Stay (ALOS) for patients in hospitals;
- the provision of care in more appropriate settings, through programs such Hospital in the Home (HiTH); and
- increased retention of country patients in their local hospitals.

When explaining the model, the Department of Health said it was "building up our own scenario on what we honestly think we can do in the reform initiatives."[372] DOH provided the following information on specific performance benchmarks which it intended to factor into its scenario modelling.

ALOS reductions

ALOS reductions are to be made by DOH increasing the number of patients treated and discharged on a same-day basis and by decreasing the durations of multi-day admissions:

> *WA Health has consistently reduced average length of patient stay over the last few years, suggesting this is an achievable target. Reductions in length of stay were benchmarked against performance across tertiary hospitals within WA, with State-wide rates reduced to the level of the best performing tertiary hospital* [emphasis added], *where this was considered appropriate.*[373]

Thus far, scenario modelling had budgeted for reductions in the Average Length of Stay across 68 extended service related groups (ESRGs). Based on its forecast reductions in ALOS, the Department was factoring in a 3% decline in service demands over the next 10 years.[374]

While the Committee has no reason to question DOH's projected downward trend in ALOS rates, it is still concerned over how this data is utilised. By using the best performing tertiary hospital as the barometer for length of stay reductions, DOH risks overestimating the efficiency gains that can be achieved in other locations. The use of a median figure across the entire hospital network would create a more realistic performance benchmark.

---

372 Ms Jodie South, Senior Project Manager Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p22.

373 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 19 February 2010, p4.

374 See, Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 19 February 2010, p4; Dr Peter Flett, Director General, Department of Health, *Response to Question in Notice*, 3 November 2009, p1.

Care in the most appropriate setting

In terms of providing care in the most appropriate setting, DOH said it:

> *sets a target of an 85% retention rate for the relevant catchment population. This means that where the hospital's role delineation permits, 85% of patients will receive health care in the site closest to where they reside.*[375]

When determining the veracity of this target, the impact that the retention of 410 tertiary beds at Royal Perth Hospital has had on the role delineation of other hospitals using the capped modelling process needs to be considered. Under the latest redistribution, the Committee has doubts that 85% of patients residing in the outer metropolitan area will be able to receive timely access to hospital care at their local facility. With future activity levels based on such assumptions, it is highly likely that future service demands will continue to be underestimated.

Finding 40

Under the current estimates for key parameters used by Department of Health in its modelling, it is likely that the efficiency gains attributable to reduced length of stays for hospital patients and the provision of hospital care in the most appropriate setting will prove to be overstated. As a result hospitals will remain under continued pressure to meet service demands beyond their budgeted capacity.

375 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, p4.

CHAPTER 6 PUBLIC HOSPITAL PROFILES

6.1 Introduction

The Reid Report argued that a 'significant reconfiguration' of the State's hospital system was necessary to improve the quality and accessibility of appropriate health care for all Western Australians. Among the risks cited in the Report's proposed reforms were "refurbishing and expanding existing hospitals on their current inappropriate sites [and the] unplanned and uncoordinated expansion of tertiary hospital services."[376] The then-Health Minister, Hon Jim McGinty, claimed that the Gallop/Carpenter Government's hospital redevelopment program would deliver Western Australians "the finest health care system in the State, if not the world."[377] Similarly, the Barnett Government now argues that its plan "positions the State to deliver high-quality health services for the entire Western Australian community in the coming decade."[378]

This chapter profiles all of the State's tertiary hospitals and their place within the post-Reid reform agenda. Also included are similar analyses of a metropolitan general hospital – Joondalup Health Campus; a Regional Resource Centre – Albany Hospital; and the Integrated District Health Service based at Katanning. These profiles indicate that much of the optimism of current and former Ministers on how the system will become more efficient appears to be misplaced. With the former Government consistently failing to meet major infrastructure deadlines, and the current Government's plans for retaining Royal Perth Hospital as a tertiary facility undermining the optimal configuration of services, it appears that the risks to practical reform identified by the Reid Report have materialised.

6.2 Tertiary hospitals

(a) Royal Perth Hospital

Royal Perth Hospital (RPH) is the State's oldest hospital and one of its largest teaching facilities. It employs over 4,700 full-time equivalent (FTE) staff including a variety of specialists and researchers. The hospital's outpatient department sees over 215,000 people each year while 59,000

376 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, ppv-vi.

377 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 21 September 2005, pp5759-5760.

378 Hon Dr Kim Hames, Minister for Health, '10-year blueprint for WA Health Services', 3 December 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132878&minister=Hames&admin=Barnett. Accessed on 15 March 2010.

people attended its Emergency Department in 2008-09.[379] The RPH campus is located on Wellington Street in East Perth and has a current on-site bed capacity of 662 beds.[380]

(i) Role within the health reform agenda – Reid Report and CSF 2005

The reconfiguration of the hospital system proposed in the Reid Report was designed to:

- rectify historically poor planning decisions; and
- provide for population growth in the northern and southern boundaries of the metropolitan area.[381]

The Reid Report singled out the proximity of the tertiary facilities at RPH and Sir Charles Gairdner hospitals as an issue that had made system-wide planning difficult. Moreover, the hospitals offered many duplicate services and displayed 'unproductive rivalry' towards each other. This scenario could have been avoided as the original planning for the opening of Sir Charles Gairdner Hospital in 1958 included the transfer of RPH services to the new facility.[382]

The Reid Report expressed a preference for again attempting to consolidate RPH services at the Sir Charles Gairdner site. This combined facility would form the northern leg of the 'north/south model' which Reid proposed as "the best long-term solution to tertiary care in Perth."[383] It enabled an expansion of secondary level services in the outer suburbs in a move that "correspond[ed] with future population growth."[384]

While clinicians contributing to the Reid Report agreed to the principle of having one tertiary hospital both north and south of the river, Reid called for a further, broader, consultative process to occur by September 2004. This would allow consensus to be reached on a final location for the northern facility.[385] The Report's relocation strategy retained RPH as a 50-bed 'inner city see and treat centre' with its designated clinical groups allocated between the 'northern' and 'southern'

---

379 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, pp2-3; Royal Perth Hospital, 'About Us', 2006. Available at: www.rph.wa.gov.au/about.html. Accessed on 30 March 2010.

380 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 19 February 2010, Appendix B.

381 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p2.

382 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

383 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p48.

384 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp48,50.

385 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p51.

tertiary hospitals.[386] Reid recommended that while the 'southern tertiary' hospital (Fiona Stanley) was under construction, specialist surgical and renal transplant services — then available at Sir Charles Gairdner and RPH — should be integrated under a single management structure.[387]

A further consultative process did not occur until March 2005. The Clinical Services Consultation was conducted over six weeks and included input from community members, key stakeholders and "all health system staff".[388] DOH reported that the vast majority of feedback from this consultation supported the closure of inpatient services at Royal Perth Hospital, albeit with a preferred relocation of its facilities to the new Fiona Stanley Hospital. [389]

In the months leading up to the release of the *Clinical Services Framework 2005-2015* (CSF 2005), then-Health Minister, Hon Jim McGinty, suggested maintaining RPH as a 200-bed facility without specifying what its purpose would be.[390] Despite this, CSF 2005 ultimately recommended that all tertiary and some secondary services be transferred to Fiona Stanley Hospital by 2011. Other services would be distributed between Sir Charles Gairdner Hospital, Swan Districts Hospital and Joondalup Health Campus. On-site services at RPH would be restricted to 28 renal dialysis beds by 2011 (increasing to 36 by 2015-16) with a limited number of rehabilitation and mental health beds provided off-site under contract.[391] These measures, if implemented would have led to the effective closure of Royal Perth Hospital as a tertiary facility by 2011.

(ii) Departures from the health reform agenda – CSF 2010

Services and beds

The *Clinical Services Framework 2010-2020* (CSF 2010) contains a new delineation of hospital services at RPH that reflects the Liberal Party's election commitment to keeping it as a tertiary facility. These new roles depart radically from the original intent of the health reform agenda, in terms of both direction and timing. Under the revised configuration, RPH will now be a 410 bed facility that retains its research centre status and includes acute inpatient mental health beds. Tertiary (Level 6) medical and surgical services including orthopaedic, cardiothoracic and neurosurgery will also remain at the site. Similarly, a major trauma centre and the State's only heart lung transplant service — both originally intended to operate only as transitional arrangements while Fiona Stanley Hospital was built — will become permanent fixtures under the

386 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp50-56.

387 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp49,57-63.

388 Department of Health, 'Clinical Services Consultation 2005 Update', 2005. Available at: www.health.wa.gov.au/HRIT/csc. Accessed on 8 July 2009.

389 Department of Health, 'Clinical Services Consultation 2005 Update', 2005. Available at: www.health.wa.gov.au/HRIT/csc. Accessed on 8 July 2009.

390 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 April 2005, pp939-940.

391 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d).

new delineation.[392] Table 6.1 illustrates the changes in bed numbers and services proposed for Royal Perth Hospital between CSF 200 and CSF 2010.

Table 6.1- Royal Perth Hospital: contrasting service delineation between CSF 2005 and CSF 2010[393]

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical	0	0	325	325
Obstetrics	0	0	0	0
Paediatrics	0	0	0	0
Same-Day	0	0	48	48
High Dependency, Critical & Intensive	0	0		
Emergency Short Stay Unit[+]	0	0		
Rehabilitation	24	24	17	17
Mental Health	12	12	20	20
Other[++]	28	36	0	0
TOTAL	**64**	**72**	**410**[*]	**410**[*]

[*] Plus 60 contracted off-site beds in 2014-15 and 84 beds in 2020-21

[+] These services are included under Medical/Surgical beds in CSF 2010

[++] 'Other' services referred to renal dialysis beds in CSF 2005. These are now incorporated in CSF 2010 'Same-Day' figure.

The Committee heard from Dr Nigel Armstrong, Chairman-elect of the RPH Clinical Staff Association (CSA), that the clinical staff at Royal Perth Hospital were looking forward to integration of the delivery of services in the South Metropolitan Area Health Service (SMAHS), and are "quite excited about the prospect of working collaboratively and collegiately (sic) in the south metro area with Fiona Stanley Hospital".[394] It was Dr Armstrong's impression that the CEO of the SMAHS intended to develop cluster networks across the SMAHS to reduce unnecessary duplication and "silo mentalities developing."[395] Dr Armstrong stated that this will enable greater efficiencies to develop within the system and allow the clinical networks that existed at RPH to be used to help Fiona Stanley Hospital develop and become a successful hospital.

---

[392] See, Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p17; Department of Health, 2005, *Clinical Services Consultation 2005-15*, Perth, p64; Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p4.

[393] See, Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d); Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

[394] Dr Nigel Armstrong, Chairman Elect, RPH Clinical Staff Association, *Transcript of Evidence*, 25 August 2009, p2.

[395] Dr Nigel Armstrong, Chairman Elect, RPH Clinical Staff Association, *Transcript of Evidence*, 25 August 2009, p6.

In response to a Question on Notice asking the CSA how beds might be delineated between tertiary and secondary in a new 410-bed RPH, the CSA answered that the mix of tertiary and secondary beds should be provided in a similar fashion to that at the Alfred Hospital in Melbourne:

> *The CSA* [Clinical Staff Association] *believes there should be a mixture of tertiary beds to service major trauma, heart and lung transplant, advanced heart failure and ICU services; and secondary beds to service patients living in metropolitan Perth and the eastern corridor who suffer from complex medical co morbidities, both medical and surgical, that require access to a tertiary hospital. It has been suggested that the tertiary/secondary bed mix should be along the lines of the Alfred Hospital in Melbourne, in which two thirds of their bed mix are tertiary beds: and one third are secondary beds.*[396]

Health Minister, Dr Kim Hames, recently indicated that RPH is to also retain its status as a major trauma centre, and that "we will have two major trauma centres in this state, … Royal Perth Hospital and Fiona Stanley Hospital."[397] The Minister stated this decision in clinical service provision is driven by population studies that project that by 2014 there will exist a need for two state trauma centres in Western Australia. He asserted this clinical demarcation will in no way impede on the new Fiona Stanley Hospital being the 'flagship new hospital' and that "by dint of the number of patients who will go there and the quality of the staff, [it] will eventually be regarded as the premier trauma centre of the state."[398]

Redevelopment timetable

The timetable for redevelopment of RPH is another area that has departed substantially from the original reform template. The initial 2011 target date for the completion of Stage One of Fiona Stanley Hospital, and the subsequent closure of RPH's inpatient services, was not met by the former Labor Government. By the end of its time in office, the Carpenter Government had conceded that Fiona Stanley Hospital's first stage might not be operational until 2014. Moreover, it had committed to retaining RPH as a 200-bed lower-level ED and surgical centre.[399]

Similarly, it is already evident that the Barnett Government reform plans for RPH will be protracted and expensive. Appearing before the Committee, Dr Philip Montgomery, in charge of the redevelopment, said that current services would be consolidated onto one block of the RPH campus. In May 2009 the Health Minister, Dr Kim Hames, confirmed that the new plan "is to

---

396 Dr Nigel Armstrong, Chairman Elect, RPH Clinical Staff Association, *Reply to Questions on Notice*, 23 September 2009, p1.

397 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 11 November 2009, p8789.

398 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 11 November 2009, p8789.

399 See, Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 10 April 2008, p2196; Ms Kate Campbell and Ms Anne Banks, 'Emergency Department to Stay at RPH: McGinty', *The West Australian*, 15 August 2008, p6.

retain the north block, which is in the order of 213 beds, and to build on the north-west corner of the complex the capacity for just under 200 beds. That will result in a 400-bed tertiary hospital."[400]

The proposed redevelopment will encompass three phases, commencing with an Emergency Department expansion and concluding with the major capital works program.[401] When asked for an indicative cost of the project, Dr Montgomery offered "a ballpark $500 million - $550 million, depending on whether we build 200 beds or 250 beds."[402] He added that:

> *nothing happens unless it is in the forward estimates—none of this was in the forward estimates. The government will obviously need to go through the process of identifying and agreeing to whatever funds will be required for this construction to take place.*[403]

The current 2009-10 budget includes an allocation of just $10 million for the redevelopment.[404] While halving the Liberal Party's 2008 election commitment of $23 million, the Minister told an Estimates Committee this amount was "adequate to do the work on the forward development plan".[405] As to the substantial funding required for the capital works:

> *it was a commitment for our second term of government, not our first term, so the allocation is not there at present, I must therefore consider ways to generate funds or to seek additional funds in future budgets.*[406]

Later in 2009, Dr Hames said the future redevelopment of RPH would not be "on stream until 2014, probably 2015"[407] and discussed the contingencies in the event that funding was not made available for the capital works:

> *There are no extra funding requirements for Royal Perth other than to do the construction that I'm very keen on, which is the new west wing, but if we don't have the funds to do the wing we'll still have Royal Perth continuing as a tertiary hospital.*[408]

---

400 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE537.

401 See, Submission No. 2 from Dr Philip Montgomery, Executive Director, Royal Perth Hospital, 8 December 2008, pp3-6; Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p11.

402 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p19.

403 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p12.

404 Department of Treasury and Finance, 2009, *2009-10 Budget* (Paper No.2 Vol.1), Government Printer, Perth, p181.

405 Hon Dr Kim Hames, Minister for Health, Western Australia Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE537.

406 Hon Dr Kim Hames, Minister for Health, Western Australia Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE537.

407 ABC Television- Stateline WA, 'Health Minister Kim Hames on How the Government Will Afford RPH', 26 June 2009. Available at: www.abc.net.au/stateline/wa/content/2006/s2611274.htm. Accessed on 20 April 2010.

408 Ms Cathy O'Leary, 'Hospital Plans in Jeopardy, Says Labor', *The West Australian*, 25 July 2009, p11.

The exact status of the Government's proposed redevelopment of RPH remains uncertain. The Committee was advised by DOH that, as at December 2009, there was still no business case prepared for this project. In addition, Dr Montgomery has resigned from his position and confirmed that the refurbishment project may be scrapped in order to save the Government $300 million.[409]

Finding 41

The status of the redevelopment plan for Royal Perth Hospital proposed by the current Government remains uncertain. Even if the project is funded, it may not commence until 2014-15.

(iii) *Impact on the reform agenda*

The impact of the decision to retain Royal Perth Hospital as a 410-bed tertiary facility is covered in detail in several other chapters (for example Chapter 4 on the CSF 2010, Chapter 5 on Health Modelling, and Chapter 7 on legislation to retain RPH). To reiterate, the Committee has found that, as a result of this policy:

- many tertiary-level medical and surgical disciplines have been retained across three sites, despite the acknowledgement in the Reid Report that this situation had promoted unnecessary service duplication and systemic inefficiencies;
- significant added pressures will be placed on future health budgets with the yet to be quantified impact of maintaining RPH in conjunction with the originally planned 'northern' [Sir Charles Gairdner] and 'southern' [Fiona Stanley] tertiary hospitals; and
- the intention of expanding the secondary-level care capacity of the outer metropolitan hospitals to cater for the burgeoning population growth rates within their catchments has been undermined.

In short, three major reform goals — the lowering of health expenditure; the promotion of efficiency gains; and the distribution of the most appropriate care in the most appropriate setting — have been significantly compromised by this decision.

409 See, Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 3 November 2009, p2; Mr Anthony Deceglie, 'Top RPH Doctor Quits Job', *The Sunday Times*, 14 June 2009, p39.

Finding 42

Three major goals of the reform program for health—the reduction of health expenditure, the promotion of efficiency gains and the distribution of the most appropriate care in the most appropriate setting—have been significantly compromised by the decision to retain Royal Perth Hospital as a 410-bed tertiary facility.

With the future development of Royal Perth Hospital essentially still in the planning stage, the Committee sees merit in reassessing the type of facility required on the site. The Committee agrees with the view that RPH should not be closed, but would argue that its status should be revised to a facility for treating lower level emergency presentations and the provision of secondary-level care for the growing inner-city population.

Population-based arguments support the case for an inner-city 'see and treat' facility of the type originally proposed by Reid. The latest ABS data shows that the Perth Local Government Area (LGA) had the fastest population growth rate in the state for 2008-09. However, this 12.8% increase was from a base population figure (15,200) that is noticeably lower than LGAs in the outer metropolitan areas.[410] Such a 'see and treat' facility would cater for the State's central business and entertainment district which see large and consistent surges in visiting populations.

Several submissions to the Inquiry made valid arguments for the retention of a medium-sized facility on the RPH site. The Health Consumers' Council (HCC) were described in the Reid Report as "an ideal organisation to advise on community and patient needs"[411] during the reform process. In its submission, the HCC described the retention of a 410-bed tertiary facility at Royal Perth as "a profound and problematic departure from the blueprint for reform".[412] They went on to add that:

> *from the time of the launch of the Reid Report the Health Consumers' Council has listened to health consumer concerns about the loss of services of RPH and actively advocated to government for the retention of an 'urgent care facility' at the RPH site.…This 'urgent care' model is consistent with the plan for only one major trauma/ED site at SCGH but allowed for a facility to meet urgent care needs between General Practice and ED/major trauma. This model also acknowledges the significant retreat in General Practice in the metropolitan area from providing a response to urgent care needs.*[413]

---

410 As at 30 June 2009 LGAs of Wanneroo, Swan and Rockingham all have populations in excess of 100,000. Australian Bureau of Statistics, '3218.0 – Regional Population Growth, Australia, 2008-2009', 30 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2008-09~Main+Features~Western+Australia?OpenDocument. Accessed on 31 March 2010.

411 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p124.

412 Submission No. 23 from Health Consumers' Council (WA), 3 August 2009, p1.

413 Submission No. 23 from Health Consumers' Council (WA), 3 August 2009, p2.

Not surprisingly, RPH's Clinical Staff Association supported the decision to retain it as a tertiary hospital. The decision, they claimed:

> *allows the continuation of vital adult community health services to the inner city and eastern corridor population in terms of recognised high quality services that are accessible and local.*[414]

Dr Philip Montgomery told the Committee that RPH:

> *services a niche market. It is a hospital of people who are poor, people who are homeless, people who are Indigenous Australians, people who are psychiatrically ill. So it is really a poor people's hospital in a lot of ways.*[415]

The Committee supports the evidence of Dr Montgomery and the Clinical Staff Association, but is confident that a second inner-city tertiary hospital is not required for such purposes. A decision to retain RPH in a substantial, but reduced, capacity would represent only a minor deviation from the Government's election commitment. However, such a revision would still honour the wishes of the more than 40,000 petitioners who lobbied Dr Hames to "strongly oppose the closure of Royal Perth Hospital and to ensure the name Royal Perth Hospital is maintained".[416] These petitions did not request the Government to maintain RPH as a tertiary facility. Critically, this decision could provide an opportunity to re-establish the reform program that was designed to improve the cost, delivery and accessibility of hospital care in Western Australia.

Recommendation 17

The Government maintain Royal Perth Hospital as a facility for treating Level 4 emergency presentations and the provision of secondary-level care for Perth's inner-city population.

Recommendation 18

A revised clinical services delineation be undertaken by the Department of Health, using ABS Series A high-growth population data, to determine the appropriate distribution of hospital services when Royal Perth Hospital is maintained as a facility for treating Level 4 emergency presentations and the provision of secondary-level care for Perth's inner-city population.

---

414 Submission No. 19 from Royal Perth Hospital, Clinical Association Executive, 7 August 2009, p1.

415 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p15.

416 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Petitions* (Hansard), 16 August 2006, p4733. A total of 14 petitions with the same wording were tabled between 16 August 2006 and 2 December 2008. These petitions contained over 40,000 signatures.

(b) Sir Charles Gairdner Hospital

Sir Charles Gairdner Hospital (SCGH) opened in 1958 and is now a facility that has over 600 beds, approximately 5,000 staff and an annual caseload exceeding 420,000 patients. Named after a former governor, the hospital is located on the Queen Elizabeth II (QEII) Medical Centre in Nedlands just 4 kilometres from the Perth's CBD and RPH. SCGH is home to the largest cancer treatment centre in Western Australia and "is the state's principal hospital for neurosurgery and liver transplants."[417] Like RPH, Sir Charles Gairdner is internationally renowned for the quality of its medical research.

(i) *Position within the health reform agenda – Reid Report and CSF 2005*

The Reid Report was critical of the placement of two large tertiary facilities (SCGH and RPH) in such close proximity when only one-fifth of hospital presentations in the State required tertiary or quaternary care. The requirement for a merger had become more pressing as these two hospitals had "grown considerably in size over the past 30 years [while] Perth's population has dispersed with major population growth in outer suburbs."[418] The reform process led to the preference for SCGH as the site of the 'northern tertiary' hospital. While the physical constraints of the site were acknowledged by the former Health Minister, Hon Jim McGinty,[419] both the Reid Report and a significant number of contributors to the Clinical Services Consultation process agreed that the QEII site was the more advantageous.

The Reid Report envisaged the future 'northern tertiary' hospital as a 700-bed facility hosting:

- the State's Major Adult Trauma Centre;
- the State Cancer Centre;
- the State's adult neurosurgery service (having merged with RPH's neurosurgery);
- cardiothoracic surgery (with a second unit, if required, placed at the Southern Tertiary Hospital);
- liver and renal transplant services (the latter having been merged with the RPH staff); and
- acute rehabilitation services.[420]

---

417 Department of Health, 'Sir Charles Gairdner Hospital: About Us', n.d,. Available at: www.scgh.health.wa.gov.au/About_Us/index.html. Accessed on 18 March 2010.

418 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

419 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 24 May 2006, pE310.

420 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp48,58,61-65.

The Reid Report suggested that the Sir Charles Gairdner Hospital was the preferred site for the 'northern' tertiary hospital for a wide range of reasons, including:

- the infrastructure at SCGH was originally designed for a larger facility (and will now house the new PMH and KEMH);
- much of the infrastructure at QEII is newer than that at RPH;
- the QEII site already houses the State's cyclotron and PET machine in purpose-built facilities;
- there is a close link to the large Hollywood Private Hospital; and
- the QEII site is close to, and the staff have strong links to, medical education and research facilities at UWA (with the Oral Health Centre of Western Australia and the University of Western Australian Dental and Medical Undergraduate Schools are on the QEII site).[421]

After the Clinical Services Consultation process, it was decided to consolidate the State's Major Trauma Service at RPH in preparation for its later transfer to Fiona Stanley Hospital. It was argued that the new hospital at Murdoch would provide the optimal road and air access for critical patients, especially those from rural and remote areas. Nonetheless, SCGH would "maintain capacity for dealing with emergencies of a tertiary nature."[422] It was also recommended that Sir Charles Gairdner be "the single site for heart and lung transplantation."[423] The capacity of the merged facility at SCGH was increased considerably from the projections of the Reid Report, with 1,068 beds proposed by 2016.[424]

By the release of CSF 2005, SCGH was being referred to as the 'central tertiary' hospital.[425] While significant growth and development was planned to expand the capacity to accommodate 1,118 beds by 2015-16, a decision was made to re-locate the State's heart and lung transplant service to RPH as an interim measure while Fiona Stanley Hospital was constructed.[426]

(ii) *Departures from the health reform agenda – CSF 2010*

Services and beds

The most significant departure from CSF 2005 in the updated CSF 2010 is the decision to abandon the 'central tertiary' hospital concept and to maintain two inner-city tertiary hospitals less than

---

421 Mr Roger Cook, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 27 November 2008, p668.

422 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, pp64-65.

423 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p71.

424 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p43. .

425 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pi.

426 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a),18.

5km apart. Consequently, two cardiothoracic and orthopaedic surgical units will be maintained, in addition to the ones planned for Fiona Stanley Hospital. Similarly, the plan for merging the RPH and SCGH neurosurgery units has been abandoned. Most of the other proposals for SCGH have been retained, although the State Cancer Centre will now be one of two 'comprehensive' facilities for cancer treatment once Fiona Stanley Hospital is operational.[427] Obviously, the retention of RPH means that the projected bed capacity for SCGH has been revised substantially lower, as Table 6.2 below illustrates:

Table 6.2- Sir Charles Gairdner Hospital: contrasting service delineation between CSF 2005 and CSF 2010[428]

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical	705	705	452	452
Obstetrics	0	0	0	0
Paediatrics	0	0	0	0
Same-Day	87	87	91	91
High Dependency, Critical & Intensive[+]	70	70		
Emergency Short Stay Unit[+]	20	20		
Rehabilitation	30	30	30	30
Mental Health	36	92[++]	30	30
Other	38	42	0	0
TOTAL	**986**	**1,046**	**603 (13)**[*]	**603 (13)**[*]

[*] Plus 13 contracted off-site beds.

[+] These services are included under Medical/Surgical beds in CSF 2010.

[++] The adjustment of acute mental health beds from 92 back to 30 beds in the CSF 2010 unwinds an earlier decision to reduce the capacity of Graylands-Selby Lemnos Hospital by a similar amount.

Under CSF 2010, there is a 38% fall in the recommended bed capacity of SCGH for Medical, Surgical and Emergency Care (HDU/CCU/ICU/ESSU) services. The 339 Medical, Surgical and Emergency Care beds removed from SCGH under the CSF 2010 is a similar number to the 373 retained at RPH. DOH confirmed that the Reid Report's recommendation to have a joint management structure between the two hospitals has "not been progressed."[429]

427 A State-wide cancer services plan was commissioned in 2006 which called for an additional cancer centre at Fiona Stanley Hospital. See, Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 24 May 2006, pE329.

428 See, Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d); and Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

429 Submission No. 8 from Dr Peter Flett, Director General, Department of Health, 25 June 2009, p2.

Redevelopment timing

Not all departures from the State's reform agenda for health are attributable to the decision to retain Royal Perth Hospital as a tertiary facility. Much of the benefits to gained from the "fundamental reprioritisation of the public health system"[430] urged by the Reid Report were contingent upon the timely completion of major infrastructure projects. The Committee has found numerous examples of delays, cost overruns and cancellations in health projects, all of which have served to undermine the overall prospects for reform. Several examples are evident in the recent history of SCGH.

Three months before the release of CSF 2005, then-Health Minister, Hon Jim McGinty, confirmed that:

> *Construction of the upgrade of Sir Charles Gairdner Hospital is planned to commence in 2008. The capital works involved will be in the order of $400 million and are due to be completed in 2011.*[431]

The Government later confirmed in the 2006-07 Budget that the project entailed the construction of:

> *research, education, pathology facilities, State Cancer Centre Stage 2, and includes the expansion of inpatient services and remodelling/refurbishing of existing inpatient facilities.*[432]

By mid-2007 design work had been 'substantially completed', but the projected cost had increased to $530 million.[433] Moreover, the expected 2011 completion date had been put back by 12 months because of an overheated construction market denying the Government access to labour.[434]

When Dr Peter Flett, then-Director General of Health, first appeared before the Committee in December 2008 he advised that further delays were expected. Having originally opposed the Reid Report's recommendation to co-locate both a new women's and children's hospital with an adult tertiary facility (see section on Princess Margaret Hospital below), the Carpenter Government had agreed to the transfer of Princess Margaret Hospital to the QEII site. This had necessitated an adjustment of the development planning across SCGH's services. Site planning is being significantly reconfigured again now to cater for the policy changes of the new Barnett

---

430 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pv.

431 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 10 June 2005, pE452.

432 Department of Treasury and Finance, 2006, *2006-2007 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p581.

433 Department of Treasury and Finance, 2007, *2007-2008 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p581.

434 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE211.

Government. The estimated total cost of the redevelopment has been revised down to $115.1 million. The drop of over $400 million is attributable to the reduced size of the hospital as per CSF 2010 and to the cancellation of a proposed $108 million diagnostic and treatment facility during the recent Capital Works Audit process.[435]

The completion date for the project remains uncertain. As far as the Committee is aware, most aspects of the SCGH redevelopment first proposed in 2006 remain well behind the original 2011 planned completion date. Over $33 million of the estimated $115 million cost remains outside the Barnett Government's Forward Estimates for 2012-13. Dr Flett displayed his frustration over the process in March 2009 when he predicted:

> *a completion date of 2012, or something like that. However,* ***like with most things, as I am finding working in this department, time has been pretty flexible*** [emphasis added], *so there has been a bit of push-out of that time*.[436]

State Cancer Centre Stage Two and multi-storey car park

In 2005, it was envisaged that the State Cancer Centre at SCGH would be 'fully operational' within five years.[437] Stage One was completed in 2007 and $65 million was allocated in the 2008-09 Budget for the construction of Stage Two.[438] DOH confirmed that construction was now not due to commence until 2010. The most recent estimate from DOH was a completion date of August 2011.[439] However, in March this year, the then-Treasurer said:

> *I am sure construction of the cancer centre has been delayed because there were delays awarding the contract….I would say it has probably been delayed three months.*[440]

If those comments prove accurate, the State Cancer Centre will not be operating to its full potential until at least 2012, two years beyond the original date. A multi-storey car park was planned for SCGH with a completion date of 2010, but this too is running behind schedule. The urgency of the project was underlined by the fact that many staff were having to park in overflow facilities at RPH Shenton Park and Graylands Hospital in Mt Claremont and board a free shuttle service to complete their commute to work.[441] The City of Nedlands has expressed its opposition

---

435 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Response to Question on Notice*, 11 November 2009, (Appendix A) p5.

436 Dr Peter Flett, Director General, Department of Health, *Transcript of Evidence*, 18 March 2009, p11.

437 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p82.

438 See, Department of Treasury and Finance, 2006, *2006-2007 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p547; Department of Treasury and Finance, 2008, *2008-2009 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p601.

439 Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 18 May 2009, p2.

440 Hon Mr Troy Buswell, Treasurer, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 17 March 2010, p792.

441 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 21 May 2008, ppE232-233.

to further developments at the QEII site, such as the construction of the new Princess Margaret Hospital, due to the ongoing transport problems.[442] The most recent advice received by the Committee was that this project will not be commencing until February 2011.[443]

Finding 43

From 2005 onwards, infrastructure projects designed to improve the operability of Sir Charles Gairdner Hospital, and enhance the productivity of its staff, have been consistently delayed.

(iii) *Impact on the reform agenda*

The decision to retain RPH as a tertiary facility has had little impact on the current capacity of SCGH. Many of its specialist services will continue operating independently and its allocated number of beds will remain largely unchanged. What will also remain, though, are the duplication of services and inefficiencies within the tertiary hospital sector that the Reid Report's recommendations address. Of added concern is the likelihood of extended delays in infrastructure development. Based on the evidence presented to the Committee it is difficult to see how the proposed redevelopment of RPH can be simultaneously undertaken while major and expensive capital works are undertaken at SCGH and Fiona Stanley Hospital.

The Committee sees no reason why tertiary services at RPH can not be distributed between Fiona Stanley Hospital, once operational, SCGH and an expanded Joondalup Health Campus. With RPH maintained as a secondary-level facility, the expansion of SCGH will not have to be as great as that originally proposed in CSF 2005. Such a move would better fit the intention of the original reform program and would reduce the unnecessary financial and timing pressures facing the Government due to its election commitment to retain RPH as a tertiary hospital.

Recommendation 19

Tertiary services currently at Royal Perth Hospital should be distributed between Fiona Stanley Hospital, Joondalup Health Campus and Sir Charles Gairdner Hospital once Fiona Stanley Hospital is operational.

---

442 Eastern Reporter, 'Parking space at a premium', 2 March 2010. Available at: http://eastern.inmycommunity.com.au/news-and-views/local-news/Parking-space-at-a-premium/7550240/. Accessed on 12 April 2010.

443 Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 18 May 2009, p2.

(c) Fiona Stanley Hospital

Fiona Stanley Hospital (FSH) is currently being constructed on a 'greenfield' site at Murdoch. It is to be developed in two stages. Mr Brad Sebbes, Executive Director Fiona Stanley Hospital, told the Committee in December 2008 that he anticipated Stage One would comprise a 643 bed facility with 16 operating theatres and parking for 3,300 cars. In an attempt to lower infection risk, 83% of the patient rooms will be single bed. Stage 2 would take bed numbers to 1,058. A Medi-Hotel facility will be included on site providing accommodation, particularly for families travelling from remote and regional areas.[444]

In May 2009, it was confirmed that the new State Rehabilitation Centre (replacing Royal Perth Rehabilitation Hospital, Shenton Park) would be added to the site after the Federal Government committed $255.7 million to fund the project.[445] Mr Sebbes described the new hospital as "the biggest building project that any government in this State has ever undertaken."[446] The project is currently budgeted at $1.76 billion with $1.3 billion held in a special purpose trust account, which was established in October 2007.[447]

(i) Position within the health reform agenda – Reid Report and CSF 2005

FSH is the manifestation of the Reid Report's call for a new 'Southern Tertiary Hospital'. The Reid Report stressed the need to expand tertiary services in the southern metropolitan area to cater for ongoing population growth in that region and to correct the imbalance that had historically seen specialist care weighted towards the city centre.[448] Fremantle Hospital currently assumes the role as the tertiary facility for Perth's southern suburbs. However, the Reid Report found that this site was no longer appropriate for this purpose. Firstly, it was badly positioned, being located in the north-west corner of the catchment population. More importantly, the site was "badly set-up as a result of unplanned growth over previous decades" and did not "lend itself to expansion."[449] The Reid Report proposed the future of Fremantle Hospital as specialising in rehabilitation, mental health and aged-care services.

---

444 Submission No. 1 from Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, 8 December 2008, pp1-8.

445 Hon Dr Kim Hames, Minister For Health, 'Joint Statement: Infrastructure Plan to Boost Elective Surgery in WA', 1 July 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?minister=Hames&admin=Barnett. Accessed on 12 April 2010.

446 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 8 December 2008, p19.

447 See the *Fiona Stanley Hospital Construction Account Act 2007.* Available at: www.austlii.edu.au/au/legis/wa/bill/fshcab2007481/. Accessed on 12 April 2010. Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p7.

448 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp49-50.

449 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

The decision to establish a larger 600-bed facility at Murdoch was strongly supported through the Reid Report's consultation process.[450] The Murdoch site was advantageous in several key ways. As a greenfield site it had greater developmental potential and would not inconvenience the delivery of health services during its construction.

However, the major benefit was its accessibility for patients traveling from within the southern corridor or from regional areas:

> *This new hospital…would be serviced by excellent transport links via the freeway and the new southern rail line, and good road access from Jandakot Airport for the Royal Flying Doctor Service.*[451]

Of further benefit was its proximity to the private hospital facilities at St John of God Hospital Murdoch which could be used to cope with issues such as elective surgery overflows. The Reid Report called for the new 'southern hospital' to "incorporate the tertiary clinical services of Fremantle Hospital together with designated clinical groups from Royal Perth and Sir Charles Gairdner hospitals."[452] Among the tertiary-level services proposed were:

- haemodialysis—FSH cited as the future Centre of Excellence for the State;
- renal transplant services;
- cardiothoracic surgery—to be determined once the hospital was operational; and
- general medical and surgical services.

The possibility of a neurosurgery service at FSH was also left open for further discussion.[453] The *Clinical Services Framework 2005-2015* enlarged the final capacity of FSH and its range of services. The 1,000+ bed facility would now include the State's Trauma and Burns Centre, its heart and lung transplant service, a Comprehensive Cancer Centre and the State Rehabilitation Centre.[454] In terms of timing, the new Fiona Stanley Hospital was to commence operation by mid-2011 with the majority of the State's tertiary-level rehabilitation services to be relocated there by 2015-16.[455]

---

450 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

451 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

452 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p49.

453 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp58-63.

454 The Reid Report (p48) had originally proposed that the State Rehabilitation Centre be rebuilt on the current Osborne Park Hospital. Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(c),19.

455 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp8,37.

(ii) *Departures from the health reform agenda – CSF 2010*

Services and beds

Table 6.3 below illustrates the contrasting projected bed capacities for the Fiona Stanley Hospital between the original CSF 2005 and the recent CSF 2010.

Table 6.3- Fiona Stanley Hospital: contrasting service delineation between CSF 2005 and CSF 2010[456]

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical	335	574	473	473
High Dependency, Critical & Intensive Care	50	80		
Emergency Short Stay Unit	12	16		
Obstetrics	25	27	48	48
Paediatrics	18	18	24	24
Same-Day	35	70	68	68
Mental Health	48	56	30	30
Other	45	70	0	0
Rehabilitation	42	147	140	180
Contract off-site beds			15	15
TOTAL	**610**	**1,058**	**798**	**838**

The Reid Report based bed numbers on population needs. Thus Stage 11 of CSF 2005 was to see 1,058 beds at FSH by 2015-16. The Table above shows:

- CSF Stage 1 and 11 projections which were based on the Reid Report; and
- CSF projections which are based on lobbying for the retention of RPH as a tertiary facility.

While CSF 2010 Stage 1 shows an additional 188 extra beds planned for FSH in 2015 (798 versus 610) the bed numbers are not directly comparable between CSF 2005 and CSF 2010. For example:

- the majority of the 188-bed increase is actually comprised of an increase in rehabilitation beds, from 42 to 140. This is the result of the re-location of the State Rehabilitation Centre from RPH Shenton Park to the FSH site — a move flagged in CSF 2005;

456 See, Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d); Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

- CSF 2010 shows a Stage One increase of 138 Medical/Surgical beds (from 335 to 473). However, supplementary notes advise that 62 beds from other clinical units listed as separate items in CSF 2005—High Dependency (HDU)/Critical Care (CCU)/ Intensive Care; and Emergency Short Stay (ESSU)—were now counted under the Medical/Surgical grouping. As a result, the actual increase in Medical/Surgical capacity at Fiona Stanley under Stage One would be only 76 beds; and

- similarly, the majority of the increase scheduled for Obstetrics (from 25 to 48 beds) and Same-Day (from 33 to 65) consists of the neonatal and dialysis beds formerly listed under 'Other' in CSF 2005.

The revised CSF 2010 Stage Two data is also concerning:

- The new framework confirms that there is currently no plan to increase bed capacity at Fiona Stanley Hospital in the six years between 2015 and 2021, despite high population growth in Perth's southern corridor. Only the State Rehabilitation Centre facility is earmarked for expansion, from 140 to 180 beds.

- In comparison with CSF 2005, the Fiona Stanley Hospital will now have 220 fewer beds (1,058 versus 838) when the Stage Two construction has been completed.

These dire outcomes become clear when the 2015 projections for both CSF 2005 and CSF 2010 are placed together. As Table 6.4 demonstrates, under the CSF 2010 it is projected that there will 260 fewer beds then originally planned for FSH by 2015. The majority of this shortfall is within the Medical/Surgical unit, where CSF 2010 proposed bed capacity is set to fall by 197 beds.

Table 6.4 – Fiona Stanley Hospital: projected bed differences between CSF 2005 and CSF 2010

Service	Original CSF 2005 Stage II (2015-16)	Revised CSF 2010 Stage I (2014-15)	Differences in Bed Numbers
Medical/Surgical	574	473	**-197**
High Dependency, Critical & Intensive Care	80		
Emergency Short Stay Unit	16		
Obstetrics	27	48	**+21**
Paediatrics	18	24	**+6**
Same-Day	70	68	**-2**
Mental Health	56	30	**-26**
Other	70	0	**-70**
Rehabilitation	147	140	**-7**
Contract off-site beds	0	15	**+15**
TOTAL	**1,058**	**798**	**- 260**

It was shown in Section (d) of Chapter 5 above, that DOH originally tried to assign this dramatic decrease in beds exclusively to delays in its capital works program, before conceding that the decision to retain RPH "has caused a change in the way patients flow."[457] While project delays (see below) and policy changes have contributed to this decline in bed numbers, population growth in the catchment area for the FSH has continued to surge. Combined with the low population projections used in DOH's modelling for CSF 2010, these factors will ensure that the FSH will be incapable of appropriately servicing residents in Perth's southern suburbs.

Redevelopment timing

As with SCGH, there have been significant deviations in the timing and cost of the development of FSH under the Gallop and Carpenter governments. The 2005-06 Budget allocated $420 million for the construction of FSH Stage One. Within a year, this figure had nearly doubled to $742 million and the 2011 completion date was maintained.

Then-Health Minister, Hon Jim McGinty, told the Estimates Committee in 2006:

> *We go to tender in December 2007, with construction starting in February 2008 and concluding in 2011. That is on target, and will be well under way by 2008 and certainly by 2009.*[458]

The following year, the first major revision to the construction timetable was conceded:

> *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.*[459]

During this later hearing in 2007, Hon Jim McGinty conceded that a completion date of 2017 for the remainder of the project was not an unrealistic assessment. By April 2008, he cited 2013-14 as the expected opening date for Stage One, while the full cost of construction was confirmed at $1.76 billion.[460] By the time of the Barnett Government's first budget (May 2009), a total of $94.2 million had been spent on the Stage One construction with the first concrete being poured in December 2009.[461] In his final appearance before the Committee, then-Director General, Dr Peter Flett said that the current status of Stage One was "both on time and on budget at this moment",[462]

---

457 Dr Robyn Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 16 February 2010, p13.

458 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 24 May 2006, pE342.

459 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE203.

460 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 10 April 2008, p2196. See also, Department of Treasury and Finance, 2008, *2008-2009 Budget* (Paper No.3 Economic and Fiscal Outlook), Department of Treasury and Finance, p30.

461 Department of Health - Fiona Stanley Hospital, 'What's New', nd. Available at: www.fionastanley.health.wa.gov.au/news/whatsnew.cfm. Accessed on 12 March 2010.

462 Dr Peter Flett, Director General, Department of Health, *Transcript of Evidence*, 10 November 2009, p13.

suggesting a completion date of 23 December 2013 with the opening day planned for 1 May 2014.[463]

Finding 44

Based on current estimates, the expected opening of Fiona Stanley Hospital is May 2014, three years beyond the original forecast. The extent of this delay was acknowledged as early as April 2008 by the then-Carpenter Government.

(iii) Impact on the reform agenda

There was never any discussion about downsizing Fiona Stanley Hospital.

Minister for Health, Hon Dr Kim Hames, 6 November 2008.[464]

Fiona Stanley Hospital will not suffer in any way because of the retention of Royal Perth Hospital.

Minister for Health, Hon Dr Kim Hames, 12 November 2008.[465]

It [Fiona Stanley Hospital] *will become a 1,000-bed hospital.*

Minister for Health, Hon Dr Kim Hames, 7 April 2009.[466]

The release of the *Clinical Services Framework 2010-2020* in December 2009 contradicts these earlier claims by the Health Minister (two of which were made in Parliament) that the retention of RPH would not affect plans for the new tertiary hospital at Murdoch.

Finding 45

Twice in the past 18 months, the Health Minister Hon Dr Kim Hames, seems to have misled Parliament as to the Government's plans for the new Fiona Stanley Hospital.

---

463 Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 18 May 2009, p2.

464 Ms Kim Macdonald, 'Saving RPH 'Won't Alter Plans for New '', .

465 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 12 November 2008, pE179.

466 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 7 April 2009, p2853.

Service beds and workforce

Despite the assurances given by the Health Minister, the retention of RPH as a tertiary facility will have a significant affect on the volume of services and workforce planning strategies at FSH. To reiterate the impact in terms of service volume:

- there is no increase in capacity planned at FSH between Stage One (2014-15) and Stage Two (2020-21), except for the 40 extra beds planned for the State Rehabilitation Centre;
- under CSF 2010 the final capacity of FSH has been reduced by 220 beds; and
- the revised 2015 capacity for FSH is 260 beds lower than projected in CSF 2005.

This reduction in the projected capacity of FSH directly undermines the intention of the Reid Report to correct the historical imbalance of tertiary services that favoured Perth's inner city suburbs over the southern and northern ones. Moreover, the final result is opposite to the current trends in population growth in Perth. In March 2009, DOH credited the proposed size of FSH under CSF 2005 (1,058 beds in Stage Two) to "a big [population] catchment in that southern corridor".[467] Population growth data from the ABS continues to support these arguments. From 2001 to 2009 three LGAs within the FSH catchment — Cockburn, Mandurah and Rockingham — have consistently placed amongst the seven fastest growing councils in the State.[468] From 2004 to 2009 the aggregate population of these councils has increased by 47,624 (see Table 6.5). In contrast, the population growth in the same period of four of the councils closest to RPH and Sir Charles Gairdner Hospital has grown by only 30,911 (see Table 6.6).[469]

Table 6.5- Fiona Stanley Hospital: catchment local government area population growth: Cockburn, Rockingham and Mandurah, 2004-09

LGA	30 June 2004	30 June 2009	Population increase
Cockburn	74,232	88,702	14,470
Mandurah	54,841	68,269	13,428
Rockingham	80,505	100,231	19,726
TOTAL	**209,578**	**257,202**	**47,624**

467 Ms Jodie South, Senior Project Manager, Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p17.

468 Taken from figures measuring 1996-2006, 2006-2007, 2007-2008 and 2008-2009, Australian Bureau of Statistics, '3218.0 Regional Population Growth, Australia', 30 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2008-09~Main+Features~Western+Australia?OpenDocument. Accessed on 1 April 2010.

469 Australian Bureau of Statistics, '3218.0 Regional Population Growth, Australia', 30 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2008-09~Main+Features~Western+Australia?OpenDocument. Accessed on 1 April 2010.

Table 6.6- Royal Perth Hospital & Sir Charles Gairdner Hospital: catchment local government area population growth: Perth, Stirling, Victoria Park and Vincent, 2004-09

LGA	30 June 2004	30 June 2009	Population increase
Perth	9,928	17,093	7,165
Stirling	181,227	198,803	17,576
Victoria Park	28,563	32,256	3,693
Vincent	28,393	30,870	2,477
TOTAL	**248,111**	**279,022**	**30,911**

Finding 46

Under the *Clinical Services Framework 2010-2020,* there is no increase planned for the bed capacity of Fiona Stanley Hospital between 2014-15 and 2020-21 despite a likely population increase of more than 40,000 in just three of the closest Local Government Areas within the hospital's catchment area.

The *Clinical Services Framework 2010-2020* has reduced the projected beds at Fiona Stanley Hospital in 2015 by 260 beds, whilst the Stage Two capacity of Fiona Stanley Hospital has been reduced by 220 beds.

The retention of RPH as a tertiary hospital also poses serious workforce planning issues for the Department of Health. Mr Brad Sebbes advised the Committee that FSH would require 4,500 FTE once operational in 2014. He added that the "initial plan had a significant number of these staff relocating from RPH."[470] As a result of the Government's retention of RPH, workforce planning was now being revised. Responding to questions about the impact of this change in policy, Dr Philip Montgomery said "the single biggest issue is the workforce."[471]

Appearing at a subsequent hearing Dr Montgomery expanded upon this point:

> *we will have to have new ways of working for people to work across sites* [especially RPH and FSH]*, because the one thing they will not do is drive backwards and forwards between hospitals. A lot of change in workforce will need to take place.*[472]

Mr Sebbes made similar arguments and highlighted that the impact of retaining RPH as a tertiary hospital may extend to staffing at other hospitals within the metropolitan network:

---

470 Submission No. 1 from Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, 8 December 2008, p14.

471 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p4.

472 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 18 March 2009, p23.

> *Going forward, workforce will be our biggest issue and it will get more complicated with the retention of Royal Perth Hospital because a lot of staff would have automatically moved to Fiona Stanley and other hospitals. There would not have been the choice issue.…The pool of staff is the critical issue for health. In reality it may well be a problem that, being new, Fiona Stanley Hospital will attract staff and that will leave shortfalls at other hospitals.*[473]

Parliament was told that Dr David Fletcher (head of surgical services at Fremantle Hospital) had been reported in *The Sunday Times* as saying that:

> *it was inconceivable there would be enough staff to service the Royal Perth, Fiona Stanley and Sir Charles Gairdner hospitals. … The impact on the planning of Fiona Stanley Hospital is going to be enormous.*[474]

Managing workforce requirements under an expanding hospital system was always going to be a challenge for the DOH. However, the evidence of these experienced staff confirms that the process has been made more complex with RPH retained as a large tertiary facility.

Finding 47

The retention of Royal Perth Hospital as a 410-bed tertiary facility will create major logistical difficulties for the Department of Health in terms of workforce management.

Service type

The services to be provided at FSH under CSF 2010 are largely consistent with the recommendations contained in CSF 2005. In the case of obstetrics and neonatal, plans for an expanded facility have actually been brought forward. In addition, a six to eight-bed 'mother baby unit', focusing on mothers suffering post-partum depression, has now been included in Stage One.[475] Other services offered at FSH should remain similar to CSF 2005, despite being reported in CSF 2010 differently. While now designated as one of several 'major' trauma centres, the Fiona

473 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 8 December 2008, p25.

474 Mr Roger Cook, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 27 November 2008, p670.

475 Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 18 March 2009, p2; Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 7 May 2009, p3608.

Stanley trauma unit is still likely to be the State's prominent provider of such services, treating over 70-80% of cases.[476]

However, a noticeable service withdrawal from FSH contained in the CSF 2010 is the heart and lung transplant unit, which will now remain at RPH. Given the evidence collected, the Committee was surprised by this decision and has concerns about the process supporting it. Both Dr Montgomery and Mr Sebbes had told the Committee that they expected the heart lung unit to be transferred to FSH.[477] As late as 26 April 2009, the Health Minister also confirmed that FSH would house this facility.[478] Yet just 10 days after his initial comment, Dr Hames announced that "follow[ing] consultation with the State's cardiothoracic surgeons on the best configuration of services"[479], the heart lung transplant team would continue to work from RPH.

The Committee has not been able to ascertain what prompted the Minister to suddenly change his mind, but is aware that cardiologists at RPH had not been supportive of a move to FSH. Dr Montgomery advised the Committee that the RPH cardiologists are much less united than other clinical groups. He added that with RPH:

> *staying on stream….All their arguments about not getting enough floor space or not getting enough whatever at Fiona Stanley tend to dissipate a little. They do not seem to have got over the physical location in the building.*[480]

With the evidence available, the Committee could not be sure that the Minister's sudden reversal on the location of the heart and lung transplant unit was not disproportionately influenced by the clinicians from Royal Perth Hospital. Such an approach to the formulation of hospital services would be in stark contrast to the broad consultation that underpinned the Reid Report and the original CSF 2005 process. In the interests of transparency, it would assist Parliament if the Minister detailed the parties with whom he consulted before reaching this decision.

---

476 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p5; Hon Dr Kim Hames, Minister for Health, Western Australia Legislative Assembly, *Parliamentary Debates* (Hansard), 11 November 2009, p8789.

477 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p4; Mr Brad Sebbes, Executive Director, Fiona Stanley Hospital, *Transcript of Evidence*, 18 March 2009, p7.

478 Hon Dr Kim Hames, Minister for Health, 'Fiona Stanley Hospital to Provide Major Boost to Obstetric and Neonatal Services', 26 April 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=131741&minister=Hames&admin=Barnett. Accessed on 12 March 2010.

479 Hon Dr Kim Hames, Minister for Health, 'Minister Sets Direction for Future Delivery of Cardiothoracic Surgery', 6 May 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=131795&minister=Hames&admin=Barnett. Accessed on 12 March 2010.

480 Dr Philip Montgomery, Executive Director, Royal Perth Hospital, *Transcript of Evidence*, 8 December 2008, p24.

Recommendation 20

The final capacity of the Fiona Stanley Hospital should be expanded from its current projections as contained in CSF 2010. The size of the expansion should be determined by a revised clinical services delineation that uses realistic population projections and accounts for the Committee's recommendation to reclassify Royal Perth Hospital to a secondary-level facility.

Finding 48

The decision to retain the State's heart and lung transplantation unit at Royal Perth Hospital was announced just 10 days after the Health Minister had confirmed that this facility would be transferred to Fiona Stanley Hospital.

Recommendation 21

The Minister for Health provide to Parliament the full details of the parties with whom he consulted before reversing his position and made the decision to retain the heart and lung transplant unit at Royal Perth Hospital.

Recommendation 22

As recommended by *Clinical Services Framework 2005-15*, the heart and lung transplant unit at Royal Perth Hospital be transferred to Fiona Stanley Hospital.

Conclusion

The health reform program recommended by the Reid Report was about unwinding the status quo where the provision of care was inefficient, or not representative of population needs. The distribution of adult tertiary hospitals was a key focus for the Report. Yet in this vital area, the maintenance of RPH as a tertiary hospital—even with a reduced capacity of 410 beds—will stifle a key component of the reform agenda. Relative to their inner city counterparts, people in the southern and northern suburbs will continue to be under-serviced in terms of convenient access to tertiary care.

The decision to reduce the Stage Two capacity of FSH should be revisited. By reclassifying RPH to a secondary-level facility — and using high-growth population projections in modelling

calculations — a revised service delineation more appropriate to population trends should be made for Fiona Stanley Hospital. With a 'greenfield' site and over $1.3 billion in funding quarantined for the project, an expansion of the second stage of Fiona Stanley Hospital is warranted by the large population growth in southern Perth.

(d) King Edward Memorial Hospital and Princess Margaret Hospital

King Edward Memorial Hospital (KEMH) is the State's tertiary maternity and gynaecological hospital. The facility also includes a 100-bed neonatal[481] nursery, the largest in the southern hemisphere. Various models of care for childbirth are offered from family birthing centres through to traditional obstetrics. The hospital oversees 6,000 births and treats over 5,000 patients with gynaecological conditions every year. Among other services provided at KEMH are the State-wide Sexual Assault Referral Centre and the State-wide Obstetric Support Unit.[482]

Princess Margaret Hospital (PMH) is Western Australia's tertiary-level paediatric facility providing specialist care for the State's children and adolescents. PMH's services include cardiac surgery, neurosurgery, oncology, rehabilitation and trauma. In addition, the hospital has its own Emergency Department and an 8-bed non-secure mental health inpatient unit. Collectively, PMH's inpatient and outpatient departments receive over 250,000 visits each year.[483] Evidence from the Department of Health confirms that over the past year it has directed more resources to acute services at PMH compared to other services such as Child and Adolescent Community Health (see Table 6.7 below).

481 Neonatal refers to the newborn period and can cover the first four to six weeks of a baby's life.

482 See, Department of Health – Women's and Newborn Health Service, 'About King Edward Memorial Hospital Western Australia', nd. Available at: http://kemh.health.wa.gov.au/general/about_us/index.htm. Accessed on 7 April 2010; Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, Department of Health, *Transcript of Evidence*, 26 August 2009, pp1-3.

483 See, Department of Health – Child and Adolescent Health Service, 'About Princess Margaret Hospital', nd. Available at: www.cahs.health.wa.gov.au/general/about_us/index.htm. Accessed on 7 April 2010; Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p2.

Table 6.7- Distribution of expenditure within Child and Adolescent Health Service, 2008-10[484]

	2008-09 expenditure	2009-10 budget	Change in expenditure
Total (Child & Adolescent Health Service)	$267.1 million	$287 million	+7.45%
Acute (Princess Margaret Hospital)	$207.7 million (77.8%)	$228.8 million (79.7%)	+10.16%
Non-acute (including Child & Adolescent Community Health)	$59.4 million (22.2%)	$58.2 million (20.3%)	-2.0%

The Committee's recent *Invest Now or Pay Later* report highlighted the increase of 82 staff (FTE) at PMH between 2007-09, and the CSF 2010 provides another 101 beds at PMH by 2014-15.[485] The Committee welcomes the Government's increased investment in acute services at PMH but it highlights the different approach this Government has to properly funding key non-acute child health services such as speech pathology.

Finding 49

The Government has increased investment in acute services at Princess Margaret Hospital. Additional funding should be provided for non-acute child health services, such as speech pathology.

KEMH and PMH have a combined capacity of 520 beds and are located 2.4 kilometres apart in Subiaco.

(i) Position within health reform agenda – Reid Report and CSF 2005

The Reid Report urged that KEMH and PMH maintain their status as centres of excellence and tertiary providers because the health needs of women and children required "safe, high quality paediatric, obstetric and gynaecological care".[486] In 2004 the general hospitals in the metropolitan area, and some regional centres, were offering non-tertiary level care across these clinical groupings. The Reid Report urged the expansion and integration of these facilities under a

484 Mr Kim Snowball, Acting Director General, Department of Health, *Reply to Questions on Notice*, 22 March 2010, p1.

485 Education and Health Standing Committee, 2010, *Invest Now or Pay Later: Securing the Future of Western Australia's Children*, Parliament of WA, Perth, p39.

486 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p51.

'networked service model' where clinical guidelines and policy advice were coordinated by the centres of excellence. Prior to this, particularly for women's health, service provision had been inconsistent across the metropolitan area with hospitals "operating fairly independently."[487]

The Reid Report argued that both tertiary hospitals were in need of significant capital investment in the medium term, for maintenance of facilities. However, the Report felt that this money could be better spent constructing a new combined facility "that could be specifically designed around [a] more integrated women's and children's health service".[488] Ultimately, the Reid Report recommended that KEMH and PMH should be "re-built and co-located with an adult tertiary hospital" [emphasis added].[489] Among the benefits cited was that "building a replacement facility can unify services that have historically operated on a fragmented basis."[490] Quoting a submission received from the Women's and Children's Health Service during its public consultation stage, the Reid Report added that:

> *co-location would better allow for the provision of acute services for women and provide better access to diagnostic services. Access to critical care and adult specialties would also be improved.*[491]

Another submission from the Clinical Staff Association at PMH expanded on the point of clinical advantages to be gained from the proposal:

> *The current geographic separation of the larger neonatal nursery at King Edward Memorial Hospital from the children's hospital may not allow optimal…care of pre-term neonates.*[492]

The Reid Report stressed that a new co-located hospital adjacent to an adult tertiary site would improve clinical outcomes and operational efficiencies. This would provide far greater long-term outcomes than "expending dollars on patching up the current inefficient facilities."[493] While the Reid Report did not firmly commit to the most appropriate location for the new facility, clinicians

---

487 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp51-52,66-67.

488 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

489 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

490 The successful re-location of Sydney's Royal Women's Hospital to the Prince of Wales Hospital in 1997 was offered as an example. Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p80.

491 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p52.

492 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p52.

493 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p118.

at both PMH and KEMH expressed a preference for the QEII site in Nedlands.[494] The Reid Report did recommended that KEMH be re-located first, "in the medium term", as it was in "greater need of capital investment".[495]

Contributors to the clinical services consultation process in 2005 agreed on the importance of co-locating the facilities, claiming that the "ability to maintain high levels of clinical care, equipment, services and infrastructure on isolated sites"[496] was not sustainable. The splitting of neonatology over two sites was also cited as a key factor undermining clinical efficiencies.[497] The *Clinical Services Consultation 2005* did not suggest the best adult tertiary hospital with which to combine any new co-located service for women and children. Instead, it included the Fiona Stanley Hospital as another potential fit.[498]

In September 2005, the release of the *Clinical Services Framework 2005-2015* provided a different direction for these two hospitals. While $25 million was committed to an upgrade of KEMH's Emergency Department, delivery suites and Adult Special Care Unit; priority was directed towards confirming the future of the children's hospital.[499] CSF 2005 acknowledged that co-location of both hospitals to an adult tertiary site "would be the preferred solution to address the issues identified."[500] Despite this, and after extensive consultation and deliberation, the decision was made to relocate PMH independently to what was anticipated to be the vacated North Block of RPH after its expected closure in 2011. According to the timetable provided, KEMH would remain operational at Subiaco until at least 2017. However, 'footprints' would be made available at the RPH, FSH and QEII sites, for the "most appropriate relocation when required."[501]

Prior to the release of CSF 2005, then-Health Minister, Hon Jim McGinty, provided Parliament with an insight into the Gallop Government's intention for this component of the hospital reform program:

> *when the Reid Report came down in March 2004, the Government's response was not to accept the recommendation to co-locate PMH and King Edward Memorial Hospital on a*

494 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, pp52-53.

495 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p53.

496 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p58.

497 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p59.

498 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p58.

499 Department of Treasury and Finance, 2005, *2005-2006 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p474.

500 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p21.

501 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp21,37.

> *tertiary hospital campus site. We thought that was biting off too much, so we left that alone.*[502]

Mr McGinty conceded that 'nobody' supported Labor's proposed move of PMH to the RPH site.[503] Nonetheless, the former Government equivocated over the future of PMH and KEMH for another three years[504] before firmly committing — in the lead-up to the 2008 election — to building both hospitals alongside the SCGH.[505] Despite the claims of 'extensive consultation and deliberation', the Committee believes that the decision to refrain from co-locating the women's and children's hospitals with an adult tertiary site in 2005 was as poor policy as the current Government's move to retain RPH. In both instances the actions of policy makers have impeded the original agenda for reform to make the State's health system more efficient.

(ii) Departures from the reform agenda – CSF 2010

Services and beds

CSF 2005 had reduced the capacity of both PMH and KEMH during the Stage Two period (see Tables 6.8 and 6.9 below) due to its use of population growth estimates lower than the actual rate. Projections in *Clinical Services Framework 2010-2020* restore the future size of each facility to around its current capacity. Dr Frazer told the Committee that:

> *it is my view that we have enough physical beds in the system to cope with maternity services; it is a matter of actually accommodating women's need for choice.*[506]

The CSF 2010 facilitates this desire for choice by expanding the capacity of non-tertiary obstetrics and neonatal services throughout the outer metropolitan hospital network. This decision, which follows the intent of the Reid Report, will increase the collective capacity of Armadale-Kelmscott, Joondalup, Swan District and Rockingham hospitals from their current 96-bed capacity to 143 by 2014-15. The Committee endorses this move, as it provides care closer to home for mothers in outer metropolitan suburbs.

---

502 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 10 June 2005, ppE464-465.

503 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, ppE205-206.

504 For example, in 2006 Mr McGinty stated that "King Edward is going there [SCGH site] anyway. It is a question of whether PMH joins it….We should be in a position to resolve that within the next couple of months". See, Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 24 May 2006, pE310

505 Hon Mr Jim McGinty, Minister for Health, *New Hospital for WA Kids – Owned by the People of WA*, Media Statement, Government Media Office, Perth, 6 July 2008.

506 Dr Frazer, Executive Director, Women and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

Table 6.8- Princess Margaret Hospital: contrasting service delineation between CSF 2005 and CSF 2010

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical			32	39
Obstetrics/Neonatal			25	25
Paediatrics	176	112	171	127
Same-Day	29	20	43	44
High Dependency, Critical & Intensive*	10	6		
Emergency Short Stay Unit*	7	6		
Mental Health	8	8	8	12
Other#	26	26		
TOTAL	**256**	**178**	**279**	**247**

* Figures for these services are included under Medical/Surgical in CSF 2010.

\# 'Other' included neonatal beds in CSF 2005. These numbers are now included under 'Obstetrics/Neonates' in CSF 2010.

Table 6.9- King Edward Memorial Hospital: contrasting service delineation between CSF 2005 and CSF 2010[507]

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical	20	20	37	37
Obstetrics/Neonatal	92	75	206	221
Paediatrics	2	2		
Same-Day	12	12	20	20
High Dependency, Critical & Intensive*	5	5		
Emergency Short Stay Unit*				
Mental Health	8	8	8	12
Other#	90	90		
TOTAL	**229**	**212**	**271**	**286**

* Figures for these services are included under Medical/Surgical in CSF 2010

\# 'Other' included neonatal beds in CSF 2005. These numbers are now counted under 'Obstetrics/Neonates' in CSF 2010, and include the redeveloped 100-bed neonatal nursery.

507 Data on both tables obtained from, Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d); and Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

Finding 50

The *Clinical Services Framework 2010-2020* has increased the projected capacity of tertiary and non-tertiary obstetric and neonatal services at King Edward Memorial Hospital, Princess Margaret Hospital and the four general hospitals. This is a positive development that is responsive to the original reform goals of providing more appropriate care.

Redevelopment timetable

Under the current Government the uncertainty surrounding the co-location strategy for PMH and KEMH has returned. The *Clinical Services Framework 2010-2020* confirms that "within the next six years, a new children's hospital will be built…adjacent to the SCGH." No mention is made of the future plans for the women's hospital. DOH advised the Committee that policy changes under the new Government included an "agreement to split KEMH and PMH."[508] However, when the Committee sought clarification on this point, the advice received was:

> *The issue of whether King Edward stays on its current site or moves to the QEII site within 10 years will be dealt with in our capital plan.…It is still government policy that it does relocate. The master plan for that site* [QEII] *still provides a footprint for King Edward to move to that site.*[509]

With the ambiguity in the current Government's plans for the future location of KEMH, the Executive Director of the Women's and Newborn Health Service offered this sobering assessment:

> *we are watching this space, but my own view is that King Edward will not be relocating for some 10 to 15 years.*[510]

While the future home of PMH is decided, doubt remains over the timing of the project. The Government has stood by its election commitment to relocate PMH to the QEII site but the original commitment to have the facility operational in 2014 has been revised.[511] Although DOH had advised the Committee that the expected completion date could be as late as 2016, it said that "late 2015 is probably the most realistic we can aim for."[512]

---

508 Submission No. 8 from Dr Peter Flett, Director General, Department of Health, 19 June 2009, p2.

509 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 16 February 2010, p8.

510 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p4.

511 Liberal Party of Western Australia, 2008, *Liberal Plan for Better Health Services*, Election Policy Document, Perth, pp4-6.

512 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 16 February 2010, p8. For 2016 forecast, see Mr Philip Aylward, Executive Director, Child and Adolescent Health Service, Department of Health, *Transcript of Evidence*, 19 August 2009, p14.

(iii) Impact on reform agenda

The Committee did not identify any direct correlation between the retention of RPH and the difficulties that have continued to beset planning for the optimal redevelopment and relocation of PMH and KEMH. Nonetheless, the Committee holds great concern over the failure of the previous and the current government to make a timely commitment to co-locating both hospitals adjacent to SCGH. This has contributed to significant timing delays and the prospect of obtaining future clinical efficiencies being further undermined.

Timing delays

While PMH will now be relocated to the QEII site, the earliest time at which this new facility will become operational is late-2015. This will be 12 years after the Reid Report had said that the children's hospital was in need of significant capital investment that would be best put towards co-locating it with KEMH on a new site. Moreover, it will be nine years after the then-Health Minister conceded that the hospital was "reaching the end of its useful life."[513] Despite calls from the Reid Report to first move KEMH due to the run down state of its facilities, it is now unclear whether the women's hospital will follow PMH to the QEII site. Current indications are that if any move eventuates, 2020 is likely to be the earliest timeframe that can be expected for it to open on the new site. This will be 16 years after the Reid Report said that the replacement and co-location of KEMH facilities was one of the cornerstones to creating a more efficient health system.[514]

Failure to co-locate

Based on the evidence received by the Committee, it is imperative that a commitment by the Government is made to expedite the redevelopment of KEMH, along with the new children's hospital, on the QEII site. The arguments in favour of co-location that were made during the consultation period preceding the Reid Report have been maintained.

The advantages of co-location for the field of neonatology were acknowledged by the former Health Minister, Hon Jim McGinty, [515] and explained to the Committee by Dr Amanda Frazer:

> *The vision of the Reid report, which was thwarted, was that women and kids would be side by side, which would take care of any neonatal issues.*[516]

---

513 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE205.

514 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p80.

515 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE205.

516 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p4.

For example:

> *If a baby is born at King Edward with a congenital heart disease, we need to transfer that baby to Princess Margaret, where there is medical and surgical infrastructure support. It would be much better in my view—it is accepted by the clinicians at the hospital—to put Princess Margaret side by side with King Edward, and we would then share the nursery. That would be a better level of care for those neonates.*[517]

While supporting the Government's decision to advance the construction of the 100-bed neonatal nursery at KEMH, Dr Frazer conceded that it would be of far greater clinical benefit alongside the neonatal unit at PMH. To demonstrate this point, Dr Frazer discussed the merit of the 25-bed maternity unit planned for FSH given its proximity to adult and neonatal specialist facilities. When offering the hypothetical example of a consultant obstetrician at KEMH treating a pregnant woman with a complex condition, Dr Frazer admitted that:

> *I would probably try to get that woman under me, if I had a conjoint appointment, or under a colleague, in the new Fiona Stanley Hospital.*[518]

Under the current plans to move only PMH, clinical outcomes for acute neonatal care could be further compromised as the women's and children's tertiary hospitals will be even further apart. Women's health will also continue to be compromised while KEMH remains isolated from SCGH. Dr Frazer told the Committee that KEMH lacked critical care infrastructure including an intensive care or high dependency unit. She explained the impact of not having an accessible interventional radiologist when a woman is haemorrhaging:

> *over the past few months we have probably sent some six or so women, with significant pelvic bleeding, over to the interventional radiologist* [at Sir Charles Gairdner]. *The disadvantage is that if we cannot access that service in a timely manner, it will mean that the obstetrician is often left with no choice but to perform a hysterectomy.*[519]

Dr Frazer confirmed that while ongoing transfer arrangements with SCGH were adequate, they were "probably not the gold standard."[520] Finally, the advantage of co-location was supported by the Australian Medical Association (AMA) who cited the economic benefits of the strategy, in that it would "facilitate economies of scale, whether it is in cleaning, parking and so on…and decrease marginal costs."[521]

---

517 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p3.

518 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p7.

519 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p4.

520 Dr Amanda Frazer, Executive Director, Women's and Newborn Health Service, King Edward Memorial Hospital, Department of Health, *Transcript of Evidence*, 26 August 2009, p5.

521 Mr Peter Jennings, Deputy Executive Director, Australian Medical Association, *Transcript of Evidence*, 25 August 2009, p12.

The Committee recognises that the recommendation for co-locating KEMH with PMH is an expensive undertaking. The latest Budget conceded that the cost of relocating PMH alone is likely to be substantial.[522] However, the current proposal to further separate PMH and KEMH will increase the inefficiencies that the Reid Report was targeting in an attempt to reduce spiralling health costs. More importantly, it further compromises the efforts of hospital staff to provide the State's women and children with the highest quality of care. Like many aspects of health, this is an area where governments should choose to invest now rather than continue to pay in the future.

Finding 51

The failure to relocate King Edward Memorial Hospital to the QEII site will exacerbate the operational difficulties currently experienced at the State's main maternity hospital.

Recommendation 23

The Government expedite the redevelopment of King Edward Memorial Hospital, along with the new children's hospital, on the QEII site. This project should be completed no later than five years after the new children's hospital becomes operational.

6.3 Metropolitan general hospital

(a) Joondalup Health Campus

There are four general public hospitals located in the outer suburbs of Perth at Joondalup, Swan Districts, Armadale-Kelmscott and Rockingham. This section profiles one of these hospitals, Joondalup, that was recommended in the Reid Report to be upgraded to a tertiary hospital. Joondalup Health Campus (JHC) is also one of two privately-owned hospitals (the other being Peel Health Campus) that offers services to public patients under contract to the Department of Health. Located on the original 85-bed Wanneroo Hospital site, JHC was redeveloped via a public private partnership (PPP) contract and commenced operation in January 1998.

The hospital provides non-tertiary medical and clinical services including adult and paediatric surgery, maternity, aged-care and mental health inpatient services. The hospital also contains a 24-hour Emergency Department (ED) which has become the State's busiest. As the hospital's catchment population has surged past 300,000, this ED (originally designed to perform 25,000

522 Department of Treasury and Finance, 2009, *2009-2010 Budget* (Paper No.3 Economic and Fiscal Outlook), Department of Treasury and Finance, Perth, p44.

services a year) now sees over 63,000 patients annually. JHC has a current capacity of 379 beds within a single facility, 280 of which are designated for the public health system.[523]

(i) Position within the health reform agenda – Reid Report and CSF 2005

The Reid Report described Joondalup (and Rockingham) as a centre of major population growth whose residents were increasingly disadvantaged by the concentration of Perth's hospital services around the inner city tertiary facilities.[524] The Report argued that it was significant for the sustainability of the public health system that the capacity of public hospitals on the metropolitan fringes was expanded to "provide safe and high quality, high volume services".[525] Recommendation 24 earmarked Joondalup[526] to become one of four 300-bed 'general hospitals', whose development would "improve access to hospital care in high-growth metropolitan areas".[527] These hospitals would offer Level 4 care and include EDs and diagnostic facilities that would alleviate the disproportionate number of people presenting to inner-city tertiary hospitals for conditions requiring only secondary-level treatments.

The Reid Report proposed that future population pressures would expedite the requirement for a new tertiary facility in the northern corridor before 2025.[528] The *Clinical Services Framework 2005-2015* was more explicit and insistent on the future role of the JHC. Having flagged the closure of RPH by 2011, CSF 2005 said that Joondalup should now operate as a 'fully-fledged tertiary facility' for the northern suburbs "by at least 2015-16".[529] Explaining the urgency of the move, the document said that "population growth in the north has resulted in building up Joondalup earlier than previously anticipated."[530] As part of the reclassification it was projected that JHC would need to have an ultimate capacity of 623 beds. The upgraded complex would also include a new private hospital on site and include an expanded mental health service.[531]

---

523 Joondalup Health Campus, 'Services Overview', 2009. Available at: www.joondaluphealthcampus.com.au/Our-Services/default.aspx. Accessed on 9 April 2010; and Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, pp3-5.

524 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p15.

525 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p45.

526 Along with Armadale-Kelmscott Memorial, Swan District and the then-Rockingham/Kwinana District hospitals.

527 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p46.

528 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p46.

529 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p8.

530 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p8.

531 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p17.

(ii) *Departures from the reform agenda – CSF 2010*

Significant revisions to the status and future capacity of JHC were contained in the CSF 2010. The earlier decision to expedite a tertiary facility by 2015-16 was reversed with confirmation that JHC "will remain a general hospital within the scope of this iteration of the CSF [out to 2021]."[532] Consequently, a range of significant health services that were originally to be upgraded to Level 5/6 by 2015 in CSF 2005 will be limited to Level 5 until at least 2021. These services included:

- General Surgery (from Level 6 back to Level 5);
- Ear, Nose, Throat (ENT) and Ophthalmology;
- Orthopaedics, Urology and Vascular; and
- Emergency Department and Rehabilitation.[533]

Similarly, projected capacity requirements for 2015 have been revised down from 623 beds in CSF 2005 to 471 in CSF 2010 (see Table 6.10 below).

532 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p17.

533 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p11(a); Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

Table 6.10- Joondalup Health Campus: contrasting service delineation between CSF 2005 and CSF 2010[534]

Service	CSF 2005 Stage I (2010-11)	CSF 2005 Stage II (2015-16)	CSF 2010 Stage I (2014-15)	CSF 2010 Stage II (2020-21)
Medical/Surgical	240	300	243	301
Obstetrics/Neonatal	30	30	53	53
Paediatrics	19	19	24	24
Same-Day	40	55	68	104
High Dependency, Critical & Intensive*	25	30		
Emergency Short Stay Unit*	10	16		
Rehabilitation	40	64	41	70
Mental Health	56	62	42	42
Other[#]	34	47		
TOTAL	**494**	**623**	**471**	**594**

* Figures for these services are included under Medical/Surgical in CSF 2010.

\# In CSF 2005, 'Other' included dialysis, neonatal and palliative care beds. In CSF 2010, these services are included under 'Same-Day', 'Obstetrics' and 'Medical/Surgical' respectively.

The Committee asked DOH to explain the factors behind the drop of 152 beds proposed for Joondalup by 2015 in CSF 2010. Their response attributed the change to delays in a number of Stage One infrastructure projects that were commissioned under CSF 2005:

> *We are only now just either completing or starting the first stage of builds. So if you look at what is planned in Stage 1 development and Stage 2, there are no fewer beds in our peripherals, but the timing has moved out from CSF1* [CSF 2005].[535]

The Committee accepts that infrastructure delays have resulted in an effective five year freeze on the timetable for increasing the capacity of JHC. The origins of these delays will be considered in the next section. However, the Committee cannot accept this as an explanation for the 4.6% decline in projected beds for Stage One and Two proposed in CSF 2010. Such revisions do not accurately reflect future service demands based on the unprecedented population growth witnessed in Perth's northern suburbs.

The catchment area for the Joondalup Health Campus includes the local government areas (LGAs) of Joondalup and Wanneroo, the second and third most populous councils in Western Australia with over 308,000 residents. Since 2001, Wanneroo (current population 144,148) has consistently

534 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp11(a)-(d); Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, pp21-22.

535 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 16 February 2010, p3.

ranked as the council with the largest annual population growth in the State. While infrastructure plans for JHC stalled between 2005 and 2009, the population in this area surged by over 33%. Across both LGAs, the rise was a rapid 15% growth in five years (see Table 6.11).[536]

Table 6.11- Population growth: Joondalup and Wanneroo, 2004-09

LGA	Population at 30 June 2004	Population at 30 June 2009	Population Increase
Joondalup	157,415	162,195	4,780
Wanneroo	107,733	144,148	36,415
TOTAL	**265,148**	**306,352**	**41,195**

It is inconceivable that projected bed requirements for a hospital servicing LGAs experiencing such rates of population growth would stall, let alone decline under the new clinical services framework. The *Clinical Services Consultation 2005* report, preceding the publication of CSF 2005, forecast a requirement of 721 beds for the Joondalup Health Campus in 2021. This is 127 beds greater than the current CSF 2010 Stage Two estimate.[537] The modelling process used during this consultation was similar to that currently undertaken by DOH. As Chapter 5 on modelling methodology has already demonstrated, these earlier forecasts used low and medium-growth population estimates from the ABS.

Under the CSF 2010 modelling process that caps the number of beds in the outer suburbs to allow for changes in government policy, the decision to retain Royal Perth as a large tertiary hospital in the inner city has significantly undercut the resources that can be provided to the Joondalup Hospital. This point was conceded by DOH witnesses. Having advised the Committee in March 2009 that population growth in the outer metropolitan areas had necessitated the expansion of hospitals like Joondalup,[538] DOH were asked to reconcile the new projections presented in CSF 2010:

> *Obviously, since the original CSF was developed up to this point, yes, we have had Reid underpinning the first one. Subsequently, there have been political decisions and government decisions around the structure….*

536 Taken from figures measuring 1996-2006, 2006-2007, 2007-2008 and 2008-2009, Australian Bureau of Statistics, '3218.0 Regional Population Growth, Australia, 2008-09', 30 March 2010. Available at: www.abs.gov.au/ausstats/abs@.nsf/Products/3218.0~2008-09~Main+Features~Western+Australia?OpenDocument. Accessed on 1 April 2010.

537 Department of Health, 2005, *Clinical Services Consultation 2005*, Perth, p7.

538 Ms Jodie South, Acting Director, Clinical Modelling and Infrastructure, Department of Health, *Transcript of Evidence*, 18 March 2009, p19.

> *we have still got Reid. That was the original foundation, and we have not moved away from that. But the big fundamental change in this was that the government made a decision to retain Royal Perth and to retain tertiary services within that facility.*[539]

Despite this concession, the Department later argued that:

> *The retention of RPH as a tertiary facility has meant that there would be sufficient capacity to meet the tertiary level service needs of the population in the north metropolitan area.*[540]

DOH's proposal promoting adequate volumes of tertiary-level service across Perth fails to acknowledge the issue of the proper distribution of health services according to population needs. This point was a key theme in the earlier reform documents[541] and remains valid given the large and rapid population growth underway in the LGAs in the JHC catchment. With over 300,000 people to service, the issue of whether JHC becomes a larger tertiary facility is now beyond debate. However, given the magnitude of the project, and the delays to the earlier infrastructure redevelopment timetable, and the current capital works underway, a revised completion date of 2020 is more realistic than the 2015-16 date proposed in CSF 2005.

Redevelopment timing

The history of the redevelopment of the JHC demonstrates that the timely implementation of the health reform program has been undermined by infrastructure delays under the previous Labor Government. In 2005, $24 million was committed as lead-in funding for the commencement of the re-development of the JHC that would result in an expanded ED and additional mental health beds.[542] The project included:

- construction of a new 150 bed private hospital co-located on the JHC site, expected to be completed by late-2008;
- a doubling in size of the Emergency Department and the creation of 30 new mental health beds (to allow 30 public/30 private); and
- a new dental clinic.

---

539 Dr Robyn Lawrence, Executive Director, Innovation and Health System Reform, Department of Health, *Transcript of Evidence*, 16 February 2010, pp3-4.

540 Mr Kim Snowball, Acting Director General, Department of Health, *Response to Question on Notice*, 16 February 2010, p3.

541 See, Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p41; Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, pp5,8.

542 Department of Treasury and Finance, 2005, *2005-2006 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, pp493,496.

Ultimately it was forecast that by 2009 the JHC would be a 500-bed complex, incorporating 350 public beds and a separate 150-bed private facility.[543] By 2009 only the 10-chair dental clinic and the mental health unit expansion had been completed. Significantly, only $1.75 million had been spent out of the $119 million that had been committed to the remainder of the redevelopment. This left JHC in 2010 with a total operating capacity of just 379 beds.[544]

Finding 52

The commitment in 2005 made by the previous government to redevelop Joondalup Health Campus into a 500-bed facility by 2009 has yet to be realised.

The current Government has announced its intention to continue with the redevelopment of the JHC. On 9 November 2009 it announced that $227.4 million would be committed to extending the ED to 2.5 times its current size. Bed capacity for public patients would increase from 280 currently to 451 by 2013. Ramsay Health Care, the private operators who operate JHC, have also committed $90 million to the construction of an 85-bed private hospital by 2013 with plans to increase future capacity to 150-beds.[545]

A successful completion of this project will mean that the initial redevelopment plans for JHC will be completed four years later than originally planned, and eight years after the urgent need for expansion was acknowledged in CSF 2005.

(iii) *Impact on reform agenda*

Mr Kevin Cass-Ryall, State Manager Operations for Ramsay Health Care, conceded that the longer-term redevelopment prospects for the JHC are uncertain given the decision to retain RPH as a tertiary hospital. He suggested that, "It is not going to have any impact on what has already been agreed, but the future development is a bit unclear now."[546] CSF 2010 is ambiguous in this respect, confirming that "2020/2021 bed numbers assume additional built capacity….The exact

543 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates Estimates* (Hansard), Supplementary Information No A59, 13 June 2005, p549.

544 Department of Treasury and Finance, 2008, *2008-2009 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p556.

545 Dr Kim Hames, Minister for Health, 'Work Starts on $317 Million Joondalup Health Campus Expansion, 9 November 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132753&minister=Hames&admin=Barnett. Accessed on 1 April 2010.

546 Mr Kevin Cass-Ryall, State Manager Operations, Ramsay Health Care, *Transcript of Evidence*, 1 September 2009, p12.

timing of these developments will be outlined in Health's updated 10 year capital plan."[547] At the time of tabling this Report, the Committee had not received a copy of the latest DOH capital plan.

It is critical that Joondalup Health Campus be converted into a tertiary facility as soon as can be managed by the Government, but at least by 2020. This should be conducted over two stages, starting with the recently agreed redevelopment. Current operational difficulties at JHC demonstrate the urgency underpinning this first stage build.

The Emergency Department at JHC was originally designed for 25,000 services a year, yet in 2008-09 it completed 61,112 attendances. Mr Kempton Cowan, Chief Executive Officer of JHC, told the Committee that the 150 public inpatient beds backing his ED pale in comparison to the 500 to 600 supporting RPH and SCGH, "hence we have enormous levels of access block".[548]

Mr Cowan also confirmed that JHC currently has the highest level of ambulance bypass in the State. He explained the implications of this situation:

> *If a person involved in a bad accident at Butler, which is about 25 kilometres north of Joondalup, needed to be resuscitated and was brought into the hospital and prioritised as a category 2 patient or lower when the hospital was on bypass, the ambulance would have to bypass Joondalup and travel another 30 kilometres to Charlies* [Sir Charles Gairdner Hospital]. *That is a 50 or 60 kilometre tip for the ambos. That was,* ***and still is*** [emphasis added], *a big issue for us.*[549]

By March 2010, Joondalup Health Campus had spent 800 hours in bypass mode. As a result, one patient suffering a heart attack had to be put back into an ambulance and taken to the private Mount Hospital in the city.[550]

Other operational difficulties at JHC include bed shifting. Mr Cowan conceded "We are so short of beds that we put adults in the children's ward, which is suboptimal but we have no choice".[551] Even with the proposed initial redevelopment of JHC, it is unlikely that these problems will abate. Joondalup Health Campus currently services only about 50% of its catchment area population who are seeking public treatment, with the rest going to the city-based hospitals.

---

547 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p22.

548 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, p3. Access block is a term used to describe delays patients experience in Emergency Departments while awaiting access to an inpatient bed.

549 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, p3.

550 Mr Anthony Deceglie, 'Hospital "Break Point"', *The Sunday Times*, 28 March 2010, p6.

551 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, p3.

Mr Cowan speculated on the future when the agreed upgrade is completed:

> *I am running bets on how many ED patients we will see in the first full year of operation of the new department. The consensus is that it will be around 90,000 plus, which is enormous. In some respects we might be creating a bigger version of the same problem, but we have to do that because we are so far behind the eight ball.*[552]

Mr Cowan evidence confirms that JHC is already chronically under-resourced to meet current demand levels. With current high population growth rates in the northern corridor expected to continue, a firm commitment must be made to further expand the JHC beyond the CSF 2010 projections for 2020-21.

The capping process used in CSF 2010 modelling is masking the true projected activity levels—and requisite bed numbers—for the JHC. Beyond the operational difficulties cited, there are financial ramifications which will further compromise other sectors of the hospital system. Mr Cowan explained that funding for the operation of JHC's public hospital service is contingent upon a fixed budget allocation received at the start of the financial year. "If I go over that budget, I do not get paid."[553] Under this contract, priority must be given to Emergency Department presentations. Therefore, "if we look like we are going over [budget], as has happened a couple of times, we have to cut elective surgery for, say, the last three months of the year."[554]

This evidence clearly show that the JHC budget allocations are not indicative of the actual activity levels and demand at the hospital. The chapter on modelling methodology has demonstrated that underestimating activity levels is an ongoing problem with the DOH modelling process. It is imperative, for the appropriate provision of future hospital services in the northern metropolitan area, that this modelling is revised to allow the JHC to replace RPH as the Perth's third adult tertiary hospital by 2020.

Finding 53

The Government's $227 commitment to redevelop Joondalup Health Campus is unlikely to resolve the operational difficulties currently affecting that hospital. Further expansion of Joondalup Health Campus is necessary to cater for the rapid population growth in the northern metropolitan area. The Joondalup Health Campus should be upgraded to a tertiary hospital, as recommended by both the Reid Report and the *Clinical Services Framework 2005-2015*.

552 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, pp3-4.

553 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, p6.

554 Mr Kempton Cowan, Chief Executive Officer, Joondalup Health Campus, *Transcript of Evidence*, 1 September 2009, p6.

Finding 54

Under the current Department of Health modelling process that caps the number of beds in the metropolitan area to allow for changes in government policy, the decision to retain Royal Perth Hospital as a tertiary hospital has significantly undercut the resources available for health services at the Joondalup Health Campus to meet the rapid population growth that is occurring in that region.

Recommendation 24

The Government should upgrade the Joondalup Health Campus to a tertiary hospital by 2020.

6.4 WA Country Health Service country hospital services

Country hospital services did not figure prominently in the 2004 Reid Report. Only four recommendations were directed towards this area. The aim of these four recommendations was to limit, 'as much as clinically appropriate', the requirement for country patients to travel to Perth for anything other than tertiary-level care.[555] In this respect, Reid implicitly endorsed the Regional Network Model for the delivery of rural health care that was described in the WACHS *Country Health Services Review* in 2003.

The Regional Network Model sought to integrate all WACHS facilities into "a single system of care with inter-dependent components different from but equal to each other."[556] This encompassed:

- **Regional Resource Centres:** based in major regional towns servicing populations of over 12,000, providing the majority of primary and secondary-level care to residents in local and outlying areas;
- **Integrated District Health Services:** based in towns with populations ranging from 4,000 to 12,000 people;
- **Health Services for Small Towns:** with populations from 1,000 to 4,000 people;
- **Health Services for Small Communities/Settlements**: providing basic health care for the most remote areas where populations were fewer than 1,000; and

555 Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p42.

556 Department of Health, 2003, *The Country Health Services Review*, Perth, p32.

- **Partner Metropolitan Health Services**: to formalize the provision of support and specialist services to country facilities.[557]

The Committee undertook investigative travel to the Wheatbelt, Goldfields and Great Southern regions to ascertain the progress of the Regional Network Model as part of the overall health reform process. The Great Southern and South West are better served relative to other WACHS regions and then-Chief Executive of WA Country Health Service, Mr Kim Snowball, confirmed that as populations become more remote, the provision of health care becomes increasingly problematic, with the North West being "very difficult to service." [558] Therefore, any deficiencies in the reform program identified in this section of the Report in regard to the Great Southern might well be exacerbated in other WACHS regions.

(a) Regional Resource Centre – Albany Hospital

The WACHS Regional Network Model uses a 'hub and spoke' analogy to describe its planned hierarchy of health facilities. The Regional Resource Centre (RRC) forms "the hub of regional services that span out to the smaller sites and services (the spokes) across the region."[559] The purpose of the RRC is to "retain as much secondary-level acute care activity within the regions as possible".[560] Both the Reid Report and the later *Clinical Services Framework 2005-2015* endorsed this concept as a way of limiting the inappropriate number of rural patients presenting at metropolitan tertiary hospitals.[561]

It was originally proposed that RRCs would provide specialist medical services while offering support for a range of non-hospital health services including:

- general medicine and surgery;
- emergency, anaesthetics and high dependency;
- obstetrics and paediatrics;
- orthopaedics and rehabilitation;
- aged-care and population health;
- mental health;

---

557 Department of Health, 2003, *The Country Health Services Review*, Perth, pp31,44.

558 Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, pp4-5.

559 Submission No. 31 from WA Country Health Service, 12 August 2009, p4.

560 Department of Health, 2003, *The Country Health Services Review*, Perth, p33.

561 See, Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p42; and Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p23.

- screening services;
- community and child health; and
- allied health.[562]

The *Country Health Services Review* stated that $100 million had been 'committed' to a capital works program across WACHS that would include the redevelopment of three Regional Resource Centres. Two years later, the CSF 2005 confirmed that "A capital and infrastructure plan has been articulated to develop the capacity of our Regional Resource Centres [and Integrated District Health Services]."[563]

(i) Albany Hospital profile

Albany Hospital is the Regional Resource Centre for the Great Southern region of WACHS. The Great Southern region has a current population of 53,000, which is predicted to increase to 63,800 by 2031. Forecasts indicate that 20% of the population will be over 65 years of age by 2016.[564]

WACHS confirmed that Albany Hospital has seen "significant growth in activity…particularly through the ED and in elective surgery."[565] Mental health presentations are also increasing.[566] With no private hospital to absorb any of the patient caseload (unlike Bunbury and Geraldton), Albany Hospital has witnessed a 33% rise in total acute separations between 2001-02 and 2007-08. Emergency Department presentations showed similar growth rates for the five years from 2003, reaching 22,483 in 2008.[567] This ED operates 24 hours a day and is supported by way of an on-call GP roster, three interns and "a small but variable number of registrars."[568]

Albany Hospital is a Level 4 facility that contains 88 multi-day beds, 34 same-day beds (for elective procedures) and a 9-bed mental health inpatient unit. Bed numbers at WACHS RRCs were not included in the CSF 2005 so a comparison with projections in the CSF 2010 can not be

---

562 See, Department of Health, 2003, *The Country Health Services Review*, Perth, p41; and Mr Kim Snowball, Chief Executive, WA Country Health Service, *Transcript of Evidence*, 26 August 2009, p9.

563 See, Department of Health, 2003, *The Country Health Services Review*, Perth, p34; Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p24.

564 Mr Garry Adams, Acting Regional Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p2.

565 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p68.

566 Mr Garry Adams, Acting Regional Director, WA Country Health Service- Great Southern, *Transcript of Evidence*, 11 September 2009, p3.

567 See, WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p58; and Mr Rob Pulsford, Regional Director, WA Country Health Service- Great Southern, *Response to Question on Notice*, 11 September 2009, Attachment 1, p8.

568 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p57.

made. Also on-site is a PathWest laboratory, the Great Southern Community Mental Health team, a DOH Dental Health Clinic, the Australian Red Cross Blood Bank and the Albany Community Hospice.[569] Albany Hospital is an older facility still awaiting a redevelopment that WACHS acknowledges will enable it to meet 'contemporary standards'.[570]

(ii) Place within the health reform agenda

The *Country Health Services Review* proposed 2008 as the year in which the Regional Network Model would be fully implemented. As part of its response, the then-Gallop Government committed $20 million in 2005 to the first stage of the redevelopment of Albany Hospital with a planned completion date of 2007-08.[571]

By 2007 nothing had been spent on the redevelopment. While $26.8 million was now allocated, the majority of the spending was pushed to the out-years through to 2010-11.[572] Under questioning about the delays from the local member during an Estimates hearing, the then-Director General, Dr Neale Fong, replied that:

> *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.*[573]

Following Dr Fong's response, the then-health Minister, Hon Jim McGinty, gave an 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 utmost urgency.*[574]

During the following year, budget papers indicate that only $205,000 had so far been spent on what had become a $44.1 million project, with completion not expected until 2011-2012.[575] In the lead-up to the 2008 State election, the Carpenter Government revised its commitment to a

---

569 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p56.

570 Mr Rob Pulsford, Regional Director, WA Country Health Service- Great Southern, *Response to Question on Notice*, 11 September 2009, Attachment 1, p2.

571 See, Department of Treasury and Finance, 2005, *2005-2006 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p496; Department of Treasury and Finance, 2005, *2005-2006 Budget* (Paper No.3 Economic and Fiscal Outlook), Department of Treasury and Finance, Perth, p67

572 Department of Treasury and Finance, 2007, *2007-2008 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p581.

573 Dr Neale Fong, Director General of Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE206.

574 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 23 May 2007, pE206.

575 Department of Treasury and Finance, 2008, *2008-2009 Budget* (Paper No.2 Vol.2), Department of Treasury and Finance, Perth, p556.

$160 million complete rebuild with a 2015 end date.[576] The Liberal Opposition responded with its own pledge to build a new hospital in one stage by 2012 at a cost of $135 million.[577]

Finding 55

The previous Government did not achieve its plan to redevelop Albany Hospital into a Regional Resource Centre by 2007-08.

Since assuming office, the current Government has increased its funding for the project to $166 million but has acknowledged that the new hospital will not be operational until 2013.[578] Under the new Government's plans, the new 'Albany Health Campus' will have a marginally larger capacity than the current facility. The CSF 2010 projects a 3-bed increase from current capacity to 134 beds by 2020-21. A marginal decline in multi-day beds will be offset by an increase in the mental health inpatient unit from 9 to 16 beds.[579]

(iii) Current status and future prospects

Regional Resource Centres are promoted as the centerpiece of a model that proposes to deliver high quality health care to rural and remote populations. The reality in Albany is that a dedicated team of health professionals is under enormous pressure to attain this goal in a workplace that still lacks adequate resources and infrastructure. During a tour of the Albany Hospital, and throughout subsequent hearings with staff, the Committee observed a facility that was dated, inappropriately configured and under-staffed. Director of Nursing with WACHS Great Southern, Ms Suzanne Seeley, told the Committee:

> *Our regional resource centres in particular work extremely hard and they have a lot of very aged equipment. That really does impact on the nurses, particularly on their ability to provide good services.*[580]

As an example the Committee saw showering facilities in the rehabilitation ward that were decades-old and lacked adequate heating. The rehabilitation ward also provides an example of the current hospital's inappropriate design. Elderly rehabilitation patients, in particular, are often placed under duress when acute mental health patients (based across the corridor) wander into the common area of the rehabilitation ward. Similarly, sub-optimal planning is evident across the

576 Mr Roger Cook, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE548.

577 Liberal Party of Australia (WA), 2008, *Liberal Plan for Better Health Services*, Perth, p6.

578 Hon Mr Troy Buswell, Treasurer and Hon Dr Kim Hames, Minister for Health, 'Funding Boost for Albany Health Campus', 18 February 2010. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=133142&minister=Hames&admin=Barnett. Accessed on 1 April 2010.

579 Department of Health, 2009, *WA Health Clinical Services Framework 2010-2020*, Perth, p23.

580 Ms Suzanne Seeley, Nurse Director, WA Country Health Service, *Transcript of Evidence*, 11 September 2009, p10.

hospital's surgical units. The WACHS Great Southern Clinical Services Plan confirms that the placement of the day surgery unit and the two general operating theatres at respective ends of the hospital "does not support surgical flows and the economies of scale which could be gained if the 'surgical services' were all co-located in one area".[581]

The most critical issue, however, is the current level of staffing. CSF 2005 listed building the clinical workforce and improving staff retention strategies among its priorities for WACHS "over the next five years".[582] Despite this, the recent Clinical Services Plan for the Great Southern has confirmed that only 13% of the local workforce is under 35 years of age and that the risk of an ageing workforce remains evident in all areas.[583]

As at 30 August 2009, the Committee was advised that there were 14 nursing vacancies across the Great Southern. Ms Suzanne Seeley confirmed that the mental health unit and the Emergency Department were the areas most affected by nursing shortages at Albany Hospital. Adding to the pressures for staff in these areas—where the number of presentations is increasing—is the fact that the hospital "does not have a robust security system because it is an old facility".[584]

A major problem continuing to plague Albany Hospital is a shortage of doctors. Medical Director of WACHS Great Southern, Dr Jonathon Mulligan, confirmed that whilst there is a good number of very competent GPs throughout the region, they are struggling to manage the increasing workload at the hospital. By June 2009 this issue had reached crisis-point with DOH having to resort to fly-in, fly-out rosters from the metropolitan area to ensure that Albany Hospital had 24-hour GP cover.

The ongoing staffing dilemma at Albany has already had tragic consequences, with the State Coroner investigating six deaths that have occurred at this hospital between 2004 and 2008. In one case Coroner Alistair Hope confirmed that workload pressures on doctors and nurses had contributed to the death of 17 year-old Kieran Watmore, who died of asphyxia after originally presenting to the hospital with acute tonsillitis. The Coroner confirmed that no doctor was in attendance, nor was one contacted, after Mr Watmore suffered "an alarming change in his condition."[585]

Citing death by 'misadventure', Coroner Hope's recommendations included:

---

581 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p57.

582 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p24.

583 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p114.

584 Ms Suzanne Seeley, Nurse Director, WA Country Health Service, *Transcript of Evidence*, 11 September 2009, pp4-5; and Mr Kim Snowball, Chief Executive Officer, WA Country Health Service, *Response to Question on Notice*, 26 August 2009, p3.

585 State Coroner's Office, 'Inquest into the Death of Kieran Darragh Watmore ', 30 September 2009. Available at: www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Watmore_finding.pdf, pp5,37. Accessed on 16 April 2010.

> *that Albany Regional Hospital review arrangements so far as is practicable to limit the hours worked by medical practitioners and to, if possible, increase the after hours availability of doctors to the hospital.*[586]

The findings of the Coroner's report have had a flow-on effect upon staff morale. The Health Minister, Hon Dr Kim Hames, confirmed that there is "frustration at the lack of a senior staff presence on the floor. I concede there is a problem in that area but we will address it."[587]

During hearings into Mr Watmore's death, the Coroner was advised that the on-call GP roster system was going to be cancelled and a full-time doctor employed at the facility.[588] The WACHS Great Southern Clinical Services Plan has also suggested a more responsive model is required to cater for increasing activity in the Emergency Department, Critical Care and Trauma units. This document proposed the option of "on-site medical coverage using a combination of local GPs, salaried Specialists, Career Medical Officers and trainees."[589]

The Committee agrees with the necessity of providing 24-hour on-site access to medical coverage and a clinically appropriate number of nurses at Albany Hospital, and all other WACHS Regional Resource Centres. Under the Regional Network Model, these major regional hospitals are expected to bear a greater burden of secondary-level and emergency care to both the town they are located in and also to many surrounding communities. It is therefore essential that they are staffed appropriately to meet the current and anticipated increases in activity.

Recommendation 25

All WA Country Health Service Regional Resource Centres be staffed to allow on-site 24-hour coverage by medical practitioners.

It is imperative that the new Albany Health Campus — currently in the planning stage — is designed to address the issues affecting the current facility and to meet the requirements expected of a Regional Resource Centre. While lauding the commitment of the current Government to outlay $135 million (since increased to $166 million), the City of Albany's Chief Executive

---

586 State Coroner's Office, 'Inquest into the Death of Kieran Darragh Watmore ', 30 September 2009. Available at: www.safetyandquality.health.wa.gov.au/docs/mortality_review/inquest_finding/Watmore_finding.pdf, pp25,39. Accessed on 16 April 2010.

587 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 10 September 2009, p6768.

588 Mr Gary Adshead, 'I Wish Nurses Had Called Me: Doctor in Teen Death', *The West Australian*, 28 August 2009, p10.

589 WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p95.

Officer, Mr Peter Madigan, said that "it is extremely important that…the hospital is built to the concept and not to the price."[590] The Health Minister, Hon Dr Kim Hames, conceded that:

> *There are inadequate funds to provide the full-size hospital that we would like to provide, that is, the size of a major regional hospital.*[591]

Even the recently increased commitment to $166 million may not suffice to satisfactorily complete this project. The Health Minister had earlier refused to confirm whether a business case from DOH and the Department of Treasury and Finance had put the project price at between $196 and $230 million. Dr Hames said "The funding is not necessarily up to $230 million….I do not intend to state that range publicly."[592]

Since this comment, the Government has confirmed that expressions of interest from the private sector have been called for the development of the new hospital and the provision of some of its operational services.[593] However funded, including the possibility of further Royalties for Regions grants, it is critical that an appropriately-staffed facility, befitting the standards of a Regional Resource Centre, is delivered promptly to people living in the Great Southern.

Finding 56

The Government has not clarified whether the funding committed to the development of the new Albany Health Campus is sufficient to provide the full requirements of a Regional Resource Centre.

Recommendation 26

The Government provide the full projected cost of the new Albany Health Campus, including the proportion that will be funded via any partnerships with the private sector or provided by the Royalties for Regions program, in the 2010-11 Health budget, or by the end of 2010.

590 Mr Peter Madigan, Chief Executive Officer, City of Albany, *Transcript of Evidence*, 11 September 2009, p4.

591 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE545.

592 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Estimates Committee* (Hansard), 28 May 2009, pE547.

593 Hon Dr Kim Hames, Minister for Health, 'Strong Private Interest in New Albany Health Campus', 24 August 2009. Available at: www.mediastatements.wa.gov.au/Pages/WACabinetMinistersSearch.aspx?ItemId=132386&minister=Hames&admin=Barnett. Accessed on 1 April 2010.

(b) Integrated District Health Service – Katanning Hospital

Integrated District Health Services (IDHS) are the second-tier of WACHS' Regional Network Model and are based in district centres whose surrounding towns and communities number between 4,000 and 12,000 people.

The CSF 2005 said that an IDHS would offer a range of "designated inpatient and primary care services". [594] These would include:

- 24-hour emergency cover;
- obstetrics to cater for planned low-risk deliveries:
- residential and community-based aged-care services; and
- some basic surgeries.

Procedures of greater complexity would be supported through visiting specialists or 'Telehealth' facilities located at the nearest Regional Resource Centre or the 'Partner Metropolitan Health Service'.[595] In 2005 it was confirmed that the capital and infrastructure requirements necessary to build the capacity of Integrated District Health Services to appropriate levels had been "articulated".[596]

(i) *Katanning Hospital profile*

Katanning Hospital is the Integrated District Health Service for the Central Great Southern and caters for a catchment population of 9,828. Katanning Hospital offers Level 3 care and has 50 beds, over a third of which are designated for Nursing Home Type Patients (NHTP). Population rates for the area are falling and acute separations have followed this trend, dropping from 1,530 to 1,430 between 2002 and 2008. Conversely, Emergency Department presentations rose 44% to 6,032 in the four years to 2007-08.[597] This trend reflects the chronic lack of GPs in country areas. WACHS confirmed that in hospitals the size of Katanning anywhere between 68 to 96% of presentations "could potentially be managed by GPs.[598]

---

594 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p23.

595 In the case of Katanning Hospital, this would be the South Metropolitan Area Health Service, which was the proposed partner of the Great Southern region. See Department of Health, 2004, *A Healthy Future for Western Australians*, Report of the Health Reform Committee, Perth, p97. For information on the use of visiting specialist and Telehealth services, see Department of Health, 2003, *The Country Health Services Review*, Perth, pp43-44.

596 Department of Health, 2005, *WA Health Clinical Services Framework 2005-2015*, Perth, p24.

597 See, Ms Suzanne Millar, Managed Aged-care, WA Country Health Service- Great Southern, *Transcript of Evidence*, 21 September 2009, p2; and WA Country Health Service- Great Southern, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, pp58,72.

598 Submission No. 31 from WA Country Health Service, 12 August 2009, pp11-12.

(ii) Current status and future prospects

Under the updated *Clinical Services Framework 2010-2020*, Katanning Hospital is scheduled to maintain its Level 3 capacity with a slight reduction in capacity to 48 beds. The residential aged-care unit will retain 19 beds while 29 will be available for multi-day medical and surgical episodes.

The Committee did not hear evidence to suggest that the capacity of the hospital would impede its ability to assume the "enhanced role in the provision of primary and secondary care"[599] expected of an IDHS under the Regional Network Model. However, a range of issues were identified that will continue to compromise the efforts of the current staff to provide the level of care expected of them. These issues surround staffing, Emergency Department resourcing and equipment and infrastructure needs.

Similar to Albany Hospital, staffing is a critical issue for the Katanning IDHS. Acting Director of Nursing, Katanning Health Service, Mrs Fiona Berger, confirmed that extra staff was the most pressing requirement:

> *particularly midwifery staff….We have midwifery staff who are over 60 now. They are very experienced, but they are getting tired.*[600]

Despite population declines in the area, a recent obstetrics review forecast further increases on the 110 deliveries at Katanning Hospital last year. Mrs Berger confirmed that quality accommodation, currently lacking in the area, was directly correlated to attracting and retaining the extra staff required. While the previous Director of Nursing had done an admirable job in acquiring extra staff housing options, maintaining and finishing these premises was an ongoing problem:

> *They* [resident nurses] *need basic furniture to sit on. The other day we ended up buying very cheap second-hand stuff just for the girls to sit on. They need mattresses they can sleep on.*[601]

Following the 2003 *Country Health Services Review*, the then-Gallop Government committed $627 million over 10 years to a WACHS capital redevelopment program that included among its priorities the provision of more staff accommodation options.[602] In addition, the 2007 *Foundations for Country Services* confirmed that WACHS received "a $24 million capital investment allocation to expand staff housing."[603] There is no evidence to suggest that the IDHS in Katanning has benefited significantly from either of these earlier initiatives.

---

599 Department of Health, 2003, *The Country Health Services Review*, Perth, p43.

600 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p2.

601 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p2.

602 Department of Health – WA Country Health Service, 2007, *Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010*, Perth, p70.

603 Department of Health – WA Country Health Service, 2007, *Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010*, Perth, pp71-72.

With 71 gazetted country hospitals under WACHS' remit, the Committee acknowledges the difficulties in providing adequate housing across the expanse of such a large state. Yet, as the example of Katanning demonstrates, staffing shortfalls will continue where quality accommodation can not be guaranteed.

Finding 57

Without appropriately maintained and furnished accommodation options, it will remain difficult to attract and retain the required nursing staff to rural and remote health facilities managed by the WA Country Health Service.

Staffing pressures are also compromising the efficient operation of the Emergency Department at Katanning. The ED facility is staffed around the clock by nurses, with GP support available on call. The WACHS Great Southern *Clinical Services Plan* argues that "This model works well and is not envisaged to require modification in the foreseeable future."[604] However, the Committee noted that in Katanning, without adequate numbers of supporting GPs, staff are put under unsustainable pressure to meet the needs of the local population, many of whom present at the ED after-hours due to a lack of GP services.

As Dr Nicolas du Preez, General Practitioner, Katanning Health Service explained:

> *The problem with smaller towns is that the people burn out. I was up last night at six o'clock, and I was called at who knows what time of the night with various phone calls from the different hospitals. Today I am here again at the hospital. Your call frequency is quite high.…It is not like being on call and being called twice a week. You get phone calls all the time. After a while, people get fed up with it. They want to have a life. …. It is very, very difficult.*[605]

Dr du Preez suggested that the GP burden could be reduced through the greater use of Nurse Practitioners:

> *If nurse practitioners can work with us and can do the shifts on the weekends and after hours when we get called in, that will help, because the frequency of our call-outs will be less.*[606]

Nurse Practitioners could also be used to reduce the demands within a General Practice:

> *If we can work together in, say, one practice, then from my perspective if the nurse practitioners can work at the hospital and take the nuisance calls away from us, that will make my life much easier, or even if I lost a doctor I could get the nurse practitioner to*

604 WA Country Health Service, 2009, *WACHS Great Southern Clinical Services Plan*, Albany, p96.

605 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, pp4,7.

606 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p6.

> *work in the practice so that she—or he for that matter—can see some of the snotty noses, or even triage and treat some of them. That would help if it was structured like that.*[607]

Despite the potential benefits of their use, the Nurse Practitioners have had their roles curtailed in Katanning via a WACHS directive withdrawing a protocol that enabled Nurse Practitioners to undertake basic treatments. Mrs Fiona Berger told the Committee:

> *We used to have a protocol—the doctors all agreed on a certain protocol—and we were able to follow that protocol. Let us say it was for ear infections, or if the person had allergies et cetera. You would make a determination and follow them up. It was then decided about two years ago that those protocols would be withdrawn. We had a directive to take them off….That came from Albany.*[608]

The Committee obtained copies of minutes from a number of meetings in 2008 of the Central Great Southern Medical Advisory Council. These confirmed that the 'Standing Orders' (now known as Standard Operational Procedures) that permitted the practices referred to by Mrs Berger could only be used at Kojonup and Gnowangerup, where there was only one General Practitioner in town.[609] Currently Katanning has four other GPs servicing the area, but they are all on visas and their future in the district cannot be guaranteed. Moreover, Dr du Preez had to pay $30,000 out of his own money to recruit two of these practitioners.

In response to a follow-up question from the Committee about this issue, then-Director General of Health, Dr Peter Flett, advised that WACHS was unaware of the directive referred to and would require more information to offer a more detailed response.[610]

The directive to withdraw protocols permitting nurse practitioners to attend to simple presentations — with the permission of a doctor — does not fit with the WA Country Health Service's admission in 2007 that it was not possible to "sustain the cost and personnel required to treat primary care type presentations in Emergency Departments" across the entire WACHS network.[611] Among the proposed strategies to alleviate this issue was for nurse practitioners to supplement, or substitute for, the current shortage of doctors. In IDHS, where GP numbers are limited, it would seem sensible to use nurse practitioners to ease the burden facing doctors who are regularly called to an IDHS Emergency Department, often to provide basic treatments.

---

607 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p8.

608 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p6.

609 Ms Hazel MacKenzie, Director of Nursing/Health Service Manager, Central Great Southern Health Service, Department of Health, *Response to Question on Notice*, 21 September 2009, p10.

610 Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 10 November 2009, p7.

611 Department of Health, 2007, *Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010*, Perth, p42.

Recommendation 27

To compensate for the chronic shortage of General Practitioners, WA Country Health Service revise its current Standard Operational Procedures to incorporate a consistent policy across all Integrated District Health Services advising on basic treatments that Nurse Practitioners can undertake with the consent of the on-call General Practitioner.

Equipment and infrastructure shortfalls

Finally, the Committee found shortcomings in infrastructure and equipment needs at Katanning Hospital that belied its status as an Integrated District Health Service. On a tour of the hospital, the Committee was shown kitchen and laundry facilities where no money had been spent for at least 15 years. Hospital staff credited the local maintenance unit for keeping the machines operational.[612]

The state of the Emergency Department was more disconcerting. Mrs Berger's assessment was that "Our ED badly needs doing up, as does our theatre."[613] A business case had been prepared ten years earlier, "but the money disappeared."[614] The frustration was evident for Dr Nicolas du Preez:

> *Even a table would be good. We do not even have a table and a chair where we can sit down and write* [medical] *notes.*[615]

Dr du Preez similarly highlighted some fundamental equipment shortages:

> *We do not have a blood gas machine.…That is a basic requirement. We are not living in a third-world country. In South Africa where I come from, you see that. This should not happen in Australia. That is not acceptable in my opinion.*[616]

Equipment shortages extended to the appropriate ward beds. The Committee was told that many of the beds at Katanning Hospital were not electric and therefore, not compliant with occupational health and safety standards. Mrs Berger explained that funding for equipment needs comes from

---

612 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p3.

613 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p13.

614 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p3.

615 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p4.

616 The Committee was advised by Mrs Berger that Collie Hospital also lacks a blood gas machine. Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, pp11-12.

an allocation provided by the Regional Resource Centre; in this case, Albany Hospital. However, by mid-September, while Mrs Berger had completed an equipment priority list with an accompanying business cases, Katanning Hospital had still not been advised of what it would receive for its equipment budget. In addition to five electric beds, other items listed as 'high priority' at Katanning Hospital included:

- an instrument washer disinfector;
- an instrument drying cabinet;
- an endoscope drying cabinet; and
- a gastroscope (due for replacement since June 2006).[617]

For some equipment it was not possible to wait for funding. In one case, Katanning Hospital had to use local donations to acquire essential equipment.

When asked how one of the monitors in the minor theatre was acquired, Mrs Berger explained:

> *That has been provided by the donations. The Health Department does not really have a lot of money at the moment, so I was asked to buy that out of our donations account. I struggled with that. I really feel that that is a vital piece of clinical equipment and it should have been bought with clinical equipment money. But we needed it. So we took $27,500 out of the donation's account to provide a safe, effective and efficient service. We cannot take those patients into the major theatre—from an infection control point of view you just do not do that—and also today we had theatre on and we needed that other monitor.*[618]

DOH has since confirmed that almost $6.9 million has been approved for equipment purchases across the WA Country Health Service. While sterilizing equipment ($1.6 million) and bed replacements ($400,000) were among the endorsed items, it was not confirmed whether Katanning Hospital would be a recipient of new equipment.[619]

In 2007 WACHS confirmed the necessity for new or redeveloped infrastructure to provide a physical environment that supports the delivery of high quality, safe and contemporary health services for country populations. To achieve this aim WACHS promoted a future strategy where "rigorous clinical planning will ensure old and inappropriate facilities will be progressively replaced or redeveloped."[620] Based on its observations at Katanning Hospital, the Committee saw little to suggest that the necessary rigour was being applied to meet this objective. Given their

---

617 Dr Nicolas du Preez, General Practitioner, Katanning Health Service, *Transcript of Evidence*, 21 September 2009, p11.

618 Mrs Fiona Berger, Acting Director of Nursing/Health Services Manager, Katanning Health Service, Department of Health, *Transcript of Evidence*, 21 September 2009, p2.

619 Dr Peter Flett, Director General, Department of Health, *Response to Question on Notice*, 10 November 2009, p7.

620 WA Country Health Service, 2007, *Foundations for Country Health Services: The WA Country Health Service Strategic Plan 2007-2010*, Perth, p71.

prominent role within the Regional Network Model, it is vital that the 15 Integrated District Health Services throughout the State are appropriately maintained and equipped.

Finding 58

The Emergency Department at Katanning's Integrated District Health Service is in urgent need of renovation. A business case was completed ten years ago for this purpose but was never implemented.

Finding 59

Due to a shortage of funds in the WA Country Health Service budget, Katanning Hospital used local donations to acquire essential clinical equipment.

Recommendation 28

The Minister for Health Service provide to Parliament by December 2010 an inventory of all outstanding clinical and non-clinical requirements for the State's Regional Resource Centres and Integrated District Health Services.

CHAPTER 7 RAMIFICATIONS OF THE ROYAL PERTH HOSPITAL PROTECTION BILL 2008

7.1 Introduction

This chapter summarises the main challenge facing the Western Australian hospital system due to the decision to legislate to retain Royal Perth Hospital (RPH) as a tertiary hospital. The Health Minister, Dr Kim Hames, introduced the Royal Perth Hospital Protection Bill 2008 to the Legislative Assembly on 6 November 2008.[621] This action honoured the election commitment outlined by the Liberal Party in a media statement on 3 September 2008.

The decision to retain both RPH and SCGH as tertiary hospitals within central Perth went against the recommendations of the Reid Report, which had been adopted by the Gallop Government. This chapter details the pre and post-2008 election debate surrounding this legislative proposal. Most importantly, in light of this Committee's Inquiry and the preceding chapters, the bulk of this chapter will summarise the major effects the decision to retain RPH as a tertiary facility has had on the pace of health reform in this state and on the overall delivery of hospital services.

7.2 History of the Royal Perth Hospital Protection Bill

As described in Chapter 3, the Liberal Party in Opposition were critical of the Government's decision to close RPH as a tertiary facility and merge its services with those at Sir Charles Gairdner Hospital. The policy to retain RPH as a tertiary hospital was maintained by the Liberal Party during the ongoing parliamentary debates on the direction of health reform in Western Australia between 2004 and the State election in 2008.

On 1 August 2004 the Opposition Coalition announced its position statement *Building for the Future: Perth's Hospitals* at the Liberal Party State Conference. This policy said that a "coalition government will build upon Royal Perth Hospital's role as a major trauma centre for the state."[622] Later in August 2006, Opposition health spokesman, Dr Kim Hames, presented the first of many petitions to Parliament to oppose the 'closure' of RPH and preserve the name of Royal Perth Hospital. In all, around 40,000 people signed these petitions. Dr Hames argued "the closure of Royal Perth Hospital is not practical and that no savings could be made from doing so".[623] Three days before the 2008 State election, a Liberal media statement announced that legislation would be introduced to retain RPH as a tertiary hospital, if they won office. The election resulted in a Liberal Party victory and the Royal Perth Hospital Protection Bill 2008 was introduced to the

621 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 6 November 2009, p18.

622 *Building for the Future: Perth's Hospitals*, paper presented at the Liberal Party State Conference, 2004.

623 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 March 2007, p852.

Legislative Assembly in November 2008. Dr Hames credited the Liberal-National victory, in part, to the proposal to save RPH as a tertiary hospital.[624]

7.3 Progress of the Bill

The first and second readings of the Royal Perth Hospital Protection Bill 2008 occurred on 11 November 2008. The Bill is just three pages long and the Opposition described it as "rather light on content".[625] The Bill's key sections are sections 5 and 6:

> *s. 5. Continuation of Royal Perth Hospital*
> *Royal Perth Hospital is to continue to operate as a public hospital unless a resolution approving the closure of the hospital has been passed by each House of Parliament.*
>
> *s. 6. Services to be provided*
> *For the purpose of maintaining Royal Perth Hospital as a tertiary hospital, the entity for the time being having management and control of Royal Perth Hospital under the* Hospitals and Health Services Act 1927 *is to provide the prescribed medical and support services at the hospital*[626]

Finding 60

If the Royal Perth Hospital Protection Bill 2008 becomes law, Royal Perth Hospital will be the only hospital in the State's health system to be protected from closure by specific legislation.

On 9 April 2009, the Bill progressed to the Consideration in Detail stage, where it remains (as at May 2010). Proponents of the Bill, particularly Health Minister, Dr Kim Hames, argue that it is about not allowing the future closure of the hospital on its current site without the approval of Parliament because "the people want protection for their hospital".[627] Minister Hames asserts this is reflected in the large number of people who signed petitions to keep RPH as a tertiary hospital. Other reasons cited to maintain RPH's status within the WA health system are:

- its 150 year history;

---

624 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3130.

625 Mr Roger Cook MLA, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 27 November 2008, p664.

626 Royal Perth Hospital Protection Bill 2008 (Western Australia). Available at: www.austlii.edu.au/au/legis/wa/bill/rphpb2008376/. Accessed on 1 April 2010.

627 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3126.

- the hospital's excellent standards of continued education, training and research by Noble Prize-winning doctors;
- its international reputation;
- it is one of Australia's largest hospitals; and
- it is one of Australia's busiest Emergency Departments, treating over 60,000 emergency cases per annum.[628]

The Committee received evidence that RPH is a preferred hospital for some Indigenous patients, both within Perth and those visiting from regional areas.[629] A key element for this preference are the convenient public transport links to RPH, both from outlying suburbs and regional centres. It has a rail station at the hospital, bus routes outside its entry and easy freeway access. A second element is that its central setting (and closeness to Wellington Park) is familiar to visiting Indigenous patients, relatives, and their friends—particularly compared to SCGH on the QEII site. In addition, the staff at RPH are experienced in dealing with Indigenous patients and employ Aboriginal health workers, who assist in overcoming cultural and linguistic barriers.[630] These factors promote a greater sense of comfort and familiarity with RPH amongst Indigenous people. For these reasons it was claimed by the Government that Indigenous patients choose RPH over other hospitals, and the retention of RPH would help address the 'untenable' health disparity between the Indigenous and non-Indigenous population.[631]

The issues of location and cost have received significant attention during parliamentary debates on the Bill. The Government contends that, unlike Labor's comments that "the days when health care could be focused on the CBD area are gone",[632] the very fact that RPH is located in the CBD is an important reason to retain it. In addition to the claim that RPH's central location benefits the State's Indigenous population, it is also needed to service the nearly 110,000 people who work in the CBD.[633] Demographic shifts indicate that further demand will come from the resident inner city population, which is expected to increase to 20,000 people by 2020.[634]

---

628 Mr Mr Michael Sutherland MLA, Deputy Speaker, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3123.

629 Mr Michael Hayden, Chair- Merredin Aboriginal Project, *Transcript of Evidence*, 7 September 2009, p9.

630 Mr Maurice Swanson, Chief Executive Officer, National Heart Foundation, *Transcript of Evidence*, 31 August 2009, p8.

631 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p12.

632 Hon Mr Jim McGinty, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 April 2005, p937.

633 City of Perth, 'Community Profile/Profile of Workers', 2006. Available at: http://profile.id.com.au/Default.aspx?id=284&pg=320&gid=10&type=enum. Accessed on 26 November 2009.

634 Mr Michael Sutherland MLA, Deputy Speaker, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3124.

Other factors cited that support a centrally located hospital are the:

- accessibility of public and private transport links into the city;
- increased availability of hotels and hostels for people travelling from regional areas;
- economic stimulus for the city derived from the 7,000 people employed at RPH; and
- advantage of having a centrally located hospital in the case of a major trauma or terrorist attack.[635]

On the issue of the cost impact of retaining RPH as a tertiary hospital, Health Minister Hames maintained in 2009 there would be no increase in cost to the system overall as there will be even less beds and full time equivalent (FTE) employees in the system as that proposed by the previous government. Minister Hames noted that "Under our plan, we will have fewer tertiary beds in the system across the three hospitals than the Labor government would have had across two hospitals."[636]

Minister Hames stated these decreases meant there would be no increase in DOH's recurrent spending due to the retention of RPH as a tertiary hospital.[637] In response to questions as to why no expenditure items were included on the 2009-10 Budget for the redevelopment of RPH, Minister Hames replied that firstly, RPH is currently being funded as a tertiary hospital in its current configuration, and secondly, any plans for the future redevelopment of RPH will not be on stream until after 2014 (probably 2015) and as such "there is not a single dollar required in the next four-year forward estimates because nothing changes."[638] He said that because of the recent upgrades in the Emergency Department of RPH and the fact that north block is only twenty years old, it was sensible to retain tertiary services at the hospital. He asserted that no business case, and therefore no evidence, was presented to show that savings would be realised if RPH was closed as a tertiary hospital and those tertiary services relocated to SCGH. He stated, despite the argument articulated in the Reid Report, that "there is not one scrap of evidence"[639] that proves there is wasteful and inefficient duplication of services between RPH and SCGH.

This position is highly contested by those arguing against the retention of the RPH as a tertiary hospital. In late 2009, DOH was already under fire for being almost $200 million over Budget for

635 Mr Michael Sutherland MLA, Deputy Speaker, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3124.

636 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates (*Hansard), 24 November 2009, p19.

637 Hon Dr Kim Hames, Minister for Health, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 8 April 2009, p3014.

638 ABC Television- Stateline WA, 'Health Minister Kim Hames on How the Government Will Afford RPH', 26 June 2009. Available at: www.abc.net.au/stateline/wa/content/2006/s2611274.htm. Accessed on 20 April 2010.

639 Hon Dr Kim Hames, Opposition Health Spokesperson, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 28 March 2007, p852.

the current financial year, and for having accessed $49.8 million from a special purpose trust account to meet budget shortfalls for 2008-2009. The then-Treasurer's criticism of the Director-General's candour over these issues when appearing before parliamentary committees led to Dr Flett's resignation in December 2009.[640] The Opposition stated that the cost of maintaining and redeveloping RPH went against the Reid Report recommendations and would further jeopardise the long term rigour of the health budget:

> *The idea that we should have an additional tertiary hospital with the construction of the Fiona Stanley Hospital and the retention of Royal Perth Hospital as a tertiary hospital means only that the whole system will become unsustainable, and there will be serious negative consequences as a result of the government abandoning rational reform in the long-term interest of the sustainability of health services.*[641]

The ALP accused the Government of making a political, not a financially responsible decision, to retain RPH as a tertiary hospital and criticised the legislation as "a stunt and a waste of parliamentary time".[642] The Opposition also claimed the decision propelled the Government into a building program that is "without genuine reform and lacks rationality"[643] and may jeopardise hospital capital works projects already planned.[644]

Finding 61

The Western Australian Government is committed to maintaining Royal Perth Hospital as a tertiary hospital in the centre of Perth, and as the State's second major trauma centre.

7.4 Ramifications of the Royal Perth Hospital Protection Bill

The decision to retain RPH as a tertiary facility, and protect it with specific legislation, has broad impacts for the WA health service. It is not yet clear what the implications of this legislation may have for the current negotiations at COAG on a new national approach to the management of Australia's hospitals. A key plank of the Federal plan is that hospitals will be managed by local

640 Mr Anthony Deceglie, 'Health boss reveals why he quit', *The Sunday Times*, 20 December 2009, p10.

641 Hon Mr Eric Ripper, Leader of the Opposition, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 24 November 2009, p16.

642 Hon Mrs Michelle Roberts MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 8 April 2009, p3006.

643 Hon Mr Eric Ripper, Leader of the Opposition, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 24 November 2009, p16.

644 Projects that might be threatened included Stage Two of Fiona Stanley Hospital, the redevelopment of the Swan Districts Hospital and infrastructure projects promised in regional areas such as Carnarvon Hospital and Nickol Bay Hospital- see Mr Vince Cantania, MLA, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 9 April 2009, p3120.

boards. It is also not clear what powers any new board might have in being able to amend the future structure of RPH and the services that it might offer, and how much their planning powers would be limited if the Bill becomes law.

Finding 62

It is also not yet clear what the implications of Royal Perth Hospital Protection Bill 2008 have for the current Council of Australian Governments' negotiations for a new national approach to the management of Australia's hospitals.

(a) Retention of Royal Perth Hospital – funding implications

On 14 May 2009, the Government tabled the 2009-10 Budget. Chapter 2 of *Budget Paper No 3- Economic and Fiscal Outlook* contained a section entitled 'Statement of Risks' which highlighted factors that could produce financially unsustainable growth in health sector expenses. The Government's decision to retain RPH as a tertiary hospital received specific mention:

> *Prior to this decision, it was intended to close RPH as a tertiary facility and transfer associated expenditures to fund the new Fiona Stanley Hospital. The health system will incur significant costs in 2013-14 from operating the 400-bed RPH trauma facility and the commissioning of the new 643-bed Fiona Stanley Hospital. These costs are yet to be determined or considered by the Government.*[645]

As noted earlier in this Chapter, the Health Minister has maintained that there would be no increase in DOH's recurrent spending as a result of this decision. This argument has been challenged, most notably by the Opposition. However, a prominent political commentator prior to the 2008 State election branded the decision to retain RPH as a tertiary hospital as "sheer economic lunacy".[646] Of greater significance is this admission from the Health Minister's representative in the Legislative Council, Hon Simon O'Brien that:

> *it must be obvious, I would have thought, to anyone in this part of the galaxy that if Royal Perth Hospital is to be retained as a tertiary hospital and major trauma facility, there would be significant recurrent cost implications for the Health Department Estimates.*[647]

However, it is primarily the continued concern expressed by the Department of Treasury and Finance that calls into question the Government's decision. The Under Treasurer, Mr Tim

---

645 Department of Treasury and Finance, 2009, *2009-10 Budget, Economic and Fiscal Outlook, Budget Paper No. 3,* Perth, pp43,162.

646 Mr Paul Murray, 'Don't expect Libs to reign in hospital costs, *The West Australian*, 14 August 2008, p20.

647 Hon Mr Simon O'Brien, Minister for Transport, Western Australia, Legislative Council, *Parliamentary Debates Estimates* (Hansard), 18 June 2009, pE679.

Marney, was asked about the Statement of Risks in the Budget papers by the Legislative Council's Estimates and Financial Operations Committee. Asked if he could add anything further given legislation was about to enshrine the retention of RPH, Mr Marney responded:

> *I think the bottom line (is) that, at this point, I do not believe we have adequate funding in place for the retention of Royal Perth Hospital. It is a serious issue because, to be quite blunt, I do not know where the money is going to come from.*[648]

During a later hearing with this Committee, Mr Marney was again asked if he thought there was sufficient funding in the budget to retain RPH, to which he responded he did not know. He explained that he was unaware at that stage of what the Government's plans for clinical services throughout the State were, or of the costing associated with these services.[649]

At that time, DOH was still to provide the Department of Treasury and Finance (DTF) with these figures, which are produced by costing the CSF 2010 using the 'whole of health' cost model. With no knowledge of this funding figure, Mr Marney felt unable to comment on if there are sufficient funds available. "I could not even give you a gut feel ballpark because I do not know what the configuration of service delivery would be."[650]

Finding 63

The decision to retain Royal Perth Hospital as a tertiary facility will have adverse recurrent cost implications for the Department of Health. The true extent of these costs can not be quantified until the hospital service configuration contained in *Clinical Services Framework 2010-2020* is incorporated into the 2010-11 Budget.

Recommendation 29

The Auditor General should investigate all of the costs associated with the duplication of services in Perth's tertiary hospitals caused by the retention of Royal Perth Hospital as a tertiary hospital, and report to Parliament by the end of March 2011.

---

648 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence, Estimates and Financial Operations Committee* , 22 June 2009, p10.

649 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p12.

650 Mr Tim Marney, Under Treasurer, Department of Treasury and Finance, *Transcript of Evidence*, 18 November 2009, p12.

(b) Other budgetary ramifications

Beyond the recurrent budget implications referred to above, significant capital cost pressures loom for DOH in the near future. Evidence presented in Chapter 6 confirms that the proposed cost of redeveloping Royal Perth Hospital could be between $250-$550 million. The full effect of this substantial commitment on the State's finances remains uncertain, as it currently sits outside the Government's Forward Estimates Period 2012-13.

Based on the Health Minister's prediction that work on the project will likely commence around 2014, greater clarity regarding the fiscal repercussions of this decision should be evident in the next State Budget.

(c) Delays to the health reform program

DOH and the Under Treasurer both acknowledged that the retention of RPH as a tertiary hospital delayed the production of the new CSF 2010. This issue, which was explored in greater detail in earlier chapters, created uncertainty over the new configuration of hospital services and the subsequent adjustments to DOH's capital works. It is also likely that this delay has further slowed the progress of projects commissioned earlier in the reform program, such as the 14-bed mental health facility in Broome.

The new Broome facility will offer much-needed services to the Pilbara and Kimberley and will generate considerable savings. Currently, about 200 mental health patients are flown to Perth annually by the RFDS, at a cost of about $20,000 per patient (Chapter 11). Announced by the Government in February 2009, the project was to be completed by January 2010. Earlier this year, it was confirmed that tenders for construction would not go out until two months after the original deadline for completion.[651]

(d) Duplication of tertiary services maintained

One of the major setbacks to making the State's health system more efficient that arises from the RPH decision is the continued duplication of services that were to be distributed exclusively between Sir Charles Gairdner and Fiona Stanley hospitals (see Chapters 3 and 6 for greater detail on these duplications).

(e) Reduction of hospital capacity for NMAHS

As Table 7.1 below illustrates, the revised delineation of tertiary hospital services in the CSF 2010 has also worked to the detriment of the residents living in the region serviced by the North Metropolitan Area Health Service (NMAHS). Two factors contribute to this outcome:

(i) the retention of RPH as a tertiary facility; and

651 ABC News, 'More delays for mental health unit', 11 January 2010. Available at: www.abc.net.au/news/stories/2010/01/11/2789776.htm. Accessed on 9 February 2010.

(ii) the transfer of the administration of RPH from NMAHS (as contained in the CSF 2005) to South Metropolitan Area Health Service in January 2006.

While the Acting Director General of Health reported that RPH's services would still be offered to residents in the northern suburbs of Perth, the original move to SMAHS was primarily designed to enable staff to prepare for the potential move to Fiona Stanley Hospital.[652] To compensate patients in the North Metropolitan Area, the capacity of Sir Charles Gairdner Hospital was to be expanded significantly. It is not clear how, with RPH retained as a provider of tertiary services and with the expansion of SCGH shelved, patients residing within the NMAHS catchment will receive equitable access to RPH services. To demonstrate, the Committee used population statistics for each Area Health Service provided by DOH to make the following observations based on RPH being located within the SMAHS, and offering services to the population the SMAHS services:

- The number of tertiary beds in NMAHS **declines** from about 120 per 100,000 people to 71 per 100,000; and
- The number of tertiary beds per 100,000 people in SMAHS **rises** from 149 per 100,000 population to 167 per 100,000.

These ratios are notional as patients will access RPH from both northern and southern suburbs of Perth. Table 7.1 below allocates the tertiary hospitals as per their area health service, and does not reflect patient use. If RPH provides services mainly to patients in northern suburbs, then the actual increase in SMAHS would be overstated.

Table 7.1- Changes to tertiary bed allocation in metropolitan area health services from CSF 2005

	CSF 2005 (beds in 2015-16)	CSF 2010 (beds in 2014-15)	Difference
North Metro AHS			
Sir Charles Gairdner	1,046	616	-430
Royal Perth Hospital	0	n/a	0
TOTAL NMAHS	**1,046**	**616**	**-430**
South Metro AHS			
Fiona Stanley Hospital	1,058	798	-260
Royal Perth Hospital	n/a	470	+470
TOTAL SMAHS	**1,058**	**1,268**	**+210**

652 Mr Kim Snowball, Acting Director General, Department of Health, *Transcript of Evidence*, 16 February 2010, p4.

This redistribution of tertiary beds between the SMAHS and the NMAHS under CSF 2010 is inconsistent with the intent of the CSF 2005, which said that bed capacity in the NMAHS would remain relatively constant and would improve access and reduce the distance travelled for services for people living to the north of Perth. It also belies the criticism made by the Premier, Hon Colin Barnett, when Opposition Leader, that the Reid Report was fundamentally flawed because it is a centre-south model and ignores the northern suburbs.[653]

Finding 64

The retention of Royal Perth Hospital as a provider of tertiary services will have many adverse implications for the Western Australian health system that far outweigh the benefit of maintaining an extra inner city tertiary hospital.

Recommendation 30

The Government should maintain Royal Perth Hospital as a secondary-level facility. This will allow planning to continue in a manner that is more appropriate to Perth's population growth patterns, future budgetary pressures and the potential impact of the new national hospital arrangements proposed by the Federal Government.

To that end, the Royal Perth Hospital Protection Bill 2008 should be amended to delete the words "as a tertiary hospital" from section 6.

653 Hon Mr Colin Barnett, Opposition Leader, Western Australia, Legislative Assembly, *Parliamentary Debates* (Hansard), 25 August 2004, p5615.