Division 11: WA Health — Service 1, Admitted Patients, $2 437 295 000; Service 3, Home-Based Hospital Programs, $47 891 000; Service 4, Palliative Care, $21 160 000; Service 5, Emergency Department, $165 477 000; Service 6, Non-Admitted Patients, $530 314 000; Service 7, Patient Transport, $102 758 000; Service 8, Prevention, Promotion and Protection, $270 322 000; Service 9, Dental Health, $66 682 000; Service 10, Aged and Continuing Care, $115 988 000; Service 12, Residential Care, $95 193 000; Service 14, Chronic Illness Support, $42 714 000 —

Mr V.A. Catania, Chairman.

Dr K.D. Hames, Minister for Health.

Dr P. Flett, Director General.

Mr J.W. Leaf, Chief Financial Officer.

Mr K. Snowball, Chief Executive, WA Country Health Service.

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

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

Mr K.G. Wyatt, Director, Aboriginal Health.

Dr R. Lawrence, Executive Director, Innovation and Health System Reform.

Dr A.G. Robertson, Director, Disaster Management, Regulation and Planning.

Mr D. Cloghan, Executive Director, Development.

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

Mr I. Wight-Pickin, Chief of Staff, Office of the Minister for Health.

Mr C. Allier, Principal Policy Adviser, Office of the Minister for Health.

Ms M. Hayes, Principal Policy Adviser, Office of the Minister for Health.

Ms J. Perkins, Media Adviser, Office of the Minister for Health.

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

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

The minister may agree to provide supplementary information to the committee, rather than asking that the question be put on notice for the next sitting week. For the purpose of following up the provision of this information, I ask the minister to clearly indicate to the committee which supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the committee clerk by Friday, 5 June 2009, so that members may read it before the report and third reading stages. If the supplementary information cannot be provided within that time, written advice is required of the day by which the information will be made available. Details in relation to supplementary information have been provided to both members and advisers, and, accordingly, I ask the minister to cooperate with those requirements.

I caution members that if the minister asks that a matter be put on notice, it is up to the member to lodge the question on notice with the Clerk's office. Only supplementary information that the minister agrees to provide will be sought by Friday, 5 June 2009. It will also greatly assist Hansard if, when referring to the program statements volumes or the consolidated account estimates, members give the page number, item, program and amount in preface to their question.

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

[Witnesses introduced.]

The CHAIRMAN: I remind members that we are dealing with WA Health, services 1, 3, 4, 5, 6, 7, 8, 9, 10, 12 and 14. I call the member for Kwinana.

Mr R.H. COOK: We have asked a number of questions for which we gave some notice. Does the minister want to provide the answers by way of supplementary information or does he want them asked today?

Dr K.D. HAMES: We had this debate yesterday. A supplementary question is a question asked by a member, and if I do not have all the information to provide the answer, I agree to provide it as supplementary information. That has certain time constraints. On Tuesday we were given a pile of questions and said that they were supplementary questions, which provides that same time constraint. That does not conform to the proceedings of the house and never has. If members have additional questions, they should be provided as questions on notice and I will answer them in the normal manner.

Mr R.H. COOK: What about questions with some notice?

Dr K.D. HAMES: The member should ask those questions when it is his turn to ask a question, the same as any other question.

I wish to ask a question in return relating to our time limits. At the end of our deliberations, we have Indigenous Affairs and Disability Services. I thought we might like to consider those after the dinner break, which gives us one hour. In the past we have tended to use all our time up with Indigenous Affairs and there is no time to do Disability Services. Perhaps we could have a loose arrangement for that last hour. It will be up to members to decide how they want to structure this.

Mr R.H. COOK: We will see how we go, but it seems like a reasonable way to proceed.

I refer the minister to the heading "Statement of Risks" on page 39 of budget paper No 3 that highlights the implications of the decision —

Dr K.D. HAMES: Did the member say budget paper No 3?

Mr R.H. COOK: Yes.

Dr K.D. HAMES: We are dealing with division 11, starting on page 161.

Mr R.H. COOK: In that case, I refer the minister to the capital expenditure under "Royal Perth Hospital — New" on page 181 of budget paper No 2. Why has the government not considered the cost implications of that decision? What action will the government take to address the risks detailed by the Department of Treasury and Finance? Can the minister please provide details of the deferred election commitment funding in relation to that decision?

[12.10 pm]

Dr K.D. HAMES: As the member can see, the election commitment of $23 million has been reduced to $10 million. That is largely because we believe that $10 million is adequate to do the work on the forward development plan for the redevelopment of Royal Perth Hospital. We have established a team, headed by Dr Phil Montgomery, including City of Perth planning officers, to consider the options, not just for the Royal Perth Hospital site but for that whole complex, which is in effect five inner city blocks. The government sees this as a great opportunity to develop that whole location. Its planners will work in conjunction with the City of Perth to see what else can be accomplished on the rest of that site. We also have to look at funding issues for the construction of Royal Perth Hospital because that is not included in this budget. As members opposite know, 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.

As members know, the plan is to 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. Another option that has been raised by staff is to refurbish that H-shaped block on the south side of Wellington Street. I have agreed to a preliminary investigation of that option. It is not my favoured option because it is considerably cheaper to refurbish the existing building.

The member for Kwinana referred to comments by Treasury that there were significant risks attached to the Royal Perth redevelopment option. I think that Treasury has got that wrong, and that the risk is not related to the retention of Royal Perth Hospital, but to a significant increase in cost from secondary beds that will come into the system. Fremantle Hospital has 250 beds, and there will be increased bed capacity at Joondalup and Rockingham. When one adds up the number of existing tertiary beds—Royal Perth Hospital, 681; Sir Charles Gairdner Hospital, 622; Fremantle Hospital, 501—the total number is 1 804 beds. In the future, Royal Perth

Hospital will have 400 beds; we will have the same 622 beds at Sir Charles Gairdner Hospital; and currently, member for Alfred Cove, 643 beds at Fiona Stanley Hospital, which totals 1 665 beds. The reality is that funding is currently in place for 1 804 beds. In fact, not all of those beds will be required as tertiary beds when Royal Perth Hospital comes on stream. That is not the constraint.

Members will recall that the commitment made in 2006 by the former Minister for Health was to increase Sir Charles Gairdner Hospital to 1 000 beds—and delete the number of beds at Royal Perth Hospital, obviously—and have 643 beds at Fiona Stanley Hospital. The current 622 beds at Charlies was going to be increased by roughly 400. Instead of that, we are retaining 400 beds at Royal Perth. Under the previous minister's scheme, bed numbers would be the same. The former minister did change the numbers towards the end of his time; instead of reducing the bed numbers at Fremantle Hospital to 250, he said he would retain its current capacity but call them secondary beds. That significant increase in secondary beds around the ring is the issue.

We need to work that through with Treasury because we will not immediately need funding for hundreds of extra beds; the demand is not there at present. It will build, but we have to massage those bed numbers through as we get the peripheral secondary hospitals. Members will recall that the tenet of the recommendations in the Reid review was that we change from having high numbers of tertiary beds to moving people out into peripheral beds—secondary beds.

Mr R.H. COOK: That is the point that Treasury is making, and it is extraordinary that the minister, as a minister of the government, is now saying that he disagrees with the Treasurer. Treasury says that the decision to retain Royal Perth Hospital as a tertiary hospital and major trauma facility will result in significant recurrent cost implications for the health system. Treasury is suggesting that having a third tertiary hospital campus providing tertiary hospital beds is where the blow-out in expenditure will occur. I stress "expenditure", as we are not talking about capital costs. We have the association of creating a third tertiary campus and the costs associated with running that. The Department of Treasury and Finance is referring to tertiary beds. How does that differ from the minister's analysis? And, indeed, as a minister of government, why does the minister have a different analysis from Treasury in the first place?

Dr K.D. HAMES: That is an excellent question to which I do not have an answer. At the end of the day that is the reality. I have discussed that subsequently with Treasury, because I do not think the projected change in demand was clear. As I said, they now have in place funding for tertiary beds to the tune of 1 804. If we did nothing else, if we did not increase numbers of secondary beds in the peripheral hospitals, the funding for tertiary beds would be less under our proposal, which is to retain Royal Perth, than it is currently and also less than it would have been if members opposite had still been in government and retained the proposal to expand Sir Charles Gairdner Hospital to 1 000 beds, which is what it was before. Those bed numbers are the same.

Mr R.H. COOK: You are not comparing apples with apples.

Dr K.D. HAMES: Yes, I am. The member should think about this. Does the member think moving a patient who needs, say, a hip replacement, from Royal Perth Hospital to Swan District Hospital, will reduce the cost of that operation? No, it will not. The cost of that operation is exactly the same. When that patient is operated on at Royal Perth Hospital, the total cost of providing those tertiary services, which are largely in the intensive care unit—the high dependency unit providing high level treatment—are averaged across the total number of patients. Therefore, those costs are added on, almost as an administrative charge, to the cost of that hip replacement surgery. When the patient goes out to a peripheral hospital, those costs are not added on. In theory, they may look less, but they are not because those costs to the tertiary hospital—the ICU beds will remain the same—will be added on to fewer patients. The costs of other procedures will then go up. As I said, the cost is the same. The issue is the number of extra beds. As the member knows, a significant number of extra beds is coming on stream at Fiona Stanley Hospital and at Joondalup, and then more will come on stream down the track at Midland. Those are the costs that will have to be managed by Treasury, but not in these four-year forward estimates. That is why they do not appear here. The member referred to a comment from Treasury on what will occur in the following four years. That was an issue for the former government and for this government. The former government would not have dealt with that issue in this budget. The former government would have dealt with that in forthcoming budgets when those secondary hospitals were operating and when the increased demand was occurring.

If bed numbers go up on a graduated level, just because we open 100 new beds at Rockingham, for example, does not mean that we will immediately need those 100 extra beds at Rockingham. Even if we did that, it may mean that secondary patients from the tertiary hospitals might move out, which is what we want to see happen. That would then reduce the demand on the tertiary hospitals. Increasing bed numbers does not mean we

suddenly increase, in a significant way, recurrent expenditure. That is staged as the demand grows. Of course, we do want to reduce the burden on our tertiary hospitals. As members know, they are running at a 95 to 105 per cent occupancy rate.

Mr J.C. KOBELKE: I have a follow-up question.

Dr K.D. HAMES: I had not quite finished, but there you go!

Mr J.C. KOBELKE: The excuses or arguments that the minister is seeking to use relating to bed numbers are irrelevant. If the minister looks at the Reid review and its recommendations, or if he listens to any health economist—I might ask later whether the minister knows any health economist who supports his position—he will know that the issue, as the member for Kwinana said, is about maintaining an additional tertiary campus, which presents large, recurrent cost implications. Treasury said it, health economists say it and Reid said it! Is there any independent health economist who will back the minister's totally untenable position?

[12.20 pm]

Dr K.D. HAMES: I do not accept the member's argument. I do not accept that over the next four years our reducing the number of tertiary beds will have a significant impact on the budget. How can the member maintain a position that is so illogical? At the end of the day we —

Mr J.C. KOBELKE: It is not just the beds; it is all the equipment, the specialist services, the support services —

Dr K.D. HAMES: They are there now; they are not additional, and —

Mr J.C. KOBELKE: Not necessarily for a tertiary level.

Dr K.D. HAMES: Mr Chairman, we need to conduct this in some sort of order. If a question is asked, I am happy to answer it, but estimates is not a matter of argument.

Mr J.C. KOBELKE: I am happy with the minister's non-answer.

Dr K.D. HAMES: I would like to have the opportunity —

Mr J.C. KOBELKE: He has been caught out, and he knows it.

The CHAIRMAN: Member for Balcatta, the minister has the call. Would the minister like to finish his answer?

Dr K.D. HAMES: I would. I do not see how the member can sustain an argument when there is a major financial difficulty outside the forward estimates. When Fiona Stanley Hospital comes on, less funding will be required for tertiary beds than either currently or under the model that the previous government put forward, which was 1 000 beds at Sir Charles Gairdner Hospital and 643 beds at Fiona Stanley Hospital. We will in fact have about the same number of tertiary beds that the previous government had planned. We made a political decision, and I believe a very sensible decision, to retain Royal Perth Hospital. The member does not understand that that, apart from some of the actions of his former leader, is what largely cost him the election. We will do it. We will retain Royal Perth Hospital. I think we can easily justify the funding that we will spend.

Mr J.C. KOBELKE: I thank the minister for putting on the record that it was a political decision, not a health decision.

Dr K.D. HAMES: If the member checks the *Hansard*, he will find that I said that it was a political decision and a sensible decision based on the facts that we had; in fact, that has been confirmed since I have been minister by health staff saying that with the growth in population in Western Australia, it would have been very difficult to provide the bed numbers that we need in this state without the retention of Royal Perth Hospital.

Mr R.H. COOK: Let us say hypothetically, is the minister seriously suggesting that 1 600 tertiary beds across three campuses as opposed to 1 600 beds across two campuses will be the same overall cost to the system?

Dr K.D. HAMES: Yes, it is in effect. I am sorry I did not understand that the member made that point before. When the proposal was put forward to move to two campuses for the north and south, the point was made that there was duplication of services and costing and that there was in fact saving to be made by having the same number of beds across two campuses as compared with three. In the late 1990s and early 2000s a study looked at that point, trying to identify what cost savings there were by doing that, and they were minimal. If the member refers to the section of the Reid report that refers to the recommendation to go to one campus, I will tell him a couple of things. First, the recommendation from Reid says two things. It first says that there should be only two campuses and that one should be closed. The preference was Sir Charles Gairdner Hospital. The member will notice in the second paragraph after that recommendation it states that a business study should be done prior to

any action being taken to investigate that proposal and to see whether those figures stack up. Of all the recommendations in the Reid report, we did not support that recommendation. Reid also made an alternative recommendation to retain two hospitals and have them operating as a single hospital. That was the least favoured. I have found out since I have been minister that a lot of the studies that were done initially by staff in the Department of Health supported the retention of Royal Perth Hospital as opposed to Sir Charles Gairdner Hospital, but the political decision was made that Sir Charles Gairdner Hospital would be retained. I think that was largely to do with landownership. Therefore, the retention of Royal Perth Hospital was not further investigated. It may be that there are some minor additional costs in having three tertiary campuses as opposed to two, but they were never evaluated or determined by the former government, and this government does not intend to because we believe that Royal Perth Hospital services the eastern corridor and that initial proposal for two campuses totally ignored the needs of the eastern corridor, and particularly the needs of Aboriginal people in the eastern corridor who are the largest of individual groupings who attend Royal Perth Hospital.

Mr P. ABETZ: I refer to page 163 and to "Outcomes-Based Service Delivery" about seven centimetres down the page, where the third of the references to services is home-based hospital programs. I notice a substantial increase in funding from $18.1 million in the 2008-09 budget to $47.9 million in the 2009-10 budget. Why the increase in funding and what are some of the new programs?

Dr K.D. HAMES: Yes, there has been a substantial increase in home-based hospital programs, which largely include the Hospital in the Home program and the Hospital at the Home program—HITH and HATH. HITH is an outreach service that is provided by the hospitals themselves, with hospital staff, and HATH is a program currently largely provided by Silver Chain, which helps look after patients in their own home, particularly some of the chronic-care patients, and also deals with such cases when an intravenous drip might be required for antibiotic management or something of a similar nature. It is interesting to go back to the former budgets to see what was done by the previous government. The member will notice on that line that $26.279 million was the actual spend in 2007-08, which was reduced in the 2008-09 budget of the former government to $18 million, so the former government cut $8 million off that program. The explanation I have is that the 31 per cent reduction in unit costs between the 2008 budget and the 2007-08 actual is attributed to WA Health initially anticipating a decrease in the 2008-09 budget for home-based hospital programs, due to extreme budget pressures. Obviously, we have been under extreme budget pressure, and it is interesting that we are not alone in that. The former government reduced it by $8 million in a single year. The fact is that those savings were not realised. We have continued, as the former government must have done, to strongly support that program. The estimated actual for the current financial year is $32 million. We are increasing it by a further almost $16 million to $47.89 million. A significant proportion of that is from our election commitment, which is the Friend in Need—Emergency scheme funding, which will largely go to the Silver Chain service. That will provide an additional service in the home; the idea being, of course, to try to reduce demand on our hospitals. If that is combined with the funding for after-hours general practitioners, we are hoping that those combined efforts will reduce the demand on our hospitals. The Silver Chain funding is starting to be rolled out now. It will go to all of those areas, working in with GPs in particular, to make sure that as many people as possible are seen within their own homes, to try to reduce the demand from people coming to the hospitals. May I ask the director general if there is any comment that he wants to make on that?

The CHAIRMAN: Will the advisers say their name before they speak, just to help *Hansard*?

Dr P. Flett: I would make a couple of comments. We are very dependent on the expansion of this Hospital in the Home program, as it is a means to an end to relieving the pressures on our emergency departments for particular illnesses that people present with that can easily be centred on the home. Patients can have nurses going to their home, perhaps even with intravenous lines and giving intravenous antibiotics at home, whereas they would have been admitted in the past.

[12.30 pm]

Dr K.D. HAMES: Some concern was expressed by the Hospital in the Home people—that is, our hospital-based physicians—that there would be some reduction in their funding and Silver Chain would be taking over their role. That is not the case. Approximately $10 million a year goes to the Hospital in the Home funding, and that will continue. The additional funding will be going to the Hospital at the Home program through the Friend in Need—Emergency program that is run by Silver Chain.

Mr R.H. COOK: I have a follow-up question about the home-based hospital programs. I note the government's $27 million commitment for the FINE program, and that there has been a $15.6 million increase in funding for the Hospital in the Home program. Assuming that that includes that $27 million increase, can the minister disaggregate across the other programs to demonstrate where the reductions in overall funding have been made?

Dr K.D. HAMES: Just to go back to those figures, the Silver Chain funding program is a funding program over four years. It is a total of $84 million. There will be funding of $16.2 million for that program this financial year. So, if we add that $16 million to that $32 million that we talked about earlier, that is approximately a $47.89 million reduction. The minimum budget that I can see is $32 million, but remembering that the former government anticipated only $18 million of funding last year —

Mr R.H. COOK: I do not know what the former Minister for Health anticipated last year, but I do know that at page 161, under "Major Policy Decisions", the estimate for 2009-10 for "Friend in Need Emergency/Silver Chain" is $27 million. Is that for other Silver Chain programs?

Dr K.D. HAMES: Mr Leaf will answer that question.

Mr J. W. Leaf: The FINE program covers a number of service initiatives. The minister has referred to the Hospital at the Home program. It also covers rehabilitation in the home and the residential care line. There are other areas within the services outlined in the *Budget Statements* that will receive funding through the FINE program. Does that assist the member?

Mr R.H. COOK: Yes. Can that be disaggregated into programs?

Dr K.D. HAMES: If I can provide further information, what Mr Leaf is saying is that the $27 million total for "Friend in Need Emergency/Silver Chain" reflects the fact that some of that $16.2 million is for the FINE program, but there is additional funding that already goes to Silver Chain to fund other programs. That makes up the total of that $27 million.

Mr R.H. COOK: Can the minister provide the details of that?

Dr K.D. HAMES: I will ask Mr Leaf to provide the details about that additional $11 million and how it will be spent.

Mr J. W. Leaf: I do not think we have that information with us today.

Dr K.D. HAMES: I am happy to provide that as supplementary information.

Mr R.H. COOK: That would be very useful, because I assume, given it is under major policy decisions, that that $27 million is all new money and not pre-committed money.

Dr K.D. HAMES: We will provide, as supplementary information, the break-up of that $27 million on page 161 for "Friend in Need Emergency/Silver Chain".

[*Supplementary Information No B25.*]

Mr R.H. COOK: The FINE program is a good program, and Silver Chain is a good organisation. However, what procurement processes were used to decide upon the provider of the FINE program? Did it go out to tender? What steps did the department go through to decide that Silver Chain would provide best value for money?

Dr K.D. HAMES: I think I could provide that answer reasonably well, but Ms Lawrence is the person who is implementing that, so I will ask her to respond.

Dr R. Lawrence: The process so far is that an exemption from tender has been given to Silver Chain, which currently is the only provider that is in a position to provide the services that we have progressed thus far. In working up the program in detail, there will then be a formal procurement process for the remainder of the funds, once we know exactly what we want out of the program. The funds that have gone out thus far are for an extension of the programs that already exist.

Mr R.H. COOK: Does the department regard Silver Chain as the only organisation that can provide these services?

Dr R. Lawrence: At this point in time, that is what will be suggested. However, once we know exactly what components we want in the program, the standard procurement process, either through a formal exemption to tender for the bulk of the funds, or a tender process, will occur.

Dr K.D. HAMES: If I could just expand on that: although I think Silver Chain is the only organisation with the capacity to provide that service throughout the metropolitan area, other groups may also be involved. The Asthma Foundation of Western Australia, which is doing work now on behalf of the Health Department, has put forward a suggestion that it can provide services in the home for people with chronic respiratory illness. It may be that a small proportion of that money will be provided to the Asthma Foundation to enable it to work, either in conjunction with Silver Chain or independently, to provide such a service. The whole point of these home-based programs is to take pressure off the hospitals by enabling people who have illnesses or injuries that do not

require treatment in a hospital to be treated at home, including in nursing homes, by providing services such as chronic disease and infections management. The Asthma Foundation has said that it would be interested in providing that service. Therefore, there are other opportunities. However, my view in the main is that Silver Chain is the organisation best placed to take up the majority of the funding for that FINE program.

Mr R.H. COOK: I just want to confirm that, because I know that Silver Chain is advertising for positions within its organisation to deliver this program; however, the minister has not made the decision about whether Silver Chain will receive funding in whole or in part to deliver this program.

Dr K.D. HAMES: That is not true. We have made a decision, and, as Ms Lawrence has just said, there will be an expansion of Silver Chain's existing services that we have agreed to. It is not the totality of the funding, and that process will follow, but we have an agreement, and that is why Silver Chain is advertising to expand its current services.

Mr R.H. COOK: The minister says he has not made an allocation of funding, yet in the budget papers, as part of that $27 million, there is a $16 million allocation for Silver Chain. What is the actual allocation?

Dr K.D. HAMES: Ms Lawrence.

Dr R. Lawrence: I think it is fair to say that that $16.5 million has been allocated to that program, but the state tender process will be complied with when we are ready to go to that point.

Dr K.D. HAMES: The member's question was, in fact, how much has been spent already on this program. As the member would know, Silver Chain is already expanding, and some of that funding to which we have already agreed will go to Silver Chain. Do we have an understanding of exactly how much that is at this stage?

Dr R. Lawrence: For the current financial year, there is $3 million.

[12.40 pm]

Mr R.H. COOK: I beg the committee's indulgence; I know it is taking up precious time, but $3 million was spent in 2008-09. Can I confirm that this was on the FINE program? In 2009-10, the minister says there is $27 million, but only part of that is for the FINE program, and the minister says this is the money that is being allocated to Silver Chain. The minister is saying that, under the Silver Chain line item, that is the entirety of the FINE program, but not all that money will go to Silver Chain because it has yet to be decided what money will go to Silver Chain and what money will go to other service providers.

Dr R. Lawrence: I will go back a step, because it is a complex process. Silver Chain has existing processes and programs, such as the Hospital at the Home program, that will be incorporated into what has been called FINE. To support the election commitment, we have nominally called the program Friend in Need—Emergency. That program is being worked up and has three components: hospital substitution, hospital avoidance and home-based care. The process is complex because of the governance and the referral base that is required, where those patients will fit in, and what models need to be supported. In the interim, to deal with the acute demand, we have applied some additional funding to expand the existing programs of Hospital at the Home and the post-acute care home care service, and that is the funding that has been allocated for this year. That increased level to meet the demand will be continued into the next financial year. The new components of the program—the chronic disease management and complex care management component—are a work in progress, and they will form the remainder of the FINE program. Hence, it is very difficult for me to provide a fixed point about how much will go to Silver Chain, because at this point in time that component of the program is still being developed.

Mr R.H. COOK: Can the minister confirm that the allocation under "Major Policy Decisions"—at this stage it is about $16.2 million—is not all new money because some of it will involve existing Silver Chain services, although beefed up under the FINE program? Can minister confirm that not all this money is new money, but some of it comes from existing programs?

Dr K.D. HAMES: No, I cannot confirm that. There is provision in the budget for existing funding for Silver Chain. The additional funds will go to the new program. As the member has said, $3 million of that is allocated this financial year, and will go through to the next financial year, but the rest is definitely new money, as the member has seen in the budget—$84 million of additional funding.

Mr R.H. COOK: Approximately $10.8 million that currently goes to Silver Chain is not included in the 2008-09 estimated actual, but the minister will provide supplementary information about that.

Dr K.D. HAMES: Sorry, I did not understand that question.

Mr R.H. COOK: Under the heading "Major Policy Decisions" on page 161, the government claims it is spending $27 million on "Friends in Need Emergency/ Silver Chain", but the minister is now saying that part of that is existing Silver Chain programs that will go to Silver Chain. The minister is also saying that $3 million in 2008-09 is purely for the Friends in Need—Emergency program, so I assume that there is some other Silver Chain funding out there that is not accounted for in that $3 million. Can the minister confirm that the supplementary information he will provide is about the $16.2 million that the minister says will go to Silver Chain, but may go to others? One assumes that on top of that there is $10.8 million on which the government will be providing supplementary information in relation to the funding to Silver Chain.

Dr K.D. HAMES: The questions the member asks relate to supplementary answers, and all that information will be provided.

Mr R.H. COOK: That is right; I am trying to clarify exactly what the minister is providing in the supplementary information.

Dr K.D. HAMES: I am providing detail of the $27 million that is being provided, as was recorded previously.

Dr J.M. WOOLLARD: My question relates to the budget for prevention, promotion and protection outlined on page 174 and page 163 of the *Budget Statements*. In the recent report of the Education and Health Standing Committee tabled in Parliament, "Healthy Child — Healthy State: Improving Western Australia's Child Health Screening Programs", it was reported that the State Child Development Centre has had to rationalise its services. The report states —

> Its staffing allocation has not changed in the last 16 years even though the primary school population (years 1 to 7) in WA has grown from 93,162 in the 1992 census to 169,870 in the 2006 census.

When was a decision made to cap front-line community and school health services? Can the minister explain the rationale for that decision? If no decision was made to cap those services, will the minister confirm that no requests for additional staffing numbers have been forthcoming over the past 16 years? Again, if no decision was made to cap those services, why was a business case put forward to the Department of Health last year seeking an additional 126 full-time equivalent staff in the State Child Development Centre, 105 community child health nurses and 135 school nurses?

Dr K.D. HAMES: That was an excellent question, and it obviously forms the subject of the inquiry of the Education and Health Standing Committee. The member may be aware that I was a member of the committee when the decision was made to launch that inquiry.

Dr J.M. WOOLLARD: That is why I am expecting the minister's support.

Dr K.D. HAMES: It was the member for Bassendean's idea to initiate this inquiry, supported by all members of the committee. This has been a major concern of our side of politics for some time. I know Hon Barbara Scott did a lot of work with communities on the lack of child health clinics and early childhood management issues, such as the need for speech therapists. There have been very long waiting periods and a significant lack of staffing across the board in Western Australia. In my own electorate there was a lack of child health nurses, and I had to go to the former Minister for Health to get him to provide extra staffing. I am not aware of any decision to cap the number of places. It has been obvious that during the time of the last coalition government, through the years of the Labor government, until the present, there has been no significant increase in numbers. The previous government was obviously aware of the issue, hence the business case put forward to Treasury for an extra 105 community child health nurses, 135 school nurses and 126 child development officers. An amount of $135 million over four years was requested, but it was rejected by the former government. The government's task now is to look through the report of the committee and look again at what was requested. It will probably be necessary to drag out that former business case, and the benefits of the recommendations made by the committee on a bipartisan basis will add a lot of weight to our request for additional funding.

In my view, this is one of the most critical failings of health in this state at the moment. We are spending a lot of money on waitlist surgery and on our hospitals and all the other areas that are perhaps more visible, but this invisible need that exists in the community is a critical one. Lack of adequate care for children in their early years, as the committee expressed in its report, actually costs government a huge amount of money in having to then treat them at a later stage. One of the issues raised in the report relates to newborn hearing tests. We committed, as did the previous government, to a newborn hearing screening program. On getting into government I was somewhat dismayed to find that the previous government had not allocated any funding to meet that commitment. We have now put some funding in place, but it will be rolled out over a four-year period. That is not adequate. We are currently searching for additional funding to reduce that roll-out time for the

newborn hearing screening program. The committee's report refers to discovering lots of children with hearing difficulties when they are almost school age, and often that it is too late. It is a critical issue that requires assessment by this government and it is one on which I will be working very hard.

[12.50 pm]

Dr J.M. WOOLLARD: Is the minister saying that the Department of Health has not capped funding for school health nurses, community health nurses and child development services? Is he also saying that the department has not denied additional funding and resources to these services? Can the minister confirm that if, pending his investigations, he discovers that that is the case—I believe it is—he will lift the cap?

Dr K.D. HAMES: I will ask the director general to answer in a minute. The health budget is a massive budget of over $5 billion and we have to determine what the needs are. Currently, there are existing staff in that service. The budget would not have been capped in that regard because it would have increased by whatever the increased costs are of running that service; for example, the increased wages and increased cost of the service. We have not been able to allocate additional funding to cater for the employment of additional people. That is what has happened over time. It is not as though somebody in the health department has said that there will be no more funding in that area. I am sure that would not happen. As far as I am aware there was a shortage in this service in the time of previous governments. That has been well recognised by Hon Barbara Scott for some time. She lobbied the former minister for an increase in funding. I will hand over to the director general to answer any further component of that.

Dr P. Flett: No additional funding has been applied to this service.

Dr J.M. WOOLLARD: For how many years?

Dr P. Flett: To my knowledge, certainly over the past four years. I am open to correction if it was longer than that. We have been running on that same budget for that period of time. Outside the CPI increase, there has been no additional funding. The problem has been that Western Australia has had a substantial population growth, in both people coming to the state and birth rates. The pressure on us is that if we do not address this issue, there will be subsequent downstream effects when these children reach adulthood with greater cost then to the community.

Dr J.M. WOOLLARD: Will the minister provide, possibly by way of supplementary information, the funding for these three areas over the past decade? I have been informed by reliable sources that there has been a cap and requests for additional staff over the past decade, but those requests have been denied by the health department even though they are front-line services. I ask the minister for the numbers and costs by way of supplementary information.

Dr K.D. HAMES: I am happy to do that if that is the advice the member has been given. Since I have been minister the advice I have been given by the health department is that there is no question there is a shortfall. There is a shortfall in dental nurses and dentists, Aboriginal health services and other areas. We are critically short of funding to provide the services that we would like to provide. These are not the only areas.

The member should not forget that we will be responding in detail to the committee's report on these issues. The member does not need supplementary information because the answer will be in that response, but perhaps it may not be. To make sure that we cover this issue, I am happy to provide details of the history of funding for those services over the past decade.

[*Supplementary Information No B26.*]

Mr P.B. WATSON: I refer to the line item "Albany Regional Resource Centre — Redevelopment Stage 1" on page 180 of the *Budget Statements*. From the current Department of Health's business plan can the minister advise what is the cost of the hospital, what is the expected start time for construction of the hospital and what is the expected completion date?

Dr K.D. HAMES: I will refer this to the director of the WA Country Health Service in a minute. I will clarify a few statements that have been made. The budget indicates that the estimated total cost of that hospital is $135 million. Concerns were expressed that some money was taken off that amount because it is not in the four-year forward estimates. It is true that we pushed some back into the fifth year. If the member goes to last year's budget and refers to Fiona Stanley Hospital —

Mr P.B. WATSON: I only want to know what is the current situation.

Dr K.D. HAMES: This is my answer. Last year's budget, as it relates to Fiona Stanley Hospital, indicates that the year after the former government, the member's government, committed to completion of that hospital the

cost was $33 million, recognising the fact that the year of completion has nothing to do with the final figure in the budget papers. During the next four years we are committed to building the Albany hospital. The member may be aware—if it has not been announced, it will be shortly—that we have appointed a steering committee comprising local residents who will be participating —

Mr P.B. WATSON: May I get a list of the people on that committee and will people who work at the hospital be members of it?

Dr K.D. HAMES: I will give the member a list and if I have not announced it, I will shortly. The names of the people on that committee will be made public.

Mr P.B. WATSON: Can the minister advise now whether people who work at the hospital will be on the committee?

Dr K.D. HAMES: Yes, including representatives from the council and Silver Chain. People representing a range of expertise will be on that committee. I have asked the people in the health department undertaking this task, as soon as they have a business plan and timetable for the construction of the hospital, to publish the information in the local newspaper. The information will provide specific target dates as we go through to completion of the hospital. The member and the community will then be in a position to see exactly what stage the hospital will be at at any particular time.

Mr P.B. WATSON: What will be the total cost?

Dr K.D. HAMES: This is important and should be of great interest to the member. That information will be published and every time the construction phase fails to meet a deadline the person responsible within the department will need to explain the reason for that delay in the media. The reason I will do that is that at the end of the day we take responsibility, and I am sure my staff are happy to share that public responsibility with me to ensure that the construction runs to time.

Mr P.B. WATSON: There are two minutes to go.

Dr K.D. HAMES: I am getting to the end of that answer.

To undertake the new option, the estimated capital funding is in excess of $135 million. We need to look at two options. We will not delay this project, no matter what. We have two options. One is to work in conjunction with the private sector for components of that construction; for example, pharmacy services, laboratory services, X-ray services and the like, as we do with other hospitals. Southern Imaging has the contract to provide the X-ray facilities at the Peel Health Campus.

Mr P.B. WATSON: During the campaign I was called a liar because I said that it would be private-public, and now it will be private-public.

Dr K.D. HAMES: I am answering the previous question, but I would be happy to answer that question later. The member is wrong.

I will pass to the officer responsible for the WA Country Health Service to answer a component of that question.

Meeting suspended from 1.00 to 2.00 pm

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

The CHAIRMAN: The minister was answering a question from the member for Albany; please continue.

Dr K.D. HAMES: The question was about the $135 million budget for the construction of the Albany hospital. 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—unless we provide additional public sector funds. However, there is and there always has been an option; that is, the potential to build a private hospital as documented in a report leaked to the Liberal Party in the lead-up to the election. I thought that the member for Albany commented during the election campaign that the Liberal Party intended to privatise the hospital. He has suggested that that may not be the case—he said I called him a liar. If the member for Albany did not say that, I apologise. However, the fact is there is a huge difference between privatisation and the provision of some privately funded facilities on a public hospital site. In fact, some of our major tertiary hospitals have some of their services contracted to the private sector—in fact some construction work is done under the same deal. We are not going to use the Joondalup or Peel health campus model. Albany will be a public hospital and all the public services, including the wards, the beds and the theatres will be funded by the government as part of the public hospital. The only areas in which we might go outside those include things like dialysis. The previous Labor government did that. In fact, in the shadow minister's own electorate, the former government contracted-out renal dialysis services, which are now

provided away from the hospital setting. Other such services might include chemotherapy, ambulatory and perhaps pathology or pharmacy. Those are the options that we are currently looking at. What is certain is that we will not let that hold us back. We will make sure that we go full steam ahead. A fast-track committee with people from Treasury and Finance, the WA Country Health Service and other government departments—whose role it is—meets regularly to fast-track that program. I will ask Mr Kim Snowball from the WA Country Health Service to talk further about this issue.

Mr K. Snowball: Indeed, this project is a high priority for the fast-track committee, which I chair, and the WA Country Health Service. By working with Treasury and Finance and the office of strategic projects, we are able to determine the combination of appropriate functions on the campus as well as look at other possible procurement options, including the involvement of the private sector. So we are drawing all of those things together and essentially providing a range of options that will deliver the facility within the time frame committed to by the government.

Dr K.D. HAMES: I will add to those comments. I am double-checking my facts and I am fairly certain that the Albany hospital will be the biggest hospital, second only to Bunbury, outside the metropolitan area. It will be bigger than Geraldton, and bigger than Northam and all those other hospitals.

The CHAIRMAN: It was a great Labor government decision to build that hospital.

I have a freedom of information document from Treasury that states that the Department of Health draft business plan currently reflects an amount of between $196 million and $230 million for the hospital yet the minister maintains it will cost $135 million. The opposition has earlier suggested that the minister plucked that figure off a plan two years ago. The minister continues to state the project will cost $135 million and that $60 million for this original Liberal Party election promise will come from the royalties for regions scheme. Is this just shifting money around on the *Titanic*?

Dr K.D. HAMES: It is funny that the member calls it the *Titanic*. I would be interested to know for how many years did the member try to get a hospital built in Albany during the term of the former government, how many times was a hospital promised, and how many plans were forthcoming? The member may recall that in the last few days before the 2008 election, the Labor Party —

Mr T.G. STEPHENS: The minister is just being political about this.

Dr K.D. HAMES: I am answering the question. In the last few days before the election, the plans changed again. The member may remember that in the early stages of that plan the building was to be upgraded. The second stage of that plan included a more extensive building upgrade and a new hospital was not even promised in a statement made by the former Premier a few days prior to that election—he only promised a major upgrade.

The CHAIRMAN: The minister is misleading the house!

Dr K.D. HAMES: I have the press release to confirm it was only a major upgrade and that no funding was in place, albeit there was some additional funding—am I right?

Mr K. Snowball: Yes.

Dr K.D. HAMES: The WA Country Health Service confirms that only a major upgrade of the original building was promised. The Liberal-National government has now decided that a new building is the best option, and I have to say that we based our decision on a well-written but leaked report. I do not know where that report came from but it was the report of an internal —

The CHAIRMAN: It was a two-year old report available on the internet.

Dr K.D. HAMES: The chair is not allowed to interject on me!

The CHAIRMAN: I will make those decisions, minister.

Dr K.D. HAMES: The report was about a health department study. It listed the various options and the very best option was the building of a new hospital. The government of the day decided that it did not have the money to build a new hospital and that it would accept a lesser option. Consequently, that $135 million budget figure is based on what that report said a new hospital would cost. I have to say—and the Deputy Leader of the Opposition will know—that it is very hard as a shadow minister to get alternate figures for each of the options. When we were in opposition we did not have access to any government or departmental figures. However, the Liberal Party committed to spend $135 million. As has turned out for all our election commitments that require funding beyond what was in the budget, there has been an option to fund components with royalties for region funds—things not on the original budget but things for which the community wishes to use its RFR funding and

be a part of. Accordingly, they put forward the option for $60 million of that $135 million to come from royalties for regions. I do not care where the money comes from. The fact is that we have $135 million and the health department people know that that is what they have to spend to develop this building. The department knows that the only way it can achieve the other facilities is to involve the private sector. In fact, as I understood the original report, that was the case previously—the private sector was an option. If, at the end of the day, those extra private facilities —

Mr V.A. CATANIA: The Minister for Regional Development was quoted —

Dr K.D. HAMES: The member is not allowed to interject in estimates. That is not how estimates works.

The CHAIRMAN: Excuse me, minister; I will deal with the member if the minister will answer the question. The member for North West will not interject.

Dr K.D. HAMES: Thank you very much, Mr Chair. The reality is that we will get this job done. The proof of the pudding will be in the eating. At the time of the next election I will proudly stand in front of the new Albany hospital with the member for Albany to say, "Look what a good job we have done."

The CHAIRMAN: I have a further question for the minister, who just said that $135 million was an election promise. The Liberal Party was not in coalition with the National Party, so it was a core Liberal Party promise. How come the National Party is giving $60 million of royalties for regions money when it said that it would not give any money to anything already promised by the Liberal Party?

Dr K.D. HAMES: I think that Mr Chair is asking the wrong person and that he would need to ask the Leader of the National Party that question. All I know is that we have a $135 million budget and that is what we have put forward. As I said, I do not care where the money comes from. In considering the funding mechanisms, where funds go and how projects are funded, the member should bear in mind that this government has funded the Nickol Bay Hospital upgrade, it has funded a chunk of the patient assisted travel scheme, and it has funded a portion of the Royal Flying Doctor Service. All of these projects were funding commitments by this government in addition to the funding in the Labor Party's budget, all of which are a legitimate use of funds.

[2.10 pm]

The CHAIRMAN: I have one final question. Is it true that the new Albany hospital is budgeted for by the Department of Health at between $196 million and $230 million?

Dr K.D. HAMES: I cannot confirm the exact figure at this stage because it has not been finalised.

Mr R.H. COOK: I have a further question. I want to get some items straight. The minister has budgeted at this stage for $135 million capital expenditure on Albany hospital.

Dr K.D. HAMES: Yes.

Mr R.H. COOK: I have a further question. The government will complete this hospital by 2012, as promised at the election.

Dr K.D. HAMES: I think it was 2012. Whatever the date was, it is to be completed in four years. I do not know whether it was 2012, but the aim is to finish it prior to the election, which will be at the beginning of 2013. That was a very sensible move on our part.

Mr R.H. COOK: I have a further question. If as the minister said he does not have the money to develop the hospital, is he saying that it is an unfunded election commitment?

Dr K.D. HAMES: I have been reassured by WA Country Health Service staff that they will be able to obtain the additional funds through commitments from the public sector for components of the hospital's structure. They are confident that they can do that and they are currently in negotiations with different organisations about their ability to provide those services. If it turns out in the lead-up to the need for the expenditure of funds on those services that we are unable to get the total of those funds that we need—I am certain we will get a significant proportion of them—the responsibility to provide those additional funds will come back to government, as have a range of such developments in the past. The member will recall that the original budget for Fiona Stanley Hospital was $400 million-odd. It went up to almost $1 billion, then went up again to, I think, $1.1 billion and finally to $1.76 billion. The Labor government, therefore, had to find $1.3 billion in excess of the original budget to build Fiona Stanley Hospital during six years of delay until it fixed on a date for completion.

Mr R.H. COOK: With respect, minister, it is a straightforward question. The minister has budgeted $135 million and his business case states that the campus will cost up to $230 million. Is it therefore an unfunded election commitment?

Dr K.D. HAMES: I am sorry, would the member say that again?

Mr R.H. COOK: The minister has budgeted $135 million, which he says will build the hospital by 2012. His business case states that the campus will actually cost up to $230 million. Essentially there is a $100 million shortfall or hole in the budget for developing this campus. Has the minister made an election commitment, therefore, without having the funds available to fulfil it?

Dr K.D. HAMES: No, that is not true. We made an election commitment that we would spend $135 million on building the hospital, and that remains our commitment. As with any other project, it remains to be seen whether that will be the final amount that needs to be considered. With the same respect that the member for Kwinana has given, I think I gave the answer in the answer I just gave; that is, the WA Country Health Service fully expects that we will have the funding through the private sector that is required for those services. If we do not, I will deal with it when it comes. The funding is not necessarily up to $230 million. As the member for Kwinana knows, I have not given the details of the expected figures because those figures are not finalised. It is therefore not necessarily the amount that the member for Kwinana is saying it is. We will build the hospital. That is the difference in the test of the former government, which it failed, and our test, in which we are determined we will succeed. Not only that, but also we intend to make this a public affair, not the private affair under the former government that was shrouded in secrecy. We will not only clearly delineate the timetable through the local media as to what that construction timetable will be, but also have a number of people from the local community on a committee following it through day by day, week by week. I am sure the local member will have access to many of those people.

The CHAIRMAN: I have been invited, have I?

Dr K.D. HAMES: The local member will have access to those people so that he can get details from them on how the development is progressing.

Mr R.H. COOK: I have a further question. The minister might not have information about the draft business plan, but we do. The draft business plan from the Department of Health currently reflects a costing of between $196 million and $230 million. When did the minister intend telling the people of Albany that he had allocated enough money for only half a hospital and that he is intends to pay for the rest of the hospital on the cheap or on the promise that he will find some resources somewhere, hopefully from the private sector?

Dr K.D. HAMES: The member referred to a figure that went from $196 million to $230 million, and he said that was a doubling of the original cost. If the starting figure is $196 million, it is obviously not double the original cost. The range that the member for Kwinana is talking about is a lot different, and I do not intend to state that range publicly. The reality is that if we in government can put in $135 million—which was a far greater amount than the previous government committed to—and from that get a hospital that will be the second-largest hospital outside the metropolitan area of this state, then we will have achieved a great deal, and certainly more than the previous government achieved with a bare patch of land that still has nothing on it.

The CHAIRMAN: I have a further question. The minister just said that the former government did not commit anything. It committed $100 million, plus $68 million for the second stage, which is about $32 million less than $196 million. I want to know also where the bare patch of land is that the minister referred to, because the previous government intended to build the hospital on the site on which it is being built now.

Dr K.D. HAMES: I will seek some additional information from my advisers. I might have last year's *Budget Statements* with me and I will look up how much the previous government committed.

The CHAIRMAN: This was an election commitment.

Dr K.D. HAMES: Sure. I am certain that the amount that was committed by the previous government was less than the $135 million that we committed. I will stand corrected if that is incorrect, but I will check those figures to see what was actually in the previous government's budget. I have last year's budget before me—2008-09—which shows that the previous government had committed only $44 million. I do not know what the previous government thought it would get for $44 million; however, that budget was far less than this government will produce. Increased election commitments were made just prior to the election, and I know that additional funds were added, but my understanding is that the amount that was put in the budget just before the election did not add up to $135 million. If I am wrong, I shall apologise and send the local member a letter of apology.

The CHAIRMAN: No, just a word of apology will be all right.

Mr R.H. COOK: I have a further question. I will assist the minister and his advisers by telling them that prior to the last election the Labor government committed $160 million towards the project and intended to complete it

by 2015. I will return to the issue, which is not a lesson on political history. I will repeat the question. The minister has committed $135 million towards the building of this project. At no stage prior to the election did the minister say that there would be a private component to the project. In fact, the minister promised the people of Albany that the first stage of the new hospital would be built by 2012. At what point did the minister intend to tell the people of Albany that he would go out and seek help from the private sector to fund the unfunded components of this project?

Dr K.D. HAMES: We said that we would build a public hospital. The hospital will be a public hospital and will provide all the services that public hospitals provide. It is quite common in the development of any public hospital to have some services provided by the private sector. I have never made a secret of the fact that we might require private sector involvement in this process, and that is just commonsense to do that. It is a good use of public funds when we can leverage that funding against the private sector to provide those additional services. Not only that, it also provides significant opportunity for people in the Chairman's (Mr P.B. Watson) electorate who might provide some of those private services outside the hospital to actually be involved in providing them at the hospital. However, in the end it will be a public hospital. If we can gear our $135 million to provide a service that is valued at upwards of $200 million, we will have done a great service to the local community.

[2.20 pm]

Mr A.P. JACOB: I refer to the national healthcare agreement and national partnership agreements on page 164. Can the Minister for Health please provide a breakdown of the budget items for the $117.4 million of state funding committed to the Indigenous national partnership agreement?

Dr K.D. HAMES: The extra $117.4 million provided by the state government is in response to the Council of Australian Governments' agreement with the commonwealth government. It is attached to significant federal government dollars to assist in Aboriginal communities. There are a number of components to that $117 million, which is all about closing the gap in Indigenous health outcomes. In primary care services an additional $35.35 million over the next four years will go to programs such as men's health networks, the Medina primary access program, multidisciplinary teams of medical services to go to remote communities, the enhanced chronic ear strategy, community health, Aboriginal chronic disease, and the like. There is $20.58 million for the "fixing the gaps and improving the patient journey" initiative, a lot of which is simply improving the way in which Aboriginal people can access health programs. For the "Making Indigenous health everyone's business" initiative there is $9.78 million. I say that these programs were not specifically established by the government; they were established in meetings between our Aboriginal health officers and the commonwealth government. There is $6.95 million to tackle smoking in Aboriginal communities. The $44.78 million for the "healthy transition to adulthood" initiative is a significant amount of funding for things such as supporting Indigenous youth, the juvenile community transition program from prison to the home, teenage maternal and child health, statewide Indigenous mental health services, nutritional and community health, and collaborative Aboriginal youth mental health initiatives. Therefore, I think members will agree that this $117 million is a significant amount of funding and that is just for those specific areas. Of course, there are also many other areas in which the health department provides services to Aboriginal communities. We have a critical task in narrowing that gap of nearly 20 years' difference to ensure that we provide the services that are necessary to Aboriginal communities.

Mr R.H. COOK: I want to draw the committee's attention to the asset investment program on page 179. There is an omission from the country health service in that it does not detail that the redevelopment of Carnarvon Regional Hospital has now been cancelled. I wonder whether the minister could provide us with some information on, firstly, the justification for the cancellation of the redevelopment of the Carnarvon hospital and, secondly, the net savings in relation to that?

Dr K.D. HAMES: The reason it does not appear is, obviously, because those funds have been deleted from the program. It was an unfortunate experience that we had to go through programs that had been committed to and find savings in the capital works program because of the huge financial problems that are being experienced not only in Western Australia, but across Australia generally. Therefore, a significant reduction in funds was needed to allow the government to, in fact, focus on a significant increase in funding for specific areas, including the commitment to Princess Margaret Hospital for Children, the patient assisted travel scheme, the Royal Flying Doctor Service and other schemes that will certainly assist country people. We must remember that the funding deleted from the program was not happening next year or the year after, other than for $200 000. It was not happening the year after that—in fact, it was only $757 000. The major funding for that project would have been in 2012-13, so it would not have been until that time that the Carnarvon community got that funding. The total amount that has been deleted is $6 million.

I must say that I would like the project to proceed in future and there are two options. The first option is that we can look to future budgets outside the current forward estimates to reinstate that funding. The other option is to look to the royalties for regions funding program to see whether in future years we can find the money within that program. That will depend, of course, on whether the royalty income for the state goes up or down. Our view is that the state's royalty income will start to go up again and will provide additional funding to allow us to do projects such as this one that we have had in the budget. This project has been in the budget for some time and we hope that we can get it back again.

Mr V.A. CATANIA: My question refers to the Carnarvon hospital redevelopment stage 2, which the government has cancelled. The previous government had that redevelopment project in the forward estimates and it had provisions for a public dentist to be included in that project. Will the minister put a public dentist in Carnarvon any time soon? I know the health minister said that royalties for regions could pay for stage 2 of the hospital redevelopment. However, in questioning the Minister for Regional Development on the grain rail network the other day, he stated that the grain rail network was core government business and therefore royalties for regions should not fund that rail network. Is the health minister of the view that core government business is to deliver health, education and police services? Does the minister believe that core government business includes delivering health services such as Carnarvon hospital stage 2 or hospitals in general, and doctors, nurses and also dentists in regional Western Australia?

Dr K.D. HAMES: It is a good question and I can relate it somewhat to the issue that the member raised the other day with the Minister for Regional Development about mattresses and equipment in hospitals. It is a bit like schools, I have to say. In my electorate one of my schools needs an administration upgrade. That is core government business and yet the school waits on the list. Communities and schools need libraries, but they wait on the list. The projects that are most important go to the top of the list and the others miss out. The recent commonwealth funding for schools has allowed those schools to catch up on areas that they would otherwise not have received funding for. I put this project into a similar category. Although stage 2 of the redevelopment of Carnarvon hospital is something that members would normally expect the government to provide—and government eventually will provide—it competes with a range of other demands throughout the regions. I put forward as one of my requests for additional funding to the commonwealth government increased funding for Aboriginal health clinics throughout the state where there is a desperate need for increased funding. We simply cannot fund everything and we cannot fund it all at once. Therefore, if the royalties for regions program has funds that can take up where routine funding is not available, I think it is a legitimate use of the money. What is the royalties for regions money there for? It is there because people in the country were bitterly complaining that the government of the day was not using the funding that it obtained to provide for regional services. The member is saying that now we have that money through the royalties for regions program to provide for regional services that previously missed out, but somehow that is inappropriate. Of course it is appropriate for royalties for regions to fund things that we do not have the capacity within our budget to fund.

[2.30 pm]

Mr V.A. CATANIA: The Minister for Regional Development will not fund the grain rail network because he says that that is core government business, yet the Liberal Party made an election commitment to provide $10 million for Nickol Bay Hospital. That has now been rebadged as royalties for regions. I find that quite remarkable.

The CHAIRMAN: Member, we are not talking about royalties for regions. Can we return to core business, please.

Mr V.A. CATANIA: The government has allocated $10 million for Nickol Bay Hospital—$3.6 million for 2009-10; $3 million for 2010-11; and $3 million for 2011-12. Can the minister tell me the breakdown of that spending—what proportion will go to housing, what proportion will go to redevelopment of the hospital, and what proportion will go to future redevelopment of the hospital?

Dr K.D. HAMES: I have only just managed to glean information for the last question! Perhaps I can briefly answer that question first, while my advisers retrieve the information that I know is there to answer this question.

The CHAIRMAN: I am sure that the minister can do two things at once!

Dr K.D. HAMES: The government is looking to funding from the commonwealth government to provide the dental health service. It is not normally the responsibility of state government, but we wanted to provide increased opportunities for dental treatment in that community. Under the current commonwealth government

scheme people with dental problems can go to a private dental practitioner—there is one in Carnarvon—and be subsidised by the commonwealth government.

Mr V.A. CATANIA: It is stretched to the maximum patient capacity.

Dr K.D. HAMES: I understand that. We are looking at additional funding through the commonwealth government, and we are looking at the option of dental facilities in Carnarvon to be funded as part of that program. We recognise that there is increased demand, and the Centre for Rural and Remote Oral Health currently provides additional visiting dental services to Carnarvon.

Mr V.A. CATANIA: Once a year.

Dr K.D. HAMES: I return to the member's question about the breakdown of funds for Nickol Bay Hospital. I do not accept the member's concern that the government is somehow cheating the electorate because we decided to put forward $10 million as an election commitment under the royalties for regions program. We are a coalition government.

Mr V.A. CATANIA: This is a coalition government?

Dr K.D. HAMES: The National Party put forward a policy and the Liberal Party put forward a policy, and we have married the two. That is a quite legitimate use of the money. The fact is that money was not going into regional centres in adequate amounts under the previous government, which is why the Labor Party lost so many votes in regional areas to the National Party, as did the Liberal Party.

Mr V.A. CATANIA: Not in North West.

Dr K.D. HAMES: The reality is that there is strong support for that funding. The breakdown is $7 million to provide —

Mr V.A. CATANIA: No, the question I asked was about the $3.6 million that the government has allocated for 2009-10, the $3 million allocated for 2010-11, and the $3 million allocated for 2011-12. Can the minister give me a breakdown of the proportion of those amounts for each year going to housing, redevelopment of the hospital, and future planning?

Dr K.D. HAMES: I refer the question to Mr Snowball.

Mr K. Snowball: In respect of the $3.6 million, the majority of master planning for the breakdown of funds will take place in 2009-10. The master planning will be for not only Nickol Bay Hospital, but also the role of the hospital within the broader West Pilbara. The second component, which is support from King Edward Memorial Hospital, will also commence in 2009-10. We are actually looking at the costs; what went into the budget was an estimate. We are working on getting the model right for Nickol Bay Hospital with support from King Edward Memorial Hospital for practitioners so that if we fall short of caesarean section cover, as we did in 2007, we will have reliable and quick backup for that service. The third component is housing. Staff housing is a priority for us, as I am sure the member is aware. We seek to make spot purchases and to undertake a development, and we are looking at options on the hospital site and within private developments that have already been established in Karratha.

Dr K.D. HAMES: I would like to add something to that if I may. Further to the issue of housing, these funds will in effect purchase only two houses, but we have much bigger plans for Department of Health staff housing. When I was Minister for Housing in the former Court government, I put forward a request to the then Minister for Health for Government Regional Officers' Housing—which was the Government Employees' Housing Authority at the time—to take over the provision of Department of Health housing. My view was that the housing provided to teachers and police was better than the housing that was being provided at the time to health workers. I have to say that my view on that has not changed significantly. We are now exploring that prospect. As the member will be aware, the Minister for Housing and Works is making available a significant amount of funding for public housing. My hope is that health will be a significant beneficiary of that money, in addition to the $10 million, for the total management of health housing, and, hopefully, it will also benefit a number of areas in the member's electorate.

Mr V.A. CATANIA: The minister said in a media statement that of the $10 million that has been allocated, $7 million is for housing, $2 million is for obstetrics, and $1 million is for future planning. Can the minister please provide me with a breakdown for the years I referred to—2009 to 2012? As accommodation makes up a large component of the $10 million, and not a lot of money is actually going to the hospital for upgrades, can the

minister please provide, perhaps by supplementary information, a detailed breakdown of spending for the amounts of $3.6 million for 2009-10, and $3 million each for 2010-11 and 2011-12?

Dr K.D. HAMES: I cannot do that, because those figures are not yet available. The member will understand that we are looking at options for housing, whether to purchase, lease or rent, and those specific figures have not yet been determined. We have determined exactly the cost of the obstetric service backup and the plan, so one would expect that the planning for forward funding would come out over the next year or two, because that is when that planning will be done. The other areas are as yet fairly flexible, and that detail will not be known until we have the final details of what is going to be done. I am very keen to ensure that obstetric services do not become the last component of the $10 million in funding, and that the money is not entirely spent on housing, thus leaving obstetric services until the fourth year. I want the obstetric services to be put in place as quickly as possible. The rest will flow on outside that.

Mr V.A. CATANIA: The minister has stated that the government is a coalition between the Liberal Party and the National Party, and that $7 million of the $10 million will be allocated to housing. The National Party made an election commitment to provide new houses and free rent for teachers, nurses, police and essential workers. Will the government uphold the National Party's commitment to provide free rental housing for nurses at Nickol Bay Hospital?

[2.40 pm]

Dr K.D. HAMES: I have seen questions go backwards and forwards from members opposite, with copies, through me, to the Minister for Regional Development about that very issue. Am I allowed to mention names of upper house members?

The CHAIRMAN: Yes

Dr K.D. HAMES: One being, I am sure, from Hon Adele Farina. A letter fully details what the Leader of the National Party's commitments are on behalf of the National Party. Provided the member opposite who receives those answers —

Mr V.A. CATANIA: Yes or no—will there be free rent for nurses?

Dr K.D. HAMES: I will be very happy to get that letter for the member.

Mr M.P. WHITELY: I refer to the fourth dot point on page 180. It makes reference to implementation of the initial components under the ICT strategy, which include —

Dr K.D. HAMES: Sorry; I have not got the page yet, member.

Mr M.P. WHITELY: It is the last dot point on page 180 —

> implementation of the initial components … under the ICT Strategy, which include the Pharmacy Management System and Patient Administration System.

I am aware of a project that requires half a million dollars in funding to enable better sharing of information between doctors and pharmacists relating to schedule 8 prescriptions. Is that what the dot point is referring to, or is it something else? If it is not covered in this dot point, is it covered elsewhere? I believe the funding is in the order of half a million dollars to have better sharing amongst pharmacists and doctors of histories of individual patients who are getting schedule 8 drugs. Is that covered under this system or is it somewhere else in the budget?

Dr K.D. HAMES: I am going to hand that question over to someone else. I do not know. Like the member, I have watched programs on TV showing what is happening in other states. In fact they tested it here—people going from hospital to hospital to get pseudoephedrine and turning it into ice. That is a significant issue that needs to be resolved. I do not know the answer to the question. I ask the director general, Dr Flett.

Dr P. Flett: The information and communications technology program for health is a $326 million program that covers many aspects of IT across the health service. Included in that is a pharmacy management program that is to be rolled out later this year. The management program is very much an internal program for the health service itself. It is the beginning of a much bigger pharmacy program across health in later years, which would incorporate the types of things the member describes. However, the immediate program is purely an internal back-of-house management program; that is, the first step only. The overall ICT program is a 10-year program.

Dr K.D. HAMES: I will add to that. Obviously, the answer is no; it does not cover those pharmacies the member is talking about. After watching a program on TV, I understand it is a federal responsibility to call in

pharmacists in relation to the transference of information. It is obviously an area of concern. Despite the responsibility of pharmacists falling within the federal domain, I had planned to raise it at our next ministerial conference with the federal minister. It is certainly something we have got to resolve. From all appearances, the proper transfer of information from one pharmacy to another is not occurring and that is allowing people to go out and buy drugs of that sort without proper checks.

Mr M.P. WHITELY: My understanding of it is that it is ready to roll. I am happy to share this information with the minister outside this place. The only barrier is half a million dollars in funding. Whether that funding comes from a state or federal source is a question we can talk about later.

Mr R.H. COOK: I refer to a statement made this morning by Commissioner Len Roberts-Smith.

Dr K.D. HAMES: Sorry, what page?

Mr R.H. COOK: It is further to the previous question. The commissioner talked about a dramatic rise in notifications from the Department of Health in relation to drug theft. The suggestion was that notifications have gone from 35 to 250 a year of schedule 4 and 8 drugs being misappropriated. Was the minister aware of this dramatic increase; and, if so, what did he do to reverse the trend?

Dr K.D. HAMES: I have only just become aware of that today. We have sought an answer. The director general has a response to that.

Dr P. Flett: I also have only just become aware of this report today. The Department of Health has a corporate governance framework that was put in place three years ago with the express purpose of monitoring the behaviour of staff across all aspects of health. Among that program was the monitoring of drugs; or, in this case, the finding that the count in drugs was discrepant. With this corporate governance, we have a formal reporting process through to our department and then ultimately through to the Corruption and Crime Commission. There have been reported circumstances within that process whereby drugs have been identified as missing. The member is correct; we are conscious of the fact there has been a substantial increase in reporting. Every one of these incidents is then investigated internally as well as being reported to the CCC. This figure has come from a base of zero—there was no such reporting process in the past. It monitors the 37 000-odd people who work for the Department of Health. Associated with this reporting is a very detailed education program about the process of misconduct within the health department. I am not suggesting that every one of these reported incidents is an example of misconduct. In some cases, the reported incident might involve one tablet or one ampoule missing. We are not talking about packages and volumes of drugs missing in that form. It is something that is of concern to us. It is now an ongoing and permanent process within the health department. It is not something we are starting up for a period and then stopping. It is a permanent part of the health department. It addresses not only drugs, but also bullying and people's behaviour throughout the health department.

Mr R.H. COOK: Minister, obviously this issue goes to the heart of security arrangements around drugs held by the department. Are we talking about a magnitude of drugs here whereby people can be using these to process or on-sell? If we are talking about the issue of security around drugs, what changes are being made, now that the minister has known of this trend for two years, around the question of security of drugs in hospitals?

Dr K.D. HAMES: There are very strong and strict procedures in our hospitals at present to deal with upper-end drugs—schedule 8 drugs with morphine, pethidine et cetera. There are very strict requirements in hospitals for proper accountability of those drugs. I have not yet seen any suggestion that the drugs we are talking about here relate to these high-end drugs that may well be used by drug addicts and the like. Whatever those drugs are, it is a significant issue. It may well be that some of them are schedule 8 drugs. We have put a new process in place, as the director general has reported, that involves the proper recording and reporting of those incidents. It is not necessarily that suddenly there are 260 notifications and there was not last year or the year before, but now that we have got this procedure in place they are being reported. Yes, I do take it very seriously, particularly to ensure that there is no consistent taking of drugs and their use for other purposes; particularly amongst drug addicts. I am very pleased that the CCC is involved. It will have ultimate responsibility for a full investigation but we, as a department, will continue to follow each and every individual case through to find out what it is and what has been taken.

[2.50 pm]

Mr R.H. COOK: Have the three per cent cuts—or efficiency dividend—affected the security numbers in hospitals, and could there be an implication for the security around drugs in hospitals?

Dr K.D. HAMES: We do not have the full details on when this review was started, but I understand that it has been going on for the past two years. Obviously, that investigation has been underway for some time.

Dr P. Flett: It is an ongoing investigation.

Dr K.D. HAMES: This is something on which the information has just become available. We will take all steps to investigate the reason for these events.

Mr R.H. COOK: My question was: have the three per cent cuts affected the level of security around drugs in hospitals?

Dr K.D. HAMES: I will ask Dr Flett to respond.

Dr P. Flett: No, not at all. That has had no impact on that whatsoever.

Mr W.R. MARMION: My question relates to the first dot point under the third heading, "Indigenous Health", on page 164, and I refer to the sixth or last hyphenated point, which refers to Indigenous people's access to health services. My question is specifically about maternal and child health initiatives. I am wondering what the minister has planned for those areas to improve the life outcomes of Indigenous people.

Dr K.D. HAMES: I thank the member. In attempting to close the gap, the commonwealth and the state have agreed on very strong efforts, particularly to address maternal and child health. There are two components to the way in which this issue has been addressed. The National Partnership Agreement for Indigenous Early Childhood Development has come out of the Council of Australian Governments. There are three elements to it. The first is being coordinated by the Department of Education and Training, and that is a whole-of-government effort to reduce mortality rates and improve Aboriginal children's education by integration of the community and health services at five WA children and family centres. That is one of the early first steps. The second and third elements are being led by the Department of Health. The second element will increase access to antenatal care during pre-pregnancy and teenage sexual and reproductive health services. They are very important aspects. The commonwealth will commit $17.12 million to that over the next five years. The third element will increase access to, and the use of, maternal and child health services by Aboriginal families. That is a critical area, and it is one in which I believe Western Australia has fallen a long way behind the other states in the level of its maternal and child assessments. Western Australia will commit $11.25 million over five years for that particular element.

Mr T.G. STEPHENS: I want to go back to the areas that were covered in earlier questions by the members for Albany and North West.

Dr K.D. HAMES: Which page?

Mr T.G. STEPHENS: It is page 181. My question is about the budget allocations to regional hospitals, and it deals with this specific issue. In the minister's earlier answers, he saw no problem associated with the health department essentially withdrawing its priority of focusing its funds on regional Western Australian communities, and relying on funding from the royalties for regions program to do whatever it is going to try to do with the Albany, Carnarvon and Karratha hospitals. I heard the minister's answer, but I wonder whether his answer was drawing on his own previous experience of portfolios, and specifically his current experience of the Indigenous affairs portfolio. If the government vacates the turf in a core agency and leaves a quarantined packet of siloed funding as the only source of funding to pick up the response to the regional communities, will those communities not be disadvantaged? Is that not on display in the absence from this list of funding for the much-needed upgrades to the Tom Price, Paraburdoo and Newman hospitals that are missing from the minister's list, presumably because they do not have the priority of the health department and the bucket of money for royalties for regions has already been blown by having to buy things for the Pilbara such as mattresses, beds, disinfectors, lamps, trolleys and other items that, if they were in the metropolitan area, would be construed, reasonably, as the core responsibility of the health department?

Dr K.D. HAMES: I am very pleased for the opportunity to answer that question, because it is a good question, but there is, in my view, a good answer. If the member were still the Minister for Housing, as he was in the previous government, he would love royalties for regions, because it provides the government with the opportunity not just to fund those things that it was funding before, but also to have access to significantly increased funds through royalties for regions to do things that it would not otherwise have money for.

Mr T.G. STEPHENS: We used to put beds into regional hospitals.

Dr K.D. HAMES: Mr Chairman, can I get some protection from you, if possible, so that I can answer the question?

The CHAIRMAN: Member for Pilbara, the Minister for Health needs protection.

Dr K.D. HAMES: I will deal with the specific items, such as mattresses and the like, that were funded. I accept that that would normally be the responsibility of the core level of government, as it is in the metropolitan area. The funding for equipment that was left to us by the member's government is in the order of only $50 million to $60 million a year. That funding covers mattresses in the metropolitan area, beds, sphygmomanometers and stethoscopes. It covers all that equipment in both the metropolitan area and the country. I sought extra funds under the royalties for regions program for areas that have fallen behind in the past eight years. We expected the funding to be there, but it was not, for a variety of reasons. I do not want to have a go at the former minister for not funding that, because he funded many other things. He funded the Port Hedland hospital, and hospital upgrades at Broome, Derby and so on. He put funding into those areas. However, the issue is recurrent funding, and there obviously was not enough to go around. The member talked about taking an isolated bucket of money from the royalties for regions program. If it is recurrent funding, it is not an isolated bucket. If they are recurrent funds, they come out of the budget forever and a day. If it is a capital investment, as it is with the mattresses, sure, that funding covers that. However, we are $34 million short of funds for equipment in country regions. Outside the metropolitan area, there is a $34 million shortfall.

I will deal specifically with the communities in which the member said the hospitals need to be upgraded. They were not in the budget under the member's government. We have not cancelled those; we have not deferred them. Funding for those hospitals was just not in existence in the 10-year forward estimates of the member's government. That is not to say that the funding is not required. However, those upgrades find their way to the top of the list, as do other projects. The same thing that happened under the previous government is happening under our government.

Royalties for regions gives us a great opportunity. The member says that that funding was already in our budget. We made election commitments to fund various projects. It was planned that they would be funded from the three per cent efficiency dividend. The three per cent efficiency dividend was earmarked to go to all those election commitments. When we came to government and formed a coalition, a significant amount of royalties money had to be found, in addition to funds for commitments we had made during the election. Of course, there had to be a balance in the funding—where it would come from and where it would go. Whichever way it went, we were committed to that component of our election commitment. The funding that has gone because of the three per cent efficiency dividend that would have funded Nickol Bay Hospital may well be going to fund other programs in rural or metropolitan areas—other programs that we would not have otherwise been able to afford.

[3.00 pm]

Mr T.G. STEPHENS: I have a further question. Does the Minister for Health think that these budget papers, and his answers to questions about them, indicate that, in the area of health, the minister does not get his department to give the needs of regional communities, whether mainstream needs or the needs of the Indigenous community, sufficient priority to get up to the level of receiving a response from state Treasury? Therefore, these regional communities are copping it. The minister relies upon commonwealth funds to meet the needs of the Indigenous community—this is also a discrete, quarantined set of funds—and in the other and wider interests of the regional communities, the minister is now almost entirely dependant upon the royalties for regions program before anything can be done. Instead of treating regional Western Australia as though it were to be met with the same priority as, for instance, the capital expenditure required to look after the head office of the Department of Health, regional funding drops down to the bottom of the pile and can only get funded for basic things like disinfectors, beds and mattresses if it can come out of this limited royalties for regions program. If those things are correct, that leaves the minister facing a charge of not being responsive to the needs of regional communities—the Aboriginal and wider communities—to get the budget priority that they are entitled to.

The CHAIRMAN: I give the call to the minister.

Dr K.D. HAMES: To start off with, I will read out the change to the WA Country Health Service budget. Under the previous government's budget, it had funding of $609.9 million for the 10 months to 30 April 2008, and under the current government it has a budget of $687 million for the 10 months to 30 April 2009.

Mr T.G. STEPHENS: Is the minister including the royalties for regions money to get to that figure?

Dr K.D. HAMES: I do not know the answer to that. Let me answer the member's question specifically. I do not accept the tenet that the member put forward—that those services are not prioritised. We have made a strong

commitment to country services, both through our own funds and through royalties for regions funds. Those commitments to the Aboriginal communities have been made not just through the Department of Health, but in conjunction with the commonwealth. We have also already detailed $117 million to Aboriginal services through the Office of Aboriginal Health.

Mr T.G. STEPHENS: Is that commonwealth money?

Dr K.D. HAMES: No, that is state money. There is a significant amount of further commonwealth funding as well as the $117 million of state money over the forward estimates, but there also has been a significant increase in funding through both the commonwealth and the state for Aboriginal housing. There is a whole range of services available, such as those through the Ord Valley Aboriginal Health Service. Many departments, through different ministers—I do not have all the specific details—have had significant increases in funding that will go to rural and regional Western Australia.

Mr T.G. STEPHENS: I have a further question. Minister, is this lack of priority for regional communities not also illustrated in the absence of a universal neonatal hearing test, which, if it was properly prioritised and funded by the health department at a cost $10 million, then babies born in regional Western Australia could get the same hearing test as a baby lucky enough to be born in metropolitan Perth? Why has the minister not yet fixed this problem, seeing that he is aware of it; and if he has not fixed it yet, when will he get on with it?

Dr K.D. HAMES: That would be an excellent question if I had not already answered it today in the member's absence. But I will repeat the answer so that it, very kindly, will appear twice in *Hansard*. A commitment was made by the former government, leading into the election, to bring in newborn screening hearing tests across this state.

Mr T.G. STEPHENS: That was out of existing resources.

Dr K.D. HAMES: That was a commitment that we matched.

Mr T.G. STEPHENS: That is probably why they cannot afford beds!

Dr K.D. HAMES: Very sadly, when we came to government and I looked into the budget and asked my staff how quickly the commitment made by the Labor Party was being rolled out, I discovered that there was no money attached to that election commitment.

Mr T.G. STEPHENS: So the government pinched it off the bed money!

Dr K.D. HAMES: We are now committed to the rollout of that hearing test. I have asked the department to instigate it, and a program has been brought forward to do that over the next four years. I have expressed that I am not happy with that time period for the rollout, and so we are considering getting funds from alternative sources at present to roll that out over two years. That is my aim.

Mr T.G. STEPHENS: It sounds like royalties for regions is going to cop another hit.

Dr K.D. HAMES: No, it will not be royalties for regions money. It was a commitment that we made going into government, as the former government did, and it will happen.

The CHAIRMAN: The member for Warnbro has the call.

Mr P. PAPALIA: Is the minister confirming that the government is intending to roll it out over two years?

Dr K.D. HAMES: I am confirming that it is already confirmed to roll it out over four years. What I am aiming to do, and hope to be able to achieve in the very near future, is bring that program forward so that it is rolled out over two years, not four. I am very pleased to tell members first. In fact, I hope that when the government provides the report to the Public Accounts Committee in response to the inquiry to which the member was a part as a coopted member, it will include the answer for that screening component. I forget the time frame in which we have to provide the report; the member will know better than I do. How long do I have respond to the report that was presented by the committee?

Mr P. PAPALIA: That is fine. I have a further question. The minister is aware of the committee's interest in that particular area, but I recall evidence given to the inquiry that is on the public record now—I will stand corrected if I am wrong—outlining that, given the funding, there is no reason why it could not be rolled out in two years anyway. The suggestion that it would take four years would tend to conflict with the evidence the committee received.

Dr K.D. HAMES: No, that is not the case.

Mr P. PAPALIA: I may be wrong.

Dr K.D. HAMES: I am not saying it was not the evidence given —

Mr P. PAPALIA: I do not want to verbal anyone.

Dr K.D. HAMES: — but there was no ability to do it. The estimated cost is $1.47 million per annum to implement the newborn screening early intervention program across all Western Australian public hospitals. That is the cost and I have to try to find $1.5 million over four years to implement that program.

Mr P. PAPALIA: Go to it, minister! More power to the minister.

Mr T.G. STEPHENS: On that same point, has the minister told the committee how he proposes to respond to the needs for the child health nurses to pick up the shortfall?

Dr K.D. HAMES: The member for Alfred Cove was in this place and asked that question, and I did respond in some detail. Perhaps I should direct the member to *Hansard*.

Mr T.G. STEPHENS: I will read it.

Mr C.J. TALLENTIRE: My question relates to page 172 of the *Budget Statements* and to palliative care. The question is in two parts. First, will the minister advise how much of the revenue is provided by the commonwealth government, and which programs and services will that funding cover? Also, will the minister advise on the progress of the Acts Amendment (Consent to Medical Treatment) Bill 2006 that was passed by the Parliament nearly a year ago; when can we hope to have that law proclaimed?

Dr K.D. HAMES: I will answer the second part first, because we are looking for the exact facts. I know it is National Palliative Care Week, and the Deputy Leader of the Opposition, the member for Gosnells and I were at a function at which the $14 million over four years that the state is providing for palliative care was discussed. I will get one of my advisers to provide more detail.

The Acts Amendment (Consent to Medical Treatment) Bill 2006—the member may not know because he was not in this place at the time—was a bill on which we had a conscience vote, and the former Minister for Health and I worked fairly tirelessly to ensure that we had strong support for that bill. It is very close to being put forward. We have been resolving some issues, related to the usual subject of funding, in terms of exactly what allocation is required to disseminate the information and to provide the training to the public. The final dollars are being nailed down now, and in the next few weeks I will be making a public announcement about that matter. We are checking how much is commonwealth funding and how much is state funding. We do not have available the split of that money. We will provide as supplementary information the detailed information on the $22.417 million listed as a cost of service for palliative care, and the break-up of what is the commonwealth and state funding and what programs it relates to.

Mr C.J. TALLENTIRE: Yes.

[*Supplementary Information No B27.*]

[3.10 pm]

Mr P. ABETZ: I refer to the item "Indigenous Health", which is dealt with on pages 164 and 165. Can the minister please explain the primary care initiatives, established under the COAG national partnership agreement, to be implemented by the Department of Health over the next four years?

Dr K.D. HAMES: I thank the member for that question. I have already referred to the $35.5 million that is part of the total package of funding from this state. This details the $35 million component of it, as part of the COAG agreement over the next four years. It will target five key areas. One is enhanced Aboriginal primary health care to make sure the primary health services being provided to Aboriginal people are adequate so that we get increased access for Aboriginal people and a much better uptake of services than we are getting at present. Part of that includes a commitment to much better assessment of the medical problems of Aboriginal people. That will be partly through screening programs, particularly blood tests, that the director general is keen to roll out across all Aboriginal communities, using single databases that record all the information—diagnoses, assessments and, particularly, management of chronic health conditions. We are getting complaints that people with chronic health problems are being sent out to die in the wilderness. The representative from the Aboriginal medical service in Geraldton is saying that prisoners with a respiratory disease, for example, whom the Aboriginal medical service has looked after in Geraldton, have been released from prison and have then disappeared into the western desert. They are, in effect, sent home to die. Mr Davies is one of the member's staunch Labor colleagues, and I will be meeting him in the next few weeks.

Mr R.H. COOK: He is happy to meet anyone.

Dr K.D. HAMES: He will abuse us both, I am sure. At least I am meeting him, which is something the former minister did not do, much to Mr Davies' great consternation

The second issue is the Aboriginal men's health network, and the plan to increase access to primary health care services. There is also the Medina Primary School primary care access project, which is for children from four to 12, and again, it increases their access to local community services. I will ask Mr Wyatt to get ready, because I am going to ask him to make further comments about the program he is developing. The next key area is the Wangen Murduin Aboriginal health brokerage model, which is a culturally appropriate referral and care coordination service. The last key area is partnering Aboriginal community-controlled health services. This is a significant area in which we are expanding our services to get better access for Aboriginal people to proper, regular medical care as a way of closing the gap. I will hand over to Mr Wyatt, who is from Aboriginal health services, to provide further information.

Mr K.G. Wyatt: The strategy will engage the divisions of general practice and general practitioners right across the metropolitan area initially to look at the way we access Aboriginal clients and Aboriginal communities to get them into pathways of primary health care. That will also optimise opportunities through nurse practitioners, who will have prescribing rights. The Medina project is to do with the capacity of Aboriginal clients in that area to travel outside the region. In this instance, we have negotiated with the divisions of GPs and local GPs to provide a service through the school that will enable disadvantaged Aboriginal families who have many young ones to cater for in that context to have better access to GPs. The partnering with GPs and with Aboriginal community-controlled health services will give a significant advantage in ensuring that the complex co-morbidities that develop in adult life will be diminished if we focus on those early years. Certainly, by coupling that with the WA men's health strategy we will start to identify those who need better access to the pathways of health care.

Mr R.H. COOK: My question relates to page 172 of *Budget Statements,* volume 1.

Dr K.D. HAMES: We need to relate to the papers before us. We are dealing with division 11, starting at page 161.

The CHAIRMAN: No, we are not, actually. We are dealing with services 1, 3, 4, 5, 6, 7, 8, 9, 10, 12 and 14.

Dr K.D. HAMES: What happened to division 11, which I have before me and which is the budget for WA Health, which number you just missed, Mr Chairman?

The CHAIRMAN: No, that is division 11.

Dr K.D. HAMES: Mr Chairman left it out.

Mr R.H. COOK: That is all we are dealing with.

Dr K.D. HAMES: The chairman left division 11 off the list.

The CHAIRMAN: It was service 11, which was dealt with by the Minister for Mental Health, Dr Jacobs.

Mr R.H. COOK: It is all division 11, but there are different service areas.

The CHAIRMAN: The areas we are asking questions on now do not include service 11. We have dealt with service 11.

Dr K.D. HAMES: There is a page relating to services —

Mr R.H. COOK: That is correct, but I am referring to service 5 on page 172.

Dr K.D. HAMES: That is not what the member said.

Mr R.H. COOK: It is what I said.

Dr K.D. HAMES: Item 5 on page 172, "Emergency Department"—I am sorry if I misheard.

Mr R.H. COOK: Yes, I am referring to the emergency department. This may be a point of clarification. The budgeted net cost of services for 2008-09 was $145.8 million and the actual net cost of services is $81.9 million for 2008-09. I assume that is because we have an injection of $76.4 million from income, which I assume is commonwealth funding. The question is: what happened to the $63.8 million that is outstanding; what was that money spent on?

Dr K.D. HAMES: I understand the question. I am wondering who will answer it for me. As the member can see, the total budget has progressed steadily. However, $76 million has been funded out of that total income, which is the commonwealth funding. I ask Mr Leaf to answer the question.

Mr J.W. Leaf: At the bottom of page 172, note 1 reads —

> Funding of $75.3 million for the five year Emergency Department program as part of the COAG Hospital and Health Workforce Reform National Partnership Agreement was allocated up-front by the Australian Government in 2008-09.

The member has referred to a large revenue item in one year, which actually covers expenditure that will be incurred in future years. A lot of that funding is directed towards the implementation of the four-hour rule across our hospitals. It is the $75.3 million that comes from the Council of Australian Governments.

[3.20 pm]

Dr K.D. HAMES: I asked this question myself when we were discussing this. It is quite confusing. We have spent the $158 million through health on providing this service. However, we have not spent the $76 million just because of the accounting procedures and the way Treasury operates. Because that money has arrived this financial year, I have to list it as an income. In fact, that $76 million is sitting there ready to be spent in the next financial year under the four-hour rule. I agree with the member that it is confusing and somewhat silly. It really looks as though we have spent considerably less money on the cost of service for this year than we have, but it is not so. We have spent $158 million on management of our emergency services, and now $76 million has appeared in the bank from the commonwealth to fund future services, and that will be used, in effect, for the four-hour rule. We have discussed the expenditure of this $76 million with the federal health minister, Hon Nicola Roxon. It will largely be spent in the metropolitan area but some will be spent in the country, in particular on a proposal to significantly expand the Bunbury emergency department. We are seeking from the minister the opportunity to use a component of that $76 million to fund the expansion of that ED. The rest will be used in our own hospitals to do with the four-hour rule—to fund the additional equipment and wards needed to implement the four-hour rule. I know that sounds as clear as mud.

Mr R.H. COOK: To clarify, is this capital funding or is this recurrent funding under the four-hour rule? I assume we are now talking about the $76.4 million. Will that money be spent solely on emergency departments?

Dr K.D. HAMES: Yes; that money is provided as a one-off capital injection from the commonwealth. All states were provided similar funding amounts on the basis of population, although our share was marginally less than that provided to other states on the basis of population—the usual 10 per cent. However, that funding has been provided by the commonwealth to use in EDs. We still have to account for it and we still have to work through the commonwealth on the expenditure of that money, but it is for EDs or matters relating to EDs. Members must remember that we are the first state in Australia to implement the four-hour rule, albeit I have to say that I think the other states will follow our lead. We have discussed with Hon Nicola Roxon opportunities for the way in which we can use those funds to implement the four-hour rule. It may be that we need to establish a ward away from the emergency department, with senior doctors managing the flow-through out of the EDs to remove the pressure of patients sitting in EDs waiting for assistance. Ms Roxon has suggested that she would be quite comfortable with us doing that by providing additional services in the emergency departments or in some instances by way of providing additional wards attached to the EDs, which will allow staff to deal with ED patients.

Mr R.H. COOK: Minister, I am confused about why that $76 million is treated as income and therefore, I assume, as part of consolidated revenue. Why is that money not in the capital account and appearing under a capital works program, if indeed we are talking about a capital expense rather than a subsidy to recurrent funding?

Dr K.D. HAMES: I will ask Mr Leaf to give the answer he gave me.

Mr J.W. Leaf: I will start by saying that no-one disputes the commonsense of the proposal the member has put forward, which argues that the revenue stream should be matched to expenditure because the expenditure will be incurred in future years.

Mr R.H. COOK: Particularly as it is capital expenditure and not recurrent, as this would suggest.

Mr J.W. Leaf: I understand that it is a mix of capital and recurrent funds. How that money is spent is, to a large extent, at the discretion of the Western Australian program, so long as we can account to the commonwealth for the proper discharge of our responsibilities. I will just explain why it is accounted for as it is. The answer is quite simple. A convention of the financial management acts and the accounting standards is that revenue received in a particular year is accounted for as revenue in that year. It is really a non-negotiable financial accounting requirement.

Dr K.D. HAMES: Further to that, Mr Chairman, Miss Lawrence is responsible for the actual implementation of that four-hour program and, in fact, for the expenditure of that money. Perhaps I could ask her to provide an additional response.

Dr R. Lawrence: The funding is a one-off lump-sum payment coming to the state, so although it is not tagged purely as capital or recurrent, we are very cognisant that it is one-off funding and therefore should not be allocated against recurrent resources to be applied in hospitals. We have cash-flowed it over the four years to support the implementation of the four-hour rule program as well as several other one-off capital initiatives, such as the Bunbury ED, which has already been mentioned.

Mr A.P. JACOB: I wish to defer my question to the member for Nedlands. Am I able to do that?

The CHAIRMAN: The member can, but as he is deferring, I will go back to the member for Kwinana.

Mr R.H. COOK: I have a further question about emergency departments about which I have provided some notice. Can the minister please provide an employee category breakdown of the 2009-10 budget target of 1 561 full-time equivalent staff? Will the minister outline the budget assumption behind the full cost impact of adding an FTE in this section? Will the minister outline the budget assumption behind the full cost or savings impact of removing an FTE in this section? Will the minister provide the following information: the actual head count derived from the approved FTE complement in this section for 2008-09; the actual head count derived from the approved FTE complement resulting from the 2009-10 budgets in this section; and the projected head count derived from the approved FTE complement in this section across the forward estimates? Has the public service FTE cap announced by the Treasurer affected the FTE numbers in this section? Will the minister outline policy changes or changes in service delivery that are being adopted, and how they account for the public service FTE cap? Which outcomes, services and performance indicators are affected by the FTE constraints, and in what way are the affected? Will the minister outline the projected impact of FTE reductions on public service equity targets within this section? What measures will be put in place to ensure that the equity targets are not compromised? In offering voluntary redundancies for this section, has the agency taken account of or been required to take account of the financial impact on the public sector as a whole of redundancies, resignations or retirements by public servants covered by earlier defined-benefit superannuation compared with those receiving market-linked superannuation?

Dr K.D. HAMES: We were given advance notice of these questions and I have a copy of the response. Rather than reading the two-and-a-bit pages of that response, perhaps I could table it.

The CHAIRMAN: The minister cannot table any documents, but I am sure that he could pass it across to the member or provide it as supplementary information.

Dr K.D. HAMES: We have it here; I am happy to hand it over to the member. I ask the clerk to provide this answer in writing to the member opposite.

Mr W.R. MARMION: I refer the minister to page 179, and to the first two dot points under the heading "North Metropolitan Area Health Service" in the "Asset Investment Program"; that is, planning for the new children's hospital at QEII and planning for the upgrade of parking and access roads at QEII, which is in my electorate. People already know that parking on the site is an issue. Given the expanded facilities for the QEII medical centre and the planned relocation of the Princess Margaret Hospital for Children to the site, my question is: what has been planned to address the current shortfall in parking and the expected increase in demand from the expanded centre?

Dr K.D. HAMES: I thank the member for the question. Obviously, it is an area of significance for his electorate and it is one we have spent a lot of time working on. I will make some comments, and then ask the north metropolitan health representative, Mr Russell-Weisz, to add his comments. The parking issues in those two areas are significant, and members will remember that in the lead-up to the last election some public meetings were held about the proposed expansion of Sir Charles Gairdner Hospital to 1 000 beds under the former Labor party model and the addition of roughly 240 or 250 beds for Princess Margaret Hospital for Children and for King Edward Memorial Hospital, bringing the total site bed numbers to 1 500. There were strong expressions of concern from local residents at those public meetings about that. The site studies had shown that there was not the capacity on the site to take that many people. We made the commitment that we would retain Royal Perth Hospital, which would obviate the need for 1 000 beds at Sir Charles Gairdner Hospital on that site. The maximum number of beds eventually under our plan will be 1 000 beds in total when King Edward Memorial Hospital comes across. However, there are issues with parking on that site and the Department for Planning and Infrastructure requires in any proposed development that the department consider the way in which parking

needs will be addressed. The department therefore has looked at alternative access roads and alternative costings—because people will have to start paying more for parking—and, particularly at the start, how to fit a new PMH on that site. We are committed to doing that and to addressing the parking needs. The way to do that, of course, is through multistorey car parks. We are therefore committed to constructing two car parks on the Sir Charles Gairdner Hospital site as well as providing a different access that will take the pressure off those local roads. We intend to initiate the construction of one car park in the near future and another soon after. Mr Russell-Weisz will talk about how many bays will be in each. Those car parks will be needed in advance of the construction of the new PMH, because car parking bays will be required for people during construction of the new PMH. Our initial focus therefore is to construct those parking bays as quickly as possible during the construction phase of the new children's hospital.

Another issue is Princess Margaret Hospital for Children, and in fact King Edward Memorial Hospital, which I think is also in the member's electorate. Both hospitals have significant parking issues. In fact, I was told by one nurse at King Edward that staff would be doing deliveries or be in theatre and have to duck downstairs and go outside to put money in the parking meters to avoid getting fined. We have been approached by Mr Newnham, who is looking after King Edward, to investigate a proposal for a multistorey car park associated with King Edward, and more particularly at PMH. There is a current multistorey car park that we could extend significantly. While that is being constructed, I have had meetings with the local council to see whether we can get an agreement to seal the land near the football ground where people currently park—it is the big open area next to the footy ground. If we can seal that land, which is between 50 and 100 metres away from the hospital, we could use it for parking for staff and perhaps for patients as well when footy patrons do not need it. We are therefore exploring all options. The issue, of course, is that there is a severe shortage of parking at those hospitals. Incidentally, there is a lot of parking in the multistorey car park at Royal Perth Hospital. Strange that! Is it not lucky that we kept it? We are dealing with the issues of parking at the other hospitals. All I can say is thank goodness that we did not proceed to expand Sir Charles Gairdner Hospital to a 1 500-bed location. I will ask Mr Russell-Weisz to make further comments about parking.

[3.30 pm]

Dr D.J. Russell-Weisz: We have done some extensive planning for the past four years. It actually started in 2005 with an extensive site restructure plan that recognised that there were significant issues at the site with parking. We then moved on to develop the master plan for the site, which is ongoing with the development of the new children's hospital. However, we recognised that there was severe congestion long before we developed these hospitals on the site. The Queen Elizabeth II Medical Centre Trust, along with the North Metropolitan Area Health Service and the current PMH, made some significant changes on 1 July last year. Those changes were aimed at facilitating patients, visitors and clinical staff to get on site. The clinical staff who could not get on site were shift workers, who had to get permits. Really, we stopped issuing permits prior to 1 July, and we will do the same this year. Parking is getting even tighter; therefore, people who work 7.30 am to 6.00 pm and who do not work on multiple sites or have special needs will get car parking at Graylands or Shenton Park only. Together with the QEII trust, we have put on shuttle buses running from those two sites. We have also developed a travel plan for the site and encouraged car pooling and other green commuter initiatives. There are therefore a number of initiatives going on at the site that are occurring long before the two or three multistorey car parks will be built. To give an idea of the number of bays we need, the current parking bays on site are for 2 600 employees and 700 patients and visitors. In stage 2, which is when we will have the new children's hospital and the Telethon Institute for Child Health Research, there will be basically two multi-deck car parks, raising the number of bays to 4 450; that will include parking for staff, visitors and patients. If and when King Edward comes on site, another car park will be built and the number of bays will increase to 5 320. However, clinical staff will continue to have priority for parking; we will continue to have in place all our rules and regulations to make sure that clinical staff, patients and visitors have priority over the nine to fivers.

Mr W.R. MARMION: The minister mentioned that there was surplus car parking at Royal Perth Hospital and I wondered whether the health planners—it may be too late now—had considered either Princess Margaret Hospital or King Edward Memorial Hospital being relocated to the Royal Perth Hospital site, where there is public transport and, obviously, ample parking.

Dr K.D. HAMES: I do not believe I said that there was excessive parking there. I said that the parking needs at Royal Perth were well catered for. I do not think there is additional parking available at that site.

Mr T.G. STEPHENS: On that same issue, can the minister tell the committee how much the QEII car parks will cost?

Dr K.D. HAMES: I think Mr Russell-Weisz will need to answer that question.

Dr D.J. Russell-Weisz: We are aiming to do this through a PPP.

Mr T.G. STEPHENS: I am sorry, did the adviser say royalties for regions?

Dr D.J. Russell-Weisz: No, a PPP. It will be privately financed. If it were traditionally procured, for instance—that is, if we were to build these two car parks ourselves—it would be in the order of $130 million to $140 million.

Dr K.D. HAMES: Each?

Dr D.J. Russell-Weisz: No; together.

Dr K.D. HAMES: Similarly, if we contracted the City of Perth, for example, to build the car park, the city would take the revenue and the revenue would fund the cost of construction. That is one option. We are also looking at the option of funding it ourselves.

Mr T.G. STEPHENS: What would be the annual cost to the health department of a PPP to provide two car parks of this sort?

Dr K.D. HAMES: Nothing, the reason being that the funds generated from car parking fees are designed to pay the cost of the PPP. A PPP would need to charge a fee in the order of $7 for a day's parking. That $7 is the cost of parking now, not in four years. Current full-day parking costs around the city are of that order but will probably be higher by the time we get there in four years. By then, parking could be in the order of $10 a day. The charge for parking then will be perhaps $1 or $2 an hour. The health department has been directed by DPI—in fact, not only since we came to government but also when the previous government was in office—that it must raise the cost of using facilities, such as hospital parking, to the cost that the rest of the community pays for them. I have to say that I have struggled a bit with that direction, but that is the agreement that has been in place, including the agreement under the former Minister for Health. We need to work to that agreement carefully. I have concerns about getting to that fee eventually because I do not want to take away from the real wages of nurses. I will be making sure that that does not happen, but that will take some work. Ultimately, $7 a day per bay pays the cost of the construction with whatever profit the builder of the car park makes out of that cost.

[3.40 pm]

Mr R.H. COOK: Can the minister confirm the advice from the adviser to the minister that this has nothing to do with the future development of the Queen Elizabeth II campus in that he says there are parking problems now? Can he also clarify the timing of the development: will the development of extra parking at Sir Charles Gairdner Hospital occur ahead of development works at the Princess Margaret Hospital for Children?

Dr K.D. HAMES: I thank the member; that is a good question. I must say that I would have much preferred the previous government to have got credit for doing something about this matter because it was possible to start work on it some time ago. Remember that it will not cost the government money. This issue has been around for a long time; we have people being transported and we have large wide-open car parks. Obviously, the best situation is to do what was done in the past at Royal Perth Hospital and have multistorey car parks, particularly when they can be, in effect, self-funding. It takes time to go through the process of developing the business case, to get the funding and to do the construction. Talking to the people who built the multistorey car park at St John of God hospital in Subiaco, it took about three to four years to get through that process to finally have that parking. Therefore, we are starting it now and, as I say, I wish it had been started earlier because it will take that time. However, at the same time we will do other things to develop what needs to be done with Princess Margaret Hospital. I anticipate that the first lot of parking will be available well before that time. We anticipate that it will take in the range of three to four years to get that first car park.

Mr R.H. COOK: Therefore, will there be any loss of car parks with the development of the Princess Margaret Hospital project prior to the development of new car parks on the campus site?

Dr K.D. HAMES: Dr Russell-Weisz.

Dr D.J. Russell-Weisz: Certainly, there are three car parks on the master plan, but the third multistorey car park will occur only if King Edward Memorial Hospital comes to the site. The first multistorey car park for the staff is currently to the western side of the site and will be built by 2012. The second car park must be built in advance of the new children's hospital being commissioned, which is currently in the northern area just to the side of Winthrop Avenue in the eastern part of the site.

Mr R.H. COOK: What is the timing of that?

Dr D.J. Russell-Weisz: The timing of that car park is 2014.

Mr R.H. COOK: Further, the minister is obviously aware that he made a promise to the people of Western Australia that the new children's hospital will be ready by 2014. However, the minister's adviser is now telling us that the car park that must be developed prior to developing the hospital will not be ready until at least 2014. Therefore, can the minister please clarify the new timings for the new children's hospital?

Dr K.D. HAMES: No, I cannot. We are in the process of doing that plan at present. The final configuration and the final completion date have yet to be determined.

Mr R.H. COOK: However, the minister accepts that he will not deliver the hospital by 2014?

Dr K.D. HAMES: No, I do not accept that. I remember when we were in opposition—the member was not around at the time, though perhaps he was campaigning—we made a commitment to build the hospital by 2014, and the then health minister said it was not possible to do that and that it would be 2015. He said that we had not accounted for the L, M and N block buildings that have to be moved to allow the construction of that hospital. That was true, and I have to say that there was nothing in the government information that allowed us to make the determination that the L, M and N block buildings had to be moved in advance. Therefore, it may well be that we would only meet the timetable of 2015; however, we have all our people working very hard. Remember, too, that the site proposed and the moving of the L, M and N block buildings is something that is still under consideration.

Mr R.H. COOK: I have a further question about the development of the Queen Elizabeth II campus.

The CHAIRMAN: I will come back to the member. The member for Albany has the call.

Mr P.B. WATSON: I refer to the "Direct patient support" line item on page 187 of the *Budget Statements*. Will the video link from Albany Regional Hospital to Royal Perth Hospital that is currently used by neurosurgeons and other specialists be operating after 30 June this year?

Dr K.D. HAMES: I do not see how that question relates to the "Direct patient support" line item.

Mr T.G. STEPHENS: It is in the vibe, minister—in the vibe!

Dr K.D. HAMES: Yes, there has been a bit of extrapolation, I think.

Mr P.B. WATSON: It is under the three per cent cuts. We have been advised about it by people. A lady in Albany, Mrs Margaret Scott, will be able to consult with her neurologist at Royal Perth Hospital by video link until 30 June this year. She has been told that under the three per cent cuts, that service will no longer be available from 30 June, which means Mrs Scott will have to come all the way to Perth. She will have to get her husband who works for the government to go with her as her carer, so the government will also be paying for his two days off work. Can the minister advise why this three per cent cut has been made for people in regional areas, whereas people in the city can simply go to their local neurosurgeon?

Dr K.D. HAMES: I am advised that Ms Feely, the chief executive of the South Metropolitan Area Health Service, has that answer.

Ms N.M. Feely: The service will continue post 30 June.

Mr P.B. WATSON: It will not?

Ms N.M. Feely: It will; telehealth will continue.

Mr P.B. WATSON: Can the minister let the people in Albany know that because they have been told it will not.

Dr K.D. HAMES: Sure.

Mr P.B. WATSON: I refer to the "Visiting medical practitioners" line item on page 187 of the *Budget Statements*. Is any money allocated in the budget for a visiting paediatrician to see patients for medical reasons, as opposed to developmental reasons as is the case now, so that young families need not take their children to Perth?

Dr K.D. HAMES: I will again refer the question to Ms Feely. However, before I do that, I want to make a general comment about trying to tie the three per cent efficiency dividend to those regional services.

Mr P.B. WATSON: I did not say anything about three per cent; I simply asked whether any money was allocated.

Dr K.D. HAMES: I know, but the member did in the previous question and I want to respond to that particular comment. The three per cent efficiency dividend does not affect doctors' provision of services in regional areas. If we are able to recruit doctors to provide those services closer to their community, we will do that. What we have found in some cases is —

The CHAIRMAN: Minister, we have another question and time is against us. Can the minister please answer the question that the member for Albany has just asked?

Dr K.D. HAMES: Am I not allowed to talk about —

Mr P.B. WATSON: The minister is backdating himself.

The CHAIRMAN: We have moved on from the previous question, and the member for Albany has just asked the minister a question.

Dr K.D. HAMES: I think the Chairman is being unduly harsh. I will ask Ms Feely to respond to that second question.

Ms N.M. Feely: Minister, I will defer to my friend next to me, Mr Snowball, to answer this question.

Mr P.B. WATSON: He had better get it right because there is no-one else sitting next to him!

Mr K. Snowball: There are a range of programs that in fact support and fund specialists to go to the country, including the commonwealth Medical Specialist Outreach Assistance Program. That was revised in the last federal budget, so we have an opportunity to put forward the priorities that we have across Western Australia for support under that program, and that is about to happen in the next few weeks. Albany has been identified for paediatric support as part of those priorities.

Mr P.B. WATSON: My further question is a question I started to ask before. I must be in the Chair in the other house, so I am sure the minister will indulge me.

Dr K.D. HAMES: It is the member's poor old shadow minister who is missing out!

Mr P.B. WATSON: But he is a good friend of mine! To 30 June 2009, $3.09 million has been spent on Albany Regional Hospital. Can the minister tell me what that money has been spent on? People in Albany such as architects, designers and draughtsmen tell me nothing has been done, but $3 million has been spent. Can the minister tell me what the money has been spent on, please?

Dr K.D. HAMES: I cannot, but I am sure Mr Snowball can.

Mr K. Snowball: Without going into the detail of it, and I would be able to supply that detail if needed, essentially what we have experienced over probably the past 18 months in Albany is a stop-start situation. For example, we had the redevelopment option within the existing hospital, so we engaged people to work out how to deliver that—how to design it, consultation processes, and so on. Then the commitment changed, which meant we had to go back to the drawing board, because more often than not the previous work did not apply to the new commitment. Therefore, a lot of these funds have actually been used in doing those plans and starting to work on those plans, before we go to a normal tender and construction process. However, as I said, I am happy to provide additional detail around those numbers.

[3.50 pm]

Dr K.D. HAMES: I will provide some additional comments in reply to that question. When the commitment of $40 billion to refurbish the hospital was initially made, plans were obviously made along those lines. Then there were additional funds for the further expansion of the redevelopment, and some further work was done. It was planned, under the previous government, for the first stage of work on the redevelopment to start in November 2009. The government has attracted some criticism from people who are saying that the redevelopment was supposed to start in November, and they are asking the government when we are going to do it. The reality is that the start date was based on the second last model, not the last model. The last model, which the previous government announced just before the election, would have required the work to go right back to square one, because it would have needed an entirely new redesign. There was never any likelihood of the previous government starting work in November this year, because it would have required full work on the major redesign that the previous government announced as the last project to go in. I see the member shaking his head. I am very happy to supply at a later date some copies of what has been confirmed by the Western Australian Country Health Service. I seem to have been promising to apologise to the member many times today; I hope he will do the same if he is wrong.

Mr P.B. WATSON: Is it not true that the government went to the election with a promise of $135 million and had no idea, no designs and no plans? The Liberal Party was going to knock the whole thing down and build again. The government made a false $135 million promise to the people of Albany and is not providing what it said it would. It has had to go to the royalties for regions program to get $60 million of the promised $135 million. We hear now that it is going to cost $230 million. The previous government tried to get it done, and I take full blame for not getting it done. The consultant's report to the Department of Health took two and half years to complete, and perhaps we should have pushed the department more quickly. The fact is that the Liberal Party went to the election on that promise, and the Labor Party queried that promise during the campaign. We knew that it could not be done for $135 million, but the Liberal Party stuck to that commitment. Now it is saying that it is sending the health department out to find ways to do it. The government has gone to royalties for regions and to private enterprise. The government has misled the people of Albany.

Dr K.D. HAMES: That is obviously not true, and I think the member is being deceptive and duplicitous. The reality is that the previous government failed, and yes, the member should share a fair whack of the blame for that not happening. The member was in the ear of the former Minister for Health.

Mr P.B. WATSON: So should the health department. It took two and half years to complete a consultant's report.

Dr K.D. HAMES: It was not just that. The previous government made that promise over two elections. The Labor Party promised the hospital in the previous election.

Mr P.B. WATSON: No, we did not. The minister should check; he has misled the committee again. I was the local member during the election, and we did not promise a new hospital.

Dr K.D. HAMES: No, the Labor Party promised the refurbishment of the existing hospital.

Mr P.B. WATSON: We promised an upgrade.

Dr K.D. HAMES: Did that happen? No. The Labor Party never promised the people of Albany a new hospital.

Mr P.B. WATSON: Yes, we did; it was an election commitment for $100 million.

Dr K.D. HAMES: It did not, and we will have this argument again in the future. Even if the Labor Party did promise a new hospital before the election, the $160 million in funds the member refers to was not in the budget; if it was, I would be laughing. I would be laughing if I had arrived in government and found $160 million. I would not have had to go and seek the additional funds to make up the $135 million required to build the hospital, because it would already have been there.

Mr P.B. WATSON: Did the government not have the $135 million that it promised?

Dr K.D. HAMES: We promised $135 million based on —

Mr P.B. WATSON: Now you are saying that you had to seek $60 million to make up the $135 million.

Dr K.D. HAMES: No, I did not. The member needs to let me answer the question without so many interruptions. We committed to the $135 million based on the resources that an opposition has at its disposal. An opposition does not have any access to architects or business development plans. All we had to rely upon were government statements about what the cost would be. The amount that the previous government was going to spend, up until two days before the election, was significantly less than $135 million. The Premier could see that the member was in trouble and had to go running down to Albany to save him, and made that commitment two days before the election because of that very issue—the member had not delivered. The amount was significantly less. There may be some confusion on the part of the government and the opposition about how much was promised and what went into the budget in the two days prior to the election, but up until that time the amount was significantly less. We made a commitment, well before that time, to fund what we assumed would be the full cost of construction of that hospital. That was the information we had, and that was the commitment we made. The royalties for regions money was nothing to do with me; I did not go to the royalties for regions program seeking additional money. That was part of a Treasury allocation, in conjunction with the Minister for Regional Development, of the royalties for regions fund. My comment was that I did not care where the money came from, as long as I got it. That was the $135 million I had to spend, regardless of what Treasury and the Minister for Regional Development had worked out. I did not go to them for anything. That is the amount of money I have and, as I said before, I believe that if we can deliver that, upgrading the total value of the hospital funding towards $200 million with private sector investment, it will be a great result for the people of Albany. Instead of jumping on our backs every five minutes saying that we have not delivered, the member for Albany

should give us a little more space, just as he gave space to Jim McGinty—eight years—in which to do something. We would be very appreciative.

Mr P.B. WATSON: The minister said that he had made the commitment to $135 million before the Labor Party made its commitment. The then Premier came to Albany and made the decision to provide $100 million for the first stage, and $68 million for the second stage of the hospital. I remember the minister making a comment in a car while driving to a radio station in Perth that the then opposition was going to make a commitment of $135 million. He had made no decision until the then Premier had made the commitment of $100 million; the minister then came out with his $135 million. If the minister would like me to go back and check, I can produce records for the committee to prove that that is correct. The minister should not say that he made his commitment before the Labor Party made its commitment, because he did not.

Dr K.D. HAMES: The time the member hears me —

The CHAIRMAN: Minister, that is not a question.

Dr K.D. HAMES: Mr Chairman, you cannot let him get away with making a statement that is not true and not let me respond, surely?

The CHAIRMAN: Minister, it was not a question.

I have a question. I refer to page 181. Under "Completed Works" there is the line item "Carnarvon Sobering Up Centre", for which $500 000 was allocated in 2009-10. That $500 000 seems to have been spent. Can the minister provide me with details about where in Carnarvon this sobering-up shelter has been built? I am sure the people of Carnarvon would like to know where it is.

Dr K.D. HAMES: I cannot provide that information, because although it is in our budget, we also fund a number of things that fall within the portfolio of the Minister for Mental Health, and that item is one of them. The expert who was here when the Minister for Mental Health was here has that information. I am sure that if the member puts the question on notice, the Minister for Mental Health will be able to answer it.

The CHAIRMAN: I can say that the sobering-up shelter has not been built. Can the minister find out, perhaps by supplementary information, where the money allocated for the sobering-up centre has gone, if it has not been built?

Dr K.D. HAMES: It looks as though the funds are still there. It may be that it should be in the 2009-10 budget. If the member says that it is not there, I accept his word that it is not there. I have a briefing sheet that shows that it might in fact be built during the coming financial year. I will ask the Minister for Mental Health to clarify that issue for the member.

Mr T.G. STEPHENS: I refer to page 164 and the "Closing the Gap" initiatives under "Indigenous Health". The Council of Australian Governments conference is in Darwin next month. Why has the minister not insisted on a focus on the issues of alcohol management strategies and the implementation of alcohol management plans? He could draw upon the experiences of the Northern Territory and Queensland that have invested in alcohol management plans as a response to the health impact. Why has the minister, as a state health minister, not insisted that that issue be on the COAG "Closing the Gap" agenda for discussion? My second question is in reference to the health department's focus on the issues of diabetes amongst the Aboriginal population. What increased effort is there on display anywhere in these budget papers to demonstrate a commitment to responding to the growing challenge of diabetes in the Aboriginal community?

[4.00 pm]

Dr K.D. HAMES: There are a couple of components to that. I will ask Mr Wyatt to help me. I am sure that when members opposite were in government, they did not insist on the Premier raising particular issues at COAG meetings.

Mr T.G. STEPHENS: Yes, we did.

Dr K.D. HAMES: COAG is a meeting of Premiers. It is not even the Premiers who decide what is on the agenda, it is normally the bureaucrats. I am very interested in the COAG agenda, which is going to largely focus on Indigenous affairs. In fact, I asked the Premier, and received his permission, to attend that COAG meeting so that I could participate in discussions on Aboriginal issues. Mr Wyatt has been involved in negotiations with commonwealth officers on what is going to be on that COAG agenda relating to Indigenous issues. I will get him to deal with that first, but remind me what the last part of the question was?

Mr T.G. STEPHENS: Diabetes. The minister should not need any reminding.

Dr K.D. HAMES: I just forgot what the member asked. I am particularly interested in the management of the diabetes program. As members know, we have an arrangement through Mr Bridge for a diabetes program in the Kimberley that we support through the health department. It is a program that is working exceptionally well. Diabetes is going to be a focus of our attention. I hope we can do some work to expand that and perhaps other programs.

Mr I. Wyatt: The COAG agenda will focus on Indigenous health but there is also an agenda item to deal with binge drinking. There will be a discussion about some of the problems that Australian society is facing. Indigenous issues will be couched within that.

I now refer to the second question about diabetes. I co-chaired the COAG health and ageing working group in its negotiations with the commonwealth. We requested that the commonwealth augment and complement state and territory programs for chronic disease. The commonwealth agreed to tackle chronic disease risk factors and contribute $161 million over four years. Chronic diseases will be the focus of that work. The funding in that arena will be targeted towards Indigenous community-controlled health services and partnering with divisions of GPs and with individual GPs. The second part was improving chronic disease management and follow-up. There is an allocation of $474 million over four years. Again, both initiatives complement the strategies funded by the state; that is, making Indigenous health everyone's business as well as enhanced Indigenous primary health care. Diabetes would be a significant factor in that initiative.

[Ms L.L. Baker took the chair.]

Mr J.M. FRANCIS: I refer the minister to page 181 under the title "Other Projects — Kimberley Renal Support Service". I note the amount of $1.4 million on that page. Can the minister provide further information about the allocation of $3.5 million from the old infrastructure program and also from the commonwealth health infrastructure program? Will that funding from the commonwealth be required?

Dr K.D. HAMES: The Kimberley renal dialysis service is something that I am particularly interested in. We had a presentation from Mr Henry Councillor, and a female doctor whose name I cannot recall. He presented on the expansion of the Kimberley renal support services out of Broome. At present large numbers of Aboriginal people cannot be properly serviced because of inadequate services in the Kimberley region. They end up coming to Perth for their treatment. The problem is that the incidence of end-stage renal disease requiring dialysis is increasing in the Kimberley. It is five times higher in the Kimberley than in the metropolitan area. There are 98 patients from the Kimberley receiving dialysis—27 of those are being treated in Perth and a further 29 are predicted to need increased services. The plan was to expand that service with a satellite service in Derby to include six chairs with the capacity to expand to 10 and a new service in Kununurra, with four chairs and 16 patients. The total capital cost of that program is $8.6 million, and recurrent costs in the forward estimates are $12.6 million. We had some funding available through an election commitment that was —

Mr T.G. STEPHENS: Did I not hear the minister mention Fitzroy and Halls Creek?

Dr K.D. HAMES: That was not the proposal that was put forward to us for the expansion of that service. I would love it also to be in Fitzroy Crossing and Halls Creek, but that was not the proposal that was put to us by the Kimberley service. The difficulty, as the member can see, is that it is a significant amount of money—$8.6 million in capital and $12.656 million in recurrent costs. We had $3.5 million left over from our health infrastructure fund that we allocated in the election. That went to fund a range of things, including the $10 million for Nickol Bay Hospital, the money for CT scanners in Carnarvon and Esperance, and similar projects. We have allocated $3.5 million of that to that project. We also needed additional funding. We were keen to get it wherever we could. We applied through the Ord development scheme to see whether it would provide the additional $3.5 million that we needed. I am pleased to say that it did provide that funding. I have to compliment Mr Gary Gray for his efforts in making sure we got that funding. We also applied to the commonwealth through its regional health infrastructure fund. As I said, we got everything we asked for in the final stage of that allocation—that is, funding for Midland hospital, the relocation of the hospital at Shenton Park, the paediatric unit at Broome District Hospital and the renal dialysis service. I have since had conversations with Mr Gray and asked whether there is another project that would be appropriate for that money to go to. There is, and that is for common nursing accommodation in the Wyndham community. He has agreed that that money can be reallocated to the Wyndham community instead.

Having secured capital funding, we now have the issue of putting together the recurrent funding to make sure that service is expanded. We have some savings of costs as a result of patients who would have largely otherwise have come to Royal Perth Hospital now not needing to do so. We have got some savings there that will be allocated. The Country Health Service now has the task of putting together the package to provide the rest of the

funding. That is certainly something I have discussed with it frequently and something I am very keen on providing to the people of the Kimberley, particularly for those Aboriginal patients who have to come all the way to Perth—often with difficulty in finding accommodation—and who need to stay here permanently to have their renal dialysis. Often it is two or three times a week that they need renal dialysis in order to survive. Some patients are choosing not to come to Perth because they do not want to leave their friends and families, and they just go away to the bush to die from end-stage renal failure.

[4.10 pm]

Mr R.H. COOK: My question relates to page 180 of volume 1 of budget paper No 2. The heading "Asset Investment Program" appears on page 179, and under the works in progress listed on page 180, I refer to the item "New Swan Health Campus". My question is: firstly, what is the total cost of this project; secondly, what is the federal government contribution to this project; and, thirdly, what is the state government contribution to this project?

Dr K.D. HAMES: It is very interesting to go back to last year's budget figures under the capital works program to see what the funding program was for that hospital under the old stage of funding. In those days, it was in fact called Swan Health Campus. That shows the run-out of funding. I keep hearing various figures. I remember the minister announcing in a press release that he was allocating more than $190 million to this project. I note that in last year's forward estimates, there was still $181.2 million for the project. The member has heard me relate the story of the conversation I had with the former Minister for Health after we won the election. He said, "I'm sorry to tell you, but I've got three lots of bad news: we're $100 million short at Joondalup, there's a $100 million overrun on the budget, and we're $120 million short for the relocation of the hospital." Estimates had been done subsequent to the allocation of $180 million. I am not blaming the minister for that. At that stage, I do not think there was any realistic way of knowing exactly what the total cost would be. The $180 million was, in effect, a guesstimate. The figure in the previous budget was $180 million.

We put to the commonwealth a proposal that it help us to fund the hospital. The member will notice that under the capital works, that amount of $180 million remains in our budget. We pushed back some of the funding, because we did not have the funds to complete the project in the time that was committed. As the member knows, 2014 was the time that we committed to for completion of the hospital. I must say that that was also the Labor Party's commitment for completion of the construction, yet the funding for the hospital in Labor's 2008-09 budget went out to 2013-14.

Mr R.H. COOK: I am not interested in our funding; I am interested in an answer.

Dr K.D. HAMES: I am not interested in the member's comment. It is my answer, and I will answer however I like.

Mr R.H. COOK: Madam Chair, could I ask the minister to get to the point of the question, rather than providing all this padding.

The CHAIRMAN: Thank you, member.

Dr K.D. HAMES: The $180 million that was provided by us was pushed out. However, when I was questioned about whether completion of the project would be late, I said publicly that I would do everything that I could to make sure that the hospital was completed within the time frame committed—that is, 2014. Other options were available to me, such as having a public-private partnership development for that site. I am pleased to say, however, that as a result of the commitment made by the federal government to provide a matching $180 million, we now have $360 million in the budget. The estimated cost of that project is in the order of $300 million. Therefore, we have funding in excess of the initial estimate. Previously, there were two options. One option was to do it as a single-stage development. The second option was to do it as a two-stage development. We are now able to do it as a single build—a single-stage construction. It is now estimated that the cost will be in the order of $360 million, which is the amount that has been put forward. I think it is a great win for this state, and in fact for the commonwealth, that we are able to build together a project that now is fully funded—something that under the former government and under our government was not the case.

Mr R.H. COOK: Now that the government has been successful in securing commonwealth funding, in what years will the state contribution be made?

Dr K.D. HAMES: We are still talking with the commonwealth to ascertain over which period its funding will be provided. In our four-year forward estimates, there are amounts, as the member can see in the budget papers, of $37 million and $41 million. The remainder of the funding falls outside the forward estimates. It may well be that the rest of the money that falls outside the forward estimates will have to be brought forward. That funding

is not in the four years of estimates in the current budget, but it is in the fifth year. That will ensure that there is funding for the final payment, as I pointed out to the member before, for Fiona Stanley Hospital. An amount of $30 million is allocated in the year following the completion of the hospital. The total amount that we are contributing, plus the $180 million of commonwealth funding, will be available in the next four years of forward estimates, which will allow us to get on with the construction as quickly as we can. With the support of the commonwealth government, our cash flow is not as significant, because the commonwealth funding will be available when it is necessary to make the final payment on completion of the construction.

Mr R.H. COOK: The minister commented in Parliament on 18 March that he believed the hospital would be completed by 2014. He is now saying that it will not be completed by 2014.

Dr K.D. HAMES: No. I do not know how the member has reached that conclusion. I think he needs to read what I just said in *Hansard*. The commitment remains, as I said at the start, to build it by 2014.

Mr R.H. COOK: Where is the money in the budget?

Dr K.D. HAMES: Let me explain. I do not know why the member is being so aggressive. The fact is —

Mr R.H. COOK: Once again, the minister is saying that we have this commitment and —

Dr K.D. HAMES: Stop talking and I will explain it.

The CHAIRMAN: Members!

Dr K.D. HAMES: Does the member want me to answer the question or does he not?

Mr R.H. COOK: It is another unbudgeted commitment.

Dr K.D. HAMES: It is not another unbudgeted commitment. I go back to the Fiona Stanley Hospital issue. During Labor's time in government, it had allocated funding that was outside the proposed completion date of Fiona Stanley Hospital, but it was still attached to the construction of the hospital. To be precise, the amount was $33 million. What will happen is this: construction will start. In the four years during which the hospital is being constructed, there will be $180 million of federal government money and $41 million-odd of state government money. The remainder of our money, the final $140 million, will be paid when the hospital is completed in 2014. It will be paid in 2014, or even in the 2015-16 financial year, once the hospital is completed in 2014. I do not know how I can make it any clearer than that.

Mr R.H. COOK: The state government has to pay only $41 million over the next four years, and the commonwealth will make up the entire shortfall in the meantime.

Dr K.D. HAMES: This is being built as a joint project between the commonwealth and the state.

Mr R.H. COOK: Yes or no.

Dr K.D. HAMES: It is not a yes or no answer. There is no issue with the commonwealth letting us use its funds to start the construction of the hospital. We do not have to pay for the hospital until it is completed. Of that $180 million, $138 million has been pushed out to 2013-14, or, indeed, 2014-15. If the hospital is finished in 2014, we do not have to pay for it until that date, and that date is outside the forward estimates.

[4.20 pm]

Mr I.M. BRITZA: Minister, I refer to budget paper No 2, volume 1, page 180, under the heading "Works in Progress", and the section related to the Princess Margaret Hospital for Children redevelopment and the replacement of the Telethon Institute for Child Health Research. What are the future plans for the Telethon Institute for Child Health Research in light of the proposal to build a new children's hospital on the QEII site?

The CHAIRMAN: The minister has the call. Sorry, I was just looking for the reference.

Dr K.D. HAMES: I do not want to ignore the Chairman!

TICHR is currently located opposite Princess Margaret Hospital for Children. In relocating Princess Margaret Hospital for Children, it is essential that we also relocate TICHR. We supported—as did the former government—the application to the commonwealth for funds for the relocation of TICHR, and we sought a total of $100 million for that relocation. Funding of $33 million was obtained from the commonwealth, in addition to the commitment of $30 million made by the state government, and TICHR will fund the additional $30 million itself. We are still very strongly in support of that relocation, and we are looking at plans to ensure that TICHR will be located next to the new Princess Margaret Hospital for Children. The government has had discussions with Professor Fiona Stanley, and I recently met the board, to investigate how TICHR can ensure that the timing

is correct and ensure that as we are building the new Princess Margaret Hospital for Children, TICHR's plans are well advanced for the construction of the new TICHR adjacent to that building.

Mr T.G. STEPHENS: Minister, I asked a question earlier in reference to pages 180 and 181 of the *Budget Statements* about where the reference might be to Tom Price District Hospital and Paraburdoo District Hospital.

Dr K.D. HAMES: The member did indeed.

Mr T.G. STEPHENS: The minister indicated that there was nothing in the budget, and there had been nothing in the previous budget.

Dr K.D. HAMES: Not to my knowledge.

Mr T.G. STEPHENS: I was wondering whether the minister would tell me whether he, as minister, will be allowing the Country Health Service to suspend, for any time, the operations of those hospitals, and allow them to cease operating as hospitals during any part of the coming financial year? Will the minister be allowing those hospitals to suspend their operations as hospitals?

The CHAIRMAN: The minister has the call.

Dr K.D. HAMES: No.

Mr T.G. STEPHENS: Good.

Dr K.D. HAMES: I inform the member that he will be very shortly receiving notification that I will be visiting that area soon.

Mr T.G. STEPHENS: I hope the minister will visit Nullagine, too, so that he will see the need for a full-blown response to the problems of that community.

Dr K.D. HAMES: Does the member want to ask me a quick question on that subject?

The CHAIRMAN: Thank you, members!

Mr R.H. COOK: No.

Mr T.G. STEPHENS: Apparently not!

Mr F.A. ALBAN: I refer to page 181 of the *Budget Statements*, under the heading "Works in Progress".

Dr K.D. HAMES: What does the question relate to?

Mr F.A. ALBAN: The Western Australian comprehensive cancer centre. The amounts in the columns related to 2009-10, the forward estimates and the estimated expenditure for 2008-09 add up to about $61.3 million, some $4 million short of the budgeted $65.3 million. Why is that; is the project on target; and what is the anticipated completion date?

Dr K.D. HAMES: Yes; I wanted to raise this issue to clarify some statements made by the opposition about the timing of the completion of this cancer centre. I make it very clear that the $65.3 million that is in the budget is committed to finishing this project at the time that it was originally proposed to be completed, which was 2011-12. It is true that $4 million of the total project budget is in the out years, in 2013-14. The cancer centre is in the same position as Fiona Stanley Hospital—about which I have made statements previously—regarding the timing of the final payment. This is just a matter of the final payment being made four years beyond when it is completed. In fact, there is also a $10 million payment to be made in 2012-13, and it may well be that the $4 million will need to be brought forward to that year to make the final payment. That will be determined closer to the time. I want to make very clear for the record that we are very committed to this project, and we will ensure that it is completed in 2011-12, as originally proposed.

Mr A.J. WADDELL: Minister, I am confused! I am not an accountant, but the total spend there is $65.4 million, of which the minister is saying that the payment of $10 million, plus this missing $4 million, will occur after the completion of the project, yet the previous answer given about the Midland health campus had $140 million of a total budget of $360 million to be paid after the completion of it. Why is it that the comprehensive cancer centre has to be paid to an 85 per cent level prior to its completion, whereas the credit terms on the Midland hospital appear to be much more generous, in that the last half of it does not have to be paid for until they rock up with their truck and deliver it on the doorstep?

Dr K.D. HAMES: That is a good question relating to Midland, rather than relating to this project. The reason is not an issue with the cancer centre—we would agree that $4 million is quite a reasonable, small amount to pay. I

accept what the member says about it being most unusual that we have the funds at Midland hospital appearing one year after the completion. That has been as a result of the balancing of the total budget that we had to do, and the capital spend we had. Remember, I said before that we had pushed Midland hospital back in the funding in the budget to those out years, and I was going to have to look at alternative methods of funding it to get it to the date that I had committed to completing it, which was 2014. I was going to have to consider using the leverage of the funding that was going to become available in the out years to build it in a different way—perhaps through a public-private partnership, which would require none of the funds up-front.

The commonwealth funding has allowed us the luxury, if we like, of not having those funds in the forward estimates, which sorts out the total balance of our capital works projects, while still being able to do the work on time and on budget. Obviously, we will have to work with the developer and get an agreement to pay such a large chunk at the end of the project. It may be that, as we get closer to completion, we will have to work with Treasury to bring some of that money—if not a significant amount of that money—forward into the forward estimates. However, that does not have to be worked out now; that can be worked out in two and three years as we are developing the contract and the construction is underway.

The member is right; it is not normal practice and it is not something that I would normally have done. We would have normally had that $180 million in the forward estimates, but remember that, with the financial crisis, in three years there will be a $19 billion deficit that would have been significantly higher had we not pushed back some areas of funding. It would have meant that either I would not have been able to meet my commitment of getting the cancer centre finished in 2014, or I would have had to find another funding mechanism, which was my plan. Now I do not need to worry. The member's good mate over there in Canberra has come to my rescue and sorted out this issue for me!

Mr R.H. COOK: Labor always has stood up for people!

[4.30 pm]

Dr K.D. HAMES: This will still be, remember, a combined state-commonwealth funded project; it will be a magnificent project. Remember, too, that the former government had only $130 million in the budget for $300 million worth of projects. If the member was in my chair, he would be in the same situation of trying to figure out how on earth, in a time of an absolute shortfall of money, he could find an additional $270 million.

Mr A.J. WADDELL: That is an extraordinary answer, because the minister has just told this committee that he recognises that this is an extraordinary circumstance and highly unusual and that he is very unlikely to get the contractor to agree to it and probably will have to ask Treasury to bring forward the estimates. Is he not telling us there is a big black hole in the budget for the centre and the health campus?

Dr K.D. HAMES: No. I think the member for Forrestfield has used some extrapolation of the comments I made. If he reads *Hansard*, he will definitely see that I did not say those things.

Mr A.J. WADDELL: I will.

Dr K.D. HAMES: There is an opportunity for us to negotiate with any contractor in providing that service. Black holes are not black holes until the time comes for funding. We look at the total amount of funds available and look at the rotation, and make the decisions when they come. We are predicting limited growth in the state over the next four years. However, it may well be that the state progresses much quicker than we thought. Things might happen that deliver additional revenues and make it easy for us to bring those funds forward. If BHP had taken over Rio Tinto, for example, as was proposed, a $1 billion fund in royalties would have come to this state. I have to say that I was very keen on using that amount of money to rebuild Princess Margaret Hospital. We were certainly looking to have that done. As it turned out, it did not happen, but there will be other opportunities, I am sure.

Mr R.H. COOK: I refer to the hospital nurses support fund in budget paper No 2, volume 1 on page 161 under "Major Policy Decisions". This is a fund that the minister promoted during the election campaign, obviously to attract the electoral support and votes of nurses, yet, since announcing this fund, he said that it would include the cost of the capital works for the procurement of childcare services at different hospitals. The funding for these particular childcare centres is already in the budget for capital works. Why are nurses paying for this cost shift from capital works to the hospital nurses support fund?

Dr K.D. HAMES: That is not the case at all. During the election campaign, in some ways we were actually competing with the Labor Party and the commitments it was making on what we felt was the best way we could assist nurses in this state. The Labor minister had put forward the proposal that he would fund the capital works

components of childcare centres to the tune of $6.678 million, which was already in the budget, I think; it is certainly now in the budget. He made that commitment to fund $6.678 million. We said that we would put together a package of $28 million that nurses would be able to use as direct support for nurses, which could be in a range of areas but which would include childcare centres. When we got into government, we found that work was already being undertaken with the $6.678 million that the former Minister for Health referred to. In fact, that was already committed to developing the Rockingham and the Joondalup childcare centres. It was also supposed to cover the Midland childcare centre and the Fiona Stanley childcare centre, yet that was nowhere near enough money to cover the four items that the former minister had announced. I therefore said that we would allow those things to continue that had been committed to. My view was that they should have been in the budget for the construction of the hospital, so that in the cost to construct the Rockingham hospital there should have been an amount for the childcare centre if it was needed. The same goes for Joondalup. I reluctantly had to take the minister's commitment out of the total fund because I was going to provide a degree of support for a lot of hospitals based on what the nurses wanted and to make sure that the hospital in the member's electorate and Joondalup Health Campus still got their childcare centres. I told the other hospitals, Swan District and Fiona Stanley Hospitals, that I believed they each needed a childcare centre but that it could be funded from the budgets for those hospitals. I have stuck by the former minister's commitment to fund those things. The remainder of the money will be available on a per capita basis for nurses in this state. Some hospitals will get up to $1 million to spend on whatever services they like. What is interesting is what nurses are saying they would like to use it for. I have said publicly that quite a few are things that the state should probably be funding itself. It shows the dedication of nurses in this state because they are saying that their patients could benefit from better services here and they would like their money to go somewhere else or for some equipment. They want to commit the money to those things. If that is what they choose, I am supportive of that. Others want upgraded rooms where they can get away from the humdrum of daily life and have tea and coffee.

Mr R.H. COOK: I have a further question, Madam Chair.

Dr K.D. HAMES: I am sorry, but I have not finished.

Mr R.H. COOK: I know. The minister has answered the question and I have a further question. I appreciate that the minister is padding beautifully, but I want to move on.

Dr K.D. HAMES: The member cannot dictate the answer to me unless I am straying from the question he asked, and I do not think I am.

Mr R.H. COOK: It was a specific question about provision of childcare centres.

Dr K.D. HAMES: The Chair will make a determination.

The CHAIRMAN: Order! I would like to let the minister finish his answer, but I remind him that we need to be succinct in our answers.

Dr K.D. HAMES: Thank you, Madam Chair. This is a very important answer —

The CHAIRMAN: I am sure it is.

Dr K.D. HAMES: — regarding the funds that are being used by those nurses. I will stop, but I think any nurse who reads what the member is saying —

Mrs M.H. ROBERTS: The minister should not canvass the ruling; he should get on with it.

Dr K.D. HAMES: Shush up. I am not canvassing the ruling.

Mrs M.H. ROBERTS: A ruling has been made. The minister is supposed to answer questions succinctly. He absolutely ignored the Chair's ruling.

Dr K.D. HAMES: The member for Midland is very rude. Where does she get off being rude in this place?

The CHAIRMAN: Order! Would the minister finish his answer please.

Dr K.D. HAMES: I would love to. As I said, I will cease my answer, but I think nurses will be very interested to hear that members are not interested in what the nurses propose to do with this fund.

Mr R.H. COOK: I want to confirm that $6.678 million has been used. Is the minister saying that it was not in the capital works budget for Joondalup or Rockingham and that he is now using the nurses' fund for —

Dr K.D. HAMES: No; that is not what I said.

Mr R.H. COOK: Is the minister saying that funds were in the capital works budgets for Joondalup and Rockingham?

Dr K.D. HAMES: I am sorry, the member is correct; they were —

Mr R.H. COOK: What?

Dr K.D. HAMES: I am sorry; I have made an error so I will correct it. They were not in the total capital works budgets for either Joondalup or Rockingham. They were in a capital works budget for those two hospitals for construction of a childcare centre, which had been allocated by the former Minister for Health. I answered the question.

Mr R.H. COOK: I think the minister answered it.

The CHAIRMAN: Order! The member for Jandakot has the call.

Mr J.M. FRANCIS: I refer the minister to the heading "Elective Surgery" at the top of page 166. I note that the commonwealth government has allocated some $300 million under stage 3 for the elective surgery program for 2009-10 and 2010-11, subject to certain targets being met. My question therefore is whether we can get some further detail. In particular, does the minister believe that Western Australia will be able to meet these targets; what will be Western Australia's share of the funds; and when will the funds be allocated? I believe we committed $30 million over two years. How has that helped with these targets?

[4.40 pm]

Dr K.D. HAMES: Yes, $300 million has been allocated under stage 3 of the federal government elective surgery program. The member will recall that $15 million was put up by the commonwealth under stage 1. The former state government allocated an additional $10 million. We committed $30 million over two years in our election commitments, which has now flowed through into the state budget. The commonwealth has now announced $30 million worth of funds, and we have to meet certain targets to achieve those funds. I will get Dr Lawrence to go through those targets. Our share will be approximately $30 million. As has tended to be the case, although these funds are offered to states on a competitive basis, the better we do in meeting targets, the better the funding result will be. The elective surgery waitlist has, over the years, continued to come down. I have to say that in earlier days I was quite critical of the former Minister for Health: although the waitlist numbers were about 18 000-odd when he came to government and he got them down to about 13 000 or 14 000, that was done without any extra surgery whatsoever taking place; we said it was smoke and mirrors. Changes made in the last days of the former government, particularly to ambulatory care surgery, significantly reduced the waitlist to meet the targets set by the commonwealth government. Those numbers have continued to reduce. For example, as of 3 May 2009, 11 727 cases were on the waitlist, which is 871 fewer than was the case at the same time the year before. 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. Dr Lawrence has been working extremely hard on that waitlist surgery program to make sure those numbers continue to reduce, and the graphs demonstrate a very impressive and continued reduction in numbers. I will ask Dr Lawrence to talk about targets.

Dr R. Lawrence: Through the minister, we are yet to receive the stage 3 formal agreement from the commonwealth, so the figures we have been given are, I guess, tentative until we receive that. Stage 3 is a very complex program. It is split into stream 1 and stream 2, with funding split equitably between the two streams but not across the two financial years. The funding is very heavily weighted into 2010-11, as opposed to 2009-10. The maximum we can receive in 2009-10 is $8 million. It is $80 million for the whole country, and we can expect to receive a maximum of $8 million in 2009-10, with the remaining $22 million in 2010-11. Stream 1 is based on patient waiting times, and again has staged targets based on a ratcheting down of wait times every six months through the course of the two years. The first target set by the commonwealth, having given us this information only a couple of months ago, is 30 June. The targets apply to those patients admitted to hospital for elective surgery—the 50 percentile and the 90 percentile—and Western Australia will currently achieve those stream 1 targets. Obviously we need to improve as we move forward, which is the whole idea of the scheme. Importantly, the targets are not standardised across the country, so each state has its own targets. Stream 2 is based on throughput, and it will be based on weighted cases rather than on raw activity; this is different from the first stage. Stream 2 is also based on coded activity, which makes it more complex for us. The commonwealth will set a baseline target, and then the states will be allocated funds proportionate to the activity they achieve in relation to the whole country. Even though the state is nominally allocated an amount, if another state does a lot

more work, it will be paid more money than this state, but the payment per case amount is much lower. There is quite a lot of risk in that stream of the program. The aim is to come in on target and no more.

Mr R.H. COOK: My question relates to the "3% Efficiency Dividend" heading on page 162 of budget paper No 2. Can the minister please provide, in the first instance, details about the breakdown of the full-time equivalents across metropolitan and country health services in terms of the actual number of staff anticipated to be part of the three per cent efficiency dividend for 2009-10 and the forward estimates?

Dr K.D. HAMES: I am just seeking who has that advice. Can we ask the member to provide more detail?

The CHAIRMAN: Dr Flett.

Dr P. Flett: Could the member just repeat his question—exactly what he wants to know about the full-time equivalents?

Mr R.H. COOK: For instance, $51 million is budgeted in 2009-10 for "Metropolitan and Country Health Services FTE Efficiencies". Can the minister please disaggregate between metropolitan and country and tell us exactly how many people that represents?

Dr K.D. HAMES: We do not have those figures here. We will have to provide that by way of supplementary information.

The CHAIRMAN: Is the minister happy to do that?

Dr K.D. HAMES: Yes.

[*Supplementary Information No B28.*]

Mr R.H. COOK: I refer to the line item "Other Efficiency Measures" and the $26.78 million found in the 2008-09 budget. Was the full $59.9 million found or does that $26.78 million represent work still to be carried out?

Dr K.D. HAMES: Yes; that amount does represent work still to be carried out. We were unable to identify savings to account for that $26 million and, as members will see in the next line item of $10 million, we were unable to do so in the subsequent year. Therefore, those savings will have to be realised over the four-year forward estimates.

Mrs M.H. ROBERTS: Therefore, that amount is, in essence, carried forward as money that has to be found in the out years?

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

Mr R.H. COOK: Would it be fair to represent that as a hangover from 2008-09—that is, savings that have to be found in subsequent years? Further, if the government is not successful in identifying savings across those other line items next year, they, too, will carry forward into the forward estimates.

Dr K.D. HAMES: It was extremely difficult, given the time line of coming to government and the need to quickly identify areas in which those three per cent savings could be made at short notice without affecting front-line services. The health department worked long and hard to identify possible savings, but it was just unable to come up with sufficient savings without affecting front-line services. What the member says is true. Consequently, we have an amount that is, in effect, a hangover for future budgets, and we will have to look for future savings in those areas. If the Labor Party were in office, it would obviously be in the same boat given it too committed to the three per cent.

Mr R.H. COOK: Does the three per cent efficiency dividend apply to staff who work in the preventive health area?

Dr K.D. HAMES: I will ask Dr Flett to answer that question.

Dr P. Flett: Through the minister, the three per cent applies to all areas that are not in the front line, and it certainly applies in all areas that would not affect any front-line activity. In fact, we are directing attention to natural attrition, reduction in employment contracts, reductions in rostered overtime and the like. The three per cent efficiency will not affect the preventive health area.

[4.50 pm]

Mr R.H. COOK: Is that because it is considered front line?

Mr K. Snowball: Prevention is one of our very important areas, obviously.

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

Mr K. Snowball: It is one of the main COAG aims of the future as well. We are not looking to cut out an area that for us is a most important forward part of medicine prevention.

Mrs M.H. ROBERTS: I refer to the same section. The minister was unable to give the member for Kwinana a breakdown of the FTE efficiencies for country and metropolitan areas. I am looking at the final out year of 2013 and the figure of $53 117 000 that is listed there. Surely the minister would have a figure to hand on how many FTEs will be cut to achieve efficiency.

Mr R.H. COOK: A global number.

Mrs M.H. ROBERTS: The Minister for Education was able to provide such a figure yesterday.

Dr K.D. HAMES: I do not know whether I have any additional answer to the one I have given.

Mrs M.H. ROBERTS: If the minister is going to make FTE efficiencies, surely he must have some target number of reduced FTEs to save $53 million per annum by the out year of 2013.

Dr K.D. HAMES: We have agreed already to provide that information by way of supplementary information and we will do so.

Mrs M.H. ROBERTS: With respect, the minister has agreed to give the breakdown between country and metropolitan areas, and no doubt that will include the total figure. However, it is astounding that the minister has no idea of how many FTEs he will abolish over that time to achieve that saving of $53 million.

The CHAIRMAN: I do not think that is a question. I give the call to the member for Swan Hills.

Mr R.H. COOK: Is this a further question, Madam Chair?

The CHAIRMAN: No. I am moving to the member for Swan Hills.

Mr F.A. ALBAN: My question relates to service 8 on page 174, "Prevention, Promotion and Protection". What steps has the minister taken to ensure ongoing funding to the area of Indigenous eye health, particularly in the Warmun community, where I understand Professor Ian Constable has been doing excellent work with the local community?

Dr K.D. HAMES: Professor Ian Constable and a team of people have been doing excellent work around the Warmun community. Professor Constable and a team of other professionals have, in effect, adopted the Warmun community as a community to look after. Professor Constable is an eye specialist, but the team is not just concentrating on eye health. He and the team go there and deal with other issues. In the past 12 months they have obtained funding for an on-site manager. She was jointly funded with $50 000 from the federal Office for Aboriginal and Torres Strait Islander Health and $50 000 from the Department of Indigenous Affairs. That enabled her to coordinate on the ground a team of experts to go to Warmun. The team of experts went to the Warmun community recently and saw a large number of adults and children and, I think, people from surrounding communities. There were 350 people in that community who came to the team seeking assessment and treatment. They leveraged the funding we provided through their own fundraising efforts, and the total amount raised from charities over two years was $470 000. They provide psychiatric support services for suicide and drug and alcohol issues. The team includes Professor Helen Milroy, who is incidentally an Aboriginal psychiatrist and is on the team of the Indigenous Implementation Board. It also includes Mr Darryl Henry and Professor Karen O'Dea, a national physician interested in Indigenous diet, giving diet and health advice. There is Dr Otto from Kununurra, a public health dentist, helping with dental care. Professor Constable led a team of eight people, including a local optometrist, Ms O'Neill, in the week beginning 12 May. Also there was an ear and hearing service; Professor Harvey Coates went there at his own expense and tested the same 180 children there for ear disease. The Warmun community has issues with water quality—a high concentration of calcium—and Jim Gill, the former chief executive officer of the Water Corporation, will go there to help the community in that regard. The community has other programs, from health and wellbeing programs through to, of all things, a Victorian hip-hop dance group! The team has made a fantastic effort. David Rose, the former CEO of Argyle Diamond, will go there and develop a further business case for whatever else the community can do.

The team and the community have again come to me as minister and asked for additional funding for another year to fund the on-site manager, and I will be very pleased to do that. We will provide an extra $50 000 through the Department of Indigenous Affairs so that they can continue the same program next year. It is a great concept and a great program, and a concept that in fact we are looking to expand to most remote and Indigenous communities. Mr Wyatt from the Office of Aboriginal Health is working on how we can do that in conjunction with the Aboriginal medical services and our own state government departments to make sure that we can get teams of people there. Perhaps we could even get volunteers, such as people who work in hospitals, to go to

remote Indigenous communities for a couple of weeks and provide them with the same level of service in multidisciplinary assessments of the needs of those communities. It is a fantastic program, and Professor Constable must be congratulated for the fantastic work that he is doing. I am looking forward to seeing the results for next year.

The CHAIRMAN: Do members wish to have a quick break?

Dr K.D. HAMES: I would very much like a five-minute break, if that is possible.

The CHAIRMAN: We have been sitting for three hours. I would like to start again at five o'clock. Is a break for four minutes pushing it?

Mr R.H. COOK: Madam Chair, could we do it quickly? We have the first 11 assembled here and it does take a while to get them in!

Dr K.D. HAMES: We will try.

The CHAIRMAN: There is more than one set of bathrooms, hopefully! We will resume again at five o'clock.

Meeting suspended from 4.56 to 5.00 pm

Mr A.J. WADDELL: I refer to the three per cent efficiency dividend on page 162 of the *Budget Statements*. Would any of the expenditure reduction line items involve a delay or cancellation of any major information technology projects?

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

Dr K.D. HAMES: The answer is no.

Mr R.H. COOK: In relation to the three per cent efficiency dividend, can the minister detail the cuts that have taken place in the number of security guards, the rosters for security guards and penalty rates?

Dr K.D. HAMES: The answer is none.

Mr R.H. COOK: Therefore, the minister can confirm that there have been no cutbacks in security guards on hospital campuses in terms of rostered times and the payment of penalty rates.

Dr K.D. HAMES: That is the advice I am given; yes.

Mr R.H. COOK: Further, can the minister therefore give us a rough outline of where he has identified the savings in full-time equivalent staff under the three per cent efficiency dividend program?

Dr K.D. HAMES: Firstly, we will go to Dr Russell-Weisz from the North Metropolitan Area Health Service.

Dr D.J. Russell-Weisz: Generally, we have targeted non-front-line services, so our major focus has been on administration and clerical staff and project officers on temporary contracts for projects that are no longer required. There has been a major focus on those non-front-line services. We have seen some reductions in hotel staff, so our health service assistants used to provide surveillance for patients but now that is provided by nursing staff. Therefore, in the North Metropolitan Area Health Service our significant focus has been on those two or three groups of staff that provide non-front-line services.

Dr K.D. HAMES: Now we will go to Ms Feely from the South Metropolitan Area Health Service.

Ms N.M. Feely: Can I clarify it is non-FTE savings?

Mr R.H. COOK: It is what the nature of the FTE efficiencies is.

Ms N.M. Feely: In addition to things such as natural attrition, we have looked at a reduction in unnecessary front-line fixed-term contracts. From a good management practice point of view, we have also looked at the claims for overtime and allowances and suchlike that from a clinical front-line perspective were not necessary. We have also looked at a reduction in projects and have made sure that we are focused on things that are time critical and we are looking across the board at things such as the use of agency nurses.

Dr K.D. HAMES: That is the answer.

Mr R.H. COOK: Further, in relation to those rostering situations, am I correct in saying that if a security guard or a health service assistant calls in sick, that person would not be replaced for that particular shift?

Dr D.J. Russell-Weisz: At the North Metropolitan Area Health Service we would replace them with a casual, if we could. There might be times when we cannot, but we would replace the security personnel with more casual

staff. That is what we are doing at Sir Charles Gairdner Hospital; we are bringing on more casual staff to ensure that we have, at a minimum, three security staff and, hopefully, at most times four security staff on board.

Dr K.D. HAMES: And the same applies for the South Metropolitan Area Health Service.

Mrs M.H. ROBERTS: I have a further question on the FTE efficiencies. Will any of those FTEs lost be doctors, nurses or other health professionals or will they all be in administrative areas?

Dr K.D. HAMES: Some of the areas that we are targeting deal with overtime and do affect doctors and nurses. I have been having meetings regarding the issue of junior doctors and the junior doctors' overtime. We have employed a considerable number of extra doctors across the state—I think it is 134 all up—and that has allowed us to look critically at the overtime being worked by existing juniors, given that we are about to have a large number of extra junior doctors come on board as the flowthrough comes from Notre Dame University. Therefore, some of those savings are from the overtime of those junior doctors or, sometimes, nurses, when we have additional staff to cover those vacancies.

Mrs M.H. ROBERTS: To clarify that by way of a further question, minister, are the savings only because of a loss of overtime or will there be a reduction in the current FTE level—that is, the number of doctors and nurses employed today—in the course of the next year or indeed four years? Will there actually be an FTE reduction? I am not necessarily asking only about overtime because I do not think the minister could make up to $53 million a year in overtime alone.

Dr K.D. HAMES: Madam Chair, no there definitely —

The CHAIRMAN: I am not a "madam".

Dr K.D. HAMES: Sorry, Mr Chair. I do not have my glasses.

The CHAIRMAN: The minister is skating on thin ice!

Dr K.D. HAMES: No, there will not be a reduction; in fact, there will be an increase. Part of the reason we can make some savings with a reduction of agency nurses is that we have had a considerable increase in the number of nurses across the system. In the past year we have had about an extra 700 nurses and, as I said, I think about 134 doctors—I hope my advisers will correct me if I am wrong—however, there is a significant increase in the numbers coming on board. We are also having a significant increase in graduate nurses coming through the system—a 15 per cent increase in graduate nurses who will start working. We also had a focused recruitment campaign to get nurses who are out of the system back into nursing, and, again, presumably partly because of the economic downturn, there has been significant interest from those nurses in coming back and working within the system.

I can give the member the FTE reductions across the system. For nursing there will be a 96 FTE reduction. However, I would like to clarify that this does not mean there will be 96 fewer nurses; there is a 96 FTE reduction in nurses as a result of the changes in overtime, and 87 in medical. Having said that, there will still be a significant increase in the total number of nurses. As I said, we have employed 700 new nurses, so the savings are in one area and there are costs in another. The reason for that is we are simply using the nurses we have more efficiently, and we have matched the previous government's commitment of an additional 800 new nurses over the next four years. It means that by reducing costs in some areas that we can identify, we have an opportunity for the further employment of additional nurses.

[5.10 pm]

Mr A.J. WADDELL: I follow up on the minister's comment that the department is losing nurses through natural attrition. How is that being strategically managed? Surely if a critical member of staff disappears, the department cannot just say, "There's one for the team; we won't replace them." Does that create pressure within the system to actually stop people from moving within the system? In other words, will managers prevent staff from taking up opportunities in other places for fear that they will not be replaced?

Dr K.D. HAMES: There are two areas to cover. We did not say that we were losing nurses—or doctors, for that matter—through natural attrition; as I said, those numbers are going up. We are losing staff on the administration side through natural attrition. There was significant growth in the public sector during the last years of the previous government. I think the Treasurer made the point that there was something like 20 or 30 new public service employees for every weekday the Labor Party was in government over eight years.

Mr R.H. COOK: I think the Treasurer would probably point out —

The CHAIRMAN: Order, member!

Dr K.D. HAMES: That was a major increase in public sector staff numbers. Significantly, the increase in staff numbers for front-line services was not as large as the increase in numbers of staff for backroom services. It has given the Department of Health the opportunity to look at backroom services and make significant reductions to achieve the three per cent efficiency dividend. No-one ever said that it was going to be easy; it creates the sorts of difficulties described by the member, with people moving or transferring. Nevertheless, we have more staff than we can afford to pay given the current economic circumstances of the state. Members should remember that the three per cent savings will go back into funding front-line services, which are critical services that we need for the state. We are, in effect, transferring that money to areas in which we think it can be better used. One such area is the provision of more nurses and doctors.

Mrs M.H. ROBERTS: I am interested to know whether, either globally or on a hospital-by-hospital basis, the minister knows how many hours are worked by nurses? It is very difficult to know whether patients are seeing more or fewer nurses, or whether there are more or fewer contact hours, unless we actually know the total global number of hours worked at a hospital by nurses in a particular year. Does the department collate those figures; and, if so, is a comparison possible?

Dr K.D. HAMES: We collate those figures regularly. In fact, I have seen them during discussions on this issue. We are looking at total FTEs and overtime worked, and how they relate to total staffing levels. It varies considerably on an almost day-to-day basis. There are 11 000 nurses in this state, so it is a very large employment pool and those numbers vary significantly. To answer the member, yes, we have those figures on a day-to-day basis.

Mrs M.H. ROBERTS: Can I have a comparison of hours worked by nurses in metropolitan hospitals for each of the past two years?

Dr K.D. HAMES: Yes, we are happy to provide that as supplementary information.

[*Supplementary Information No B29.*]

Mr I.M. BRITZA: I refer to page 180, under "Works in Progress", the "Metropolitan Plan Implementation", with particular regard to Shenton Park. I have a four-part question. Given the run-down condition of this facility, will the commonwealth government funds that are to be made available be used on a new facility at the current location? If so, is there a time line for the project? When will the commonwealth government funds be received? Will the $5 million in the holding fund be enough to keep the current facility in reasonably good repair until the new facility is built?

Dr K.D. HAMES: We need to thank the commonwealth government for providing this money. This facility has been severely run down for a long time, and, sadly, other facilities in Perth that are more well-known have received funding first. The government supported the process of funding for Fiona Stanley Hospital, Midland Hospital, Joondalup Health Campus and Rockingham General Hospital. Those facilities have always received funding before Shenton Park, which has been on the backburner for a long time. One of the Reid review recommendations was that the Shenton Park facility be relocated. The preference for relocation was the Fiona Stanley Hospital site. The Liberal Party supported the recommendation. It was in stage 2 of the former Minister for Health's budget; stage 1 was supposedly to be completed by 2010, and stage 2 by 2015. Unfortunately, stage 1 was moved out progressively until it got to 2013-14, and we could assume a date five years further along for the completion of stage 2, including Shenton Park, in 2018-19. That is a long way into the never-never. We received a considerable number of complaints from nursing staff, doctors, patients and visitors about the standard of the Shenton Park facilities. When the opportunity arose to ask the commonwealth government for additional funds under the health infrastructure program, Shenton Park was the government's equal top priority along with Midland Hospital. We had no funding for that; we were looking for ways to do it. We had been given an estimate of the value of the land out there and it was in the order of $200 million, because it is prime land. We were looking at ways by which we could leverage the funds, perhaps by doing a deal with those who are developing Fiona Stanley Hospital to come to a land swap construction arrangement so that we could get it sooner. In the end, we did not need to do that because the full amount of funding required to effect the relocation was provided.

There are two components to Shenton Park. There are patients with head injuries and spinal injuries, and there are elderly patients, including those who have suffered strokes, who need rehabilitation. It is a 240-bed hospital. The funding will provide an extra 140-bed facility at the Fiona Stanley Hospital site for patients with spinal injuries and head injuries. That is due to commence construction in December 2011 and to be completed by 2014, which is the same time that Fiona Stanley Hospital is expected to be completed. Whether it is done by the contractor for Fiona Stanley Hospital or an alternative contractor, we will presumably have to go through the

normal tender process. The rest of the capacity at Shenton Park—approximately 90 beds—will go to other locations. As part of the redevelopment of the Joondalup, Rockingham and Armadale facilities, those rehabilitation services will be provided by those facilities. That was planned by the previous government and we will continue with that plan. It is extremely exciting that we are now able to get on with that work. We still have some issues with the current site. In the meantime, we have submitted a business case to the Department of Treasury and Finance for $4.8 million of allocated capital works funds so that we can get some work done. We are looking at other work that can be done. The facility is part of Royal Perth Hospital, so the funding is attached to that. We have already spent $4.65 million on upgrading aspects of the infrastructure that were identified in a recent report on safety services at that hospital to make sure that they were brought up to scratch. It is unfortunate that it is still four years away but it is really a great outcome. I know that people who work at that hospital are extremely excited about the potential change and what will happen. They have got everything they could have wanted.

[5.20 pm]

Mr R.H. COOK: My question relates to budget paper No 2, volume 1, page 173. I refer to service 7, "Patient Transport": Can the minister aggregate the cost of patient transport across the various categories, including St John Ambulance, the Royal Flying Doctor Service and the patient assisted travel scheme?

Dr K.D. HAMES: I am sure someone, if I dawdle for long enough, will be able to find the breakdown detail for me. I remember seeing St John Ambulance recently, in the order of $37 million.

Dr P. Flett: In 2008-09 the estimated RFDS budget is $38.4 million—an increase from 2007-08 of $19.4 million—and in 2009-10 it is expected to rise to $39 million.

Dr K.D. HAMES: We will just switch to Mr Leaf, who has the St John Ambulance breakdown.

Mr J.W. Leaf: The current St John Ambulance expenditure for 2008-09 is $21.7 million. In 2009-10 it is expected to be $34.29 million.

Dr K.D. HAMES: That is the figure I remember seeing.

Mr R.H. COOK: It was $21.7 million to $34.32 million; is that correct?

Dr K.D. HAMES: Yes. I can see that. I recall that when we arrived in government there was a group of union people camped on the doorstep outside our offices campaigning for additional funding. I am pleased to say that, through my contacts with St John, I stopped and met that group. I spoke to Mr John Thomas and discussed with him the funding issues that they had. It was their desire that ambulance staff have a comparable rate with what equivalent nurses were being paid, given they were performing similar type of work. They required additional state funding to get the increase they wanted. We had tripartite negotiations between the health department, St John Ambulance and the union to achieve the increases that were sought.

Mr R.H. COOK: I overlooked the fact that we actually gave some notice of this question. The minister might have it in those other papers.

Dr K.D. HAMES: The answers will not change.

Mr R.H. COOK: I understand that, but I am indicating, for brevity, the minister may have the answers as part of a different package of documents. Assuming the minister's benchmark is correct, based on the performance of various aspects of the patient transport system, can the minister provide some indication of where St John Ambulance services sit relative to other jurisdictions in terms of efficiency, be it a response time or a per capita cost?

Dr K.D. HAMES: I will hand over to Mr Leaf. Without being official, I can talk anecdotally about that initiative. The union was campaigning for the state government to take over the management of those services. I had an assessment done at that time that compared us and our costs with the service provided in other states. We found that our service was considerably better in both figures.

The CHAIRMAN: Minister, I do not know whether it will assist, but a document was just placed in front of you. I do not think you noticed. It is to the right of your glass.

Dr K.D. HAMES: It is the answer to the previous question that the member put on notice. I do not know what I have done with them; I thought I had them here. As members can see, I have lots of papers. We do have that figure here on the St John Ambulance break-up. As with the previous papers, I will give them to the member. Dr Flett will read out the cost and compare the difference in cost; and then I will read out the timing and compare the difference in timing.

Dr P. Flett: I am reading from a table, "Ambulance Service Organisations — Expenditure Per Capita". These are 2007-08 costs. First of all, the cost to government of ambulance services per capita is Western Australia, $17; Queensland, $76; Victoria, $52; New South Wales, $55; South Australia, $42; Tasmania, $57; ACT, $49; and Northern Territory, $58. We are substantially lower there. The second line is that of expenditure per capita by ambulance service. I will read out the lot. Western Australia is again substantially lower than almost half the other states. They are: Western Australia, $49; Queensland, $94; Victoria, $89; New South Wales, $80; South Australia, $92; Tasmania, $73; ACT, $65; and Northern Territory, $84.

Dr K.D. HAMES: I will further read out the response times. First, I have some clarifying comments. St John Ambulance operates only in WA and the Northern Territory. Other jurisdictions' ambulance services are operated by government. I will provide ambulance code 1 response times for all jurisdictions, but the document does point out that response time data is not directly comparable between jurisdictions. I do not know why that is. There are two dates, 2006-07 and 2007-08. The member will get a copy of this after I have given this answer. In 2006-07 the response times were: New South Wales, 20 minutes; Victoria, 15 minutes; Queensland, 15 minutes; Western Australia, 14.9 minutes; Tasmania, 14.4 minutes—that state beat us slightly; ACT, 14.2 minutes—again the territory slightly beat us; and Northern Territory, 20.5 minutes. In 2007-08 the response times are reasonably comparable: Western Australia had gone up slightly to 15.6 minutes; Queensland, 15.3 minutes; Victoria, 15.5 minutes; New South Wales, 17.8 minutes; Tasmania, 16 minutes; ACT, 16.2 minutes; and Northern Territory, 22 minutes. We are not the best but we are close to it in most of those comparisons.

Mr R.H. COOK: The minister mentioned that he had a review conducted. Assuming that there is no sensitive information in that, would he be able to share a copy of that review?

Dr K.D. HAMES: I do not recall saying there was a review.

Mr R.H. COOK: The minister said that when he came to office and following discussions with —

Dr K.D. HAMES: What happened when I came to office —

Mr R.H. COOK: Not a review as in a fully fledged review but a review document.

Dr K.D. HAMES: I just asked at that stage for these same comparisons. I think it was actually over the phone that I was told those comparisons between the states. It arose when we were discussing the argument of whether the service should be a government service. I was satisfied that it should not. Members can see by the figures that St Johns was providing an excellent service to this state. In my view it was not appropriate for us to interfere, given those comparative figures. I ask the clerk to take these and pass them to the Deputy Leader of the Opposition.

[5.30 pm]

Mr F.A. ALBAN: My question relates to page 165 and to the heading "'The Four Hour Rule' — Managing Unplanned Care". There are several parts to this question. Has the $75.3 million provided by the commonwealth government to help alleviate demand on emergency departments been transferred to the state; how much of that $75.3 million will be used to implement the four-hour rule; how realistic will it be to meet the 98 per cent target for arriving patients; and when will the regional country hospitals be included in this program?

Dr K.D. HAMES: We have covered the first two components of the question in previous answers—that is, the $75.3 million of commonwealth government funding to initiate the four-hour rule. I think that the second two components are particularly important in meeting that four-hour rule. As the member will be aware, I joined with a team of people from the health department, headed by Dr Robyn Lawrence, to go to the United Kingdom to look at how that four-hour rule had been implemented in the past across more than 130 hospitals in the United Kingdom, and to see whether it was appropriate for Western Australia. The team was very impressed by what had happened over there. Even the worst hospitals were able at most stages to achieve that 98 per cent compliance—that is, 98 per cent of patients, within four hours of arriving at the ED, being admitted, transferred or discharged. That required considerable streamlining of the process, particularly up-front assessment of the patients when they came in. Instead of people waiting for two or three hours to be seen by a medical person, in the first half-hour blood would be taken and X-rays would be done. Senior doctors or experienced doctors or nurse practitioners would assess the patients up front and put them into streams, so that they could get their treatment and get out of the hospital within the four-hour rule. Each individual case that failed to make the four-hour rule was investigated to see what had gone wrong, what the problem was and what action needed to be put in place to fix it. The hospitals that failed were highly scrutinised. In fact, some chief executives lost their jobs over not being able to implement the four-hour rule in their hospitals.

We came back very enthused. At one stage we were considering looking at 95 per cent compliance rather than 98 per cent compliance. However, on the recommendation of Dr Lawrence and the team, we decided to go for 98 per cent compliance to make sure that we put pressure on the hospitals. Those hospitals in the UK had some funding almost as a reward for achieving compliance. We have $75 million that has been allocated, and it will be used not as a reward, but to help the hospitals to achieve compliance with the program. We have started with our three tertiary hospitals. The implementation period is 18 months. If after that any one of the hospitals fails consistently to meet the 98 per cent compliance, despite reviewing its processes and working out what it can do differently, we will get teams of people involved at the two other tertiary hospitals to go into that hospital that is not succeeding to tell it what it is doing wrong. I am sure that Dr Russell-Weisz from the North Metropolitan Area Health Service—who is mostly associated with Sir Charles Gairdner Hospital—would agree that the people who run Sir Charles Gairdner Hospital would be abhorred if people from the other hospitals came in and told them what they were doing wrong. We think that that will be a great incentive for the hospitals to achieve compliance. However, it is not just that; the hospitals and the staff with whom we have spoken want to achieve it. They think that this will be a great step forward.

This will mean that it will not be the responsibility of just the EDs any more. The people in the EDs used to work their hearts out getting the patients ready for admission. No beds would be available, so the patients would be stuck in a corridor. Often, more than 50 per cent of patients waited more than eight hours for a bed and for admission. Under this program, that will have to go. It will be the responsibility of the whole hospital. The proper management of discharges and the proper management of patients in the hospital will lead to the end result of achieving the 98 per cent target.

There is a program of implementation. Stage 1 commenced in April for Royal Perth Hospital, Sir Charles Gairdner Hospital, Fremantle Hospital and Princess Margaret Hospital for Children. I think the implementation period is 18 months. I will ask Dr Lawrence to correct me if I am wrong, and to make some further comments at the end. Stage 2 sites—that is the second phase—are Rockingham, Armadale-Kelmscott, Swan District and Graylands hospitals, and the special health care service. Bunbury and Joondalup hospitals will commence in October this year. The stage 3 sites, which are the Kalgoorlie, Albany, Broome, Geraldton, Port Hedland, Nickol Bay, King Edward and Peel hospitals, will commence in April 2010. That is the planned roll-out that has been put forward by the team. I will ask Dr Lawrence to comment on how the implementation of that four-hour rule is progressing.

Dr R. Lawrence: I will make two quick corrections. The teams have two years to reach the target from commencement of the program. The first six months is essentially the diagnostic phase, and then they will begin implementation of their solutions. Stage 3 will commence in April 2010—so it is April, October, April. The commencement times are staggered at six-monthly intervals. The first four sites have just come to the end of the first six weeks of the program, which is essentially the mapping of the process. We have seen some amazing commitment and dedication by the teams and some fortuitous gains already in improvements in access for patients through the emergency departments. That is really unrelated to the program. It predates the work that has already occurred in clinical service redesign in those units, but it supports the decision to continue to use that methodology and the success that that can bring about. I think at this point we are very much on track. There is a lot of commitment. A lot of questions are still coming forward from staff and the community, which we are addressing as they come up, but in general there is a commitment by staff and the community to make this a success.

Mr R.H. COOK: I refer the minister to page 170. I assume this line item would come under service 1, "Admitted Patients". It is about the provision of junk foods in hospitals. I noticed recently that the minister had made a ruling to eliminate black foods—I hate that expression "black foods", by the way; it has dreadful semiotic connotations.

Dr K.D. HAMES: I do not think we are using it.

Mr R.H. COOK: Yes. There are also the red foods, and the minister has watered down the requirements to allow higher sugar levels and higher fat levels. I want to understand the reasons behind making that decision.

Dr K.D. HAMES: Sure. Can I say that the report in *The West Australian* was not completely accurate. I guess it was accurate in what it said but not in what it portrayed. It portrayed that there had been a significant increase in the amount of fat foods that were available and that we had blown out the change. The former Minister for Health had committed to significant reductions in what had been available. Large amounts of these foods were available, but the former minister committed to a major reduction in the availability of those foods. This even went to what was available in schools, with the red, yellow and green programs. A lot of people came to see me

to talk about this issue. The most vocal were the ladies who worked in the canteens. They were extremely unhappy with how the situation had changed progressively. There had been some changes over time restricting what they were able to sell. They could no longer sell a box of Cadbury Roses chocolates that someone might want to buy for his or her ailing grandmother, for example. They could not sell those sorts of items because they were no longer on their list. There is a lolly shop in the Armadale-Kelmscott Memorial Hospital, and the people from that shop came to see me and said, "Look, all the staff come to us in the middle of the night when they are working hard. They just want a little bag of lollies to keep them going, and we've been told that we have to stop selling all those things." I must say that I had some sympathy for their view.

[5.40 pm]

I also had the vendors coming to me; they obviously had a vested interest in what was going to happen. They were going to have to significantly cut back on some of the fat items. They were not going to be allowed to provide things like potato chips and large chocolate bars any more. Also, I have to say that I did not have a great concern with people eating those foods occasionally. I know we all need to be healthy, but the reality is that unsupervised school children will always buy food that is the top end of the scale; they will always pick the fatty foods. But other kids and adults will go into a deli where all the bad stuff is and not buy it. It is up to adults to make that decision, and workers are adults who can make their own decisions about what food is available. I decided on a compromise position and I went backwards and forwards and discussed it. I will pass to Dr Andrew Robertson in a minute to find out what the final split of foods to go in hospitals was, if he knows.

Dr A.G. Robertson: Yes, I do.

Dr K.D. HAMES: I will pass to Dr Robertson in a second to give us that information.

When I read in the newspaper that they were allowed to provide chicken drumsticks coated in fat and stuff, I thought, "I don't remember saying that was okay; I don't remember saying that was approved". But maybe they snuck in because the allowed foods must have no more than 20 per cent of fat in them—so it is possible. I will look into that soon

Mr R.H. COOK: I suspect it is possible.

Dr K.D. HAMES: The issue for me is about choice. The vast majority of the food being provided was yellow or green. I do not mind someone buying a bar of chocolate for their grandmother who is sick in hospital. It might not be great for their health, but we are talking about sick people.

Mr R.H. COOK: Can I have that bit of *Hansard*!

Dr K.D. HAMES: I mean people who are sick from other conditions such as cancer and heart disease which might be life threatening—whether or not they have a chocolate bar will not make a difference to their total life expectancy. I want to look after people's comfort while they are in hospital, and not worry about whether they are allowed to have a chocolate bar. That has been my focus.

Also the staff were complaining that they work hard and they work long hours at night, and they want to buy something that might not be the most healthy for them, but outside those working hours they might be the healthiest people around—probably a lot healthier than the member and me when we go off at morning tea and have our bits of cake. It is about choice, in my view.

We had some argy-bargy because, as members can imagine, the department loved what former Minister for Health Jim McGinty was proposing, and it wanted those far stricter guidelines to be in place. It was my choice alone that led to the end result. We will tell the member what the results are, and then he can ask another question.

Mr R.H. COOK: Perhaps if we can have that information as a supplementary.

Dr K.D. HAMES: I want those splits recorded, so Mr Robertson can tell us.

Dr A.G. Robertson: Members will be pleased to hear that the new option was to get rid of the black, merge the black and red together, and then the figures were 50 per cent for green, 30 per cent for orange, and 20 per cent for red.

Mr R.H. COOK: I have a further question. I know this subject provides a certain amount of merriment for people, but what sort of message is the minister sending to the people of Western Australia if in the places that promote healthy living the minister is saying it is okay to eat these foods? What is the message that the minister is delivering?

Dr K.D. HAMES: I am about to tell the member—he has to stop and pause! The message I am sending is that as a doctor and as the minister in charge of hospitals in this state, I am much more focused on the comfort of my patients and my staff than I am on whether or not they eat a chocolate bar. That is the message I am trying to send. When we look at the overall statistics about the effect of certain foodstuffs on the lifespan expectancy of people in the community, a chocolate bar will not make much difference.

Mr R.H. COOK: Is the minister going to sell cigarettes there as well?

Dr K.D. HAMES: I will give the member the example of salt intake. Everyone says one must not eat salt. If we read all the studies across population groups, there is very strong evidence that shows that as a population group we need to reduce total salt intake. The reason for that is that salt intake can cause elevations in blood pressure, causing further hardening of the arteries, leading to early myocardial infarctions and other cardiovascular events. But if we take an individual person within that group, salt actually does not necessarily make any difference at all. Providing my blood pressure is okay, I can eat salt without any harm whatsoever.

Mrs M.H. ROBERTS: The minister barely needs any policy advice; maybe he could make the cuts there!

Dr K.D. HAMES: The same applies to those foods that can be eaten in a hospital canteen. If the member for Midland was a person who had a lifestyle that meant that she ate excessive chocolates or cakes and if she were to be overweight and lacking in exercise, there is no doubt that that would have a negative impact on her health. But somebody like the member in the chair, or the Deputy Leader of the Opposition, who is fit, healthy and young, eats a good diet and does plenty of exercise, a chocolate bar when he is sick after he has had his appendix removed will do him absolutely no harm whatsoever.

Mr R.H. COOK: I have a further question. I did not ask a question about broad dietary nutritional principles, I asked the minister what sort of message he was sending. I will explain what I am saying.

Dr K.D. HAMES: I thought I told the member what my message was.

Mr R.H. COOK: Why is it that the Minister for Education can bring about a culture change in education through the promotion of healthy eating, yet the Minister for Health cannot change the eating culture the Department of Health? I again ask what sort of message is the minister sending to the people who visit the hospitals and the sick people in hospitals?

Dr K.D. HAMES: The same message I was sending when I answered the question last time—that is, I am far more concerned about the comfort of my staff and my patients than I am about the issue of sending a message. When I want to send a message to the public, I will not send it through what I do in a hospital where sick people go; I will send it to the community via advertising and public education campaigns about preventive health care to ensure that they are aware of the long-term health effects of eating those types of foods. That is what education campaigns need to be based on. The issue in schools is that children are unsupervised and would eat entirely the wrong foods if allowed to. Children need to be sent a message about the long-term effects of having a daily intake of healthy food or unhealthy food.

Mr R.H. COOK: Then the answer is that the vendors got to the minister?

The CHAIRMAN: Member, we have stretched this bow as far as it can go.

Dr K.D. HAMES: No, the answer is not that the vendors got to me. I paid less attention to what the vendors said than I did to any of the other groups.

The CHAIRMAN: The member for Mount Lawley has the call.

Mr M.W. SUTHERLAND: I refer the minister to page 180 of the *Budget Statements* which has a reference to "Albany Regional Resource Centre — Redevelopment Stage 1". Will the minister outline the government's election commitments and progress on this project?

Dr K.D. HAMES: I thank the member for the question. I cannot find my notes on the Albany Regional Resource Centre.

The CHAIRMAN: Perhaps, minister, if the member is willing, we can move on to another question and come back to this one.

Dr K.D. HAMES: If we have time, we can come back to that question.

The CHAIRMAN: The member for Morley has the call.

Mr I.M. BRITZA: I refer the minister to page 181 of the *Budget Statements* and the heading of "Works in Progress", and the section relating to "Southern Tertiary Hospital — New Stage 1 (Fiona Stanley Hospital)". I have three questions: at what stage will obstetrics be included in the new hospital; how is the government improving obstetric services in other hospitals such as Nickol Bay and Kalamunda; and, will obstetrics remain at Osborne Park, given the cancellation of phase 2?

Dr K.D. HAMES: I will answer the questions in a different order from how they were put. 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.

Mr I.M. BRITZA: My son was born there!

[5.50 pm]

Dr K.D. HAMES: Is that right. It is an excellent hospital. Unfortunately, for most of the term of the Labor government it had recommended that the maternity section be closed. I do not know why that was the case, given it was meeting the requirement of, I think, 150 births a year to warrant it staying open. As I said, it has excellent facilities. I am pleased to say that prior to the former Minister for Health leaving that job he changed his mind and committed to retaining that unit. The Fiona Stanley Hospital obstetric service was in the very early proposal of stage 1 of the development of Fiona Stanley. It was supposed to be built right up front and part of that was to replace the Woodside Maternity Hospital service that had been closed and moved to Kaleeya. Subsequently, in about the middle of the Labor government's term, it moved the inclusion of that obstetric unit at Fiona Stanley back to stage 2. We discussed earlier that stage 2, which was initially due for completion in 2015, was to be completed in 2018-19. Again that went into the never-never. There were no funds whatsoever in the budget.

One of the additional good things that has come about through the retention of Royal Perth Hospital is that it has created some space within the structure of the 643 beds to be provided at Fiona Stanley Hospital. That has enabled us to bring forward placing the maternity section there. We recently announced that. It will have a significant impact on King Edward hospital. About 25 beds that had been going to King Edward will be coming back and be placed in Fiona Stanley. I do not have the exact details of what was going into Fiona Stanley, but it was not just beds for deliveries and neonatal beds, but also beds within the psychiatric component for mothers who had post-natal depression. That provides a significant number of units for mothers with that condition. It is great progress. There is no suggestion that that will affect the operation of Fiona Stanley because it provides a number of mental health beds that would have otherwise had to be provided at that hospital. We will still have a large number of mental health beds, a significant component of which will be able to stay at Royal Perth and service that eastern corridor. The design provided the opportunity for that flexibility in the construction of wards, so virtually no changes have needed to be made to the design of Fiona Stanley Hospital to cater for that.

As the member knows, Kalamunda maternity service was closed by the former government, at great distress to the local community, particularly some of the GPs there who provide obstetric services. We will bring that back in partnership with the community midwifery program, which is an excellent program, in conjunction with local GPs to make sure we get that localised maternity service available in Kalamunda District Community Hospital. I am sure Hon Helen Morton and the Minister for Planning will be very pleased with that announcement.

Mr I.M. BRITZA: What about Nickol Bay Hospital?

Dr K.D. HAMES: I did not answer the component about Nickol Bay, largely because I think we have dealt with that in former questions. Funding is available within the $10 million for the Nickol Bay Hospital to cover it. We are working with King Edward hospital to provide a support service largely to GPs who are operating that obstetric service in Nickol Bay.

Mr R.H. COOK: Prior to today, I provided a number of written questions with some notice dealing with FTEs across a number of service areas. Would the minister be prepared to provide the responses to those questions or would he like me to read them out now? I am happy to do so.

The CHAIRMAN: The member is required to provide me with a page number and line item.

Dr K.D. HAMES: We have had this issue before when we have been asked to provide supplementary information. The member asks a question and I answer it if I can within the time provided. Given we are scheduled to sit after dinner from 7.00 to 8.00 pm and I indicated that it might be appropriate to do the other services from 7.00 to 8.00 pm, I do not want to accept them as supplementary questions because I said that I would not. I think we have the answers here. If we do not have them here, I will get them to the member within the next few days without worrying about supplementary information, because the member has given notice and

it is reasonable that I provide the answers. Usually, one member asks a question then someone else asks one. It depends whether the member's questions are about the same thing. I have them and I apologise because I cannot find them.

The CHAIRMAN: If it is acceptable to the member for Kwinana, the minister will give an undertaking to provide those answers in the next few days and we will move on.

Mr F.A. ALBAN: I refer to the health services development fund under "Works in Progress" on page 180. The election promises added up to $24 million. This has been reduced to $13.3 million. Can the minister indicate what is included in the health services development fund and why it has been reduced by $10 million?

Dr K.D. HAMES: We have covered this in part. I want to make it clear that the total of that amount of funding is there. It is not in the line item because of the $10 million we referred to previously for Nickol Bay, which is now funded under the royalties for regions scheme. The other commitments for funding as part of that are for a CT scanner for Carnarvon at a cost of $1.7 million; Bunbury breast cancer unit, $4 million; and Bunbury ICU at $500 000, although that has now been encapsulated into the project of expanding the emergency department services in Bunbury. It will still be used within the forward estimates in four years but perhaps not as quickly because we need to link that with the ICU expansion. Kalamunda obstetrics will receive $2 million to cover what has been paid to bring in the service there; and the Peel Health Campus paediatric unit will receive $500 000. A former member of Parliament, Mr Arthur Marshall, has been working as chair of that committee to build a new paediatric unit at the health campus there and has raised more than $3 million, I think. This is the state government contribution. The amount of $300 000 is for the Esperance CT scanner. The residents down there have raised a lot of money to fund the scanner. This funding is for installation costs and the Multiple Sclerosis Society Bunbury facility for disabled youth for the purchase of land. It has raised the money for the development of that MS society of $1.5 million. That adds up with that additional $10 million to the total of that funding. Again, as I said before, I am not sure whether he was here, but there is $3.5 million in excess of that to be put into the Kimberley renal dialysis services.

Mr R.H. COOK: I refer to age and continuing care in volume 1, page 175 of the *Budget Statements*. When is it anticipated that the care awaiting placement will be fully replaced by the transitional care program?

Dr K.D. HAMES: I will ask Dr Lawrence to answer that question. While Dr Lawrence is looking for that information, I would like to point out that this specific CAP funding was committed to by government but not funded. It had to be internally funded out of existing health department funds. We have talked about the difficulties we have had going so much over budget. It is components like this that contribute to that because we have had to find that money out of internal funds.

Dr R. Lawrence: Is the member talking about the TCS transition or the CAP beds?

Mr R.H. COOK: When will the CAP be replaced by the transitional care program?

Dr R. Lawrence: I cannot give any more detail on that. I can talk about the CAP beds.

Dr K.D. HAMES: Can Dr Lawrence tell us about the closure of the CAP beds? We will see how that answer fits with what is required.

Dr R. Lawrence: Shall I talk about the transition from the CAP beds to the TCS program?

Mr R.H. COOK: Can we have it as supplementary information?

The CHAIRMAN: Let Dr Lawrence finish her sentence.

Dr R. Lawrence: The 86 CAP beds will progressively close, with six closed by the end of June and the remainder closed sequentially up to the end of December. The 86 CAP beds will close and the TCS beds will transition over a similar period, but I cannot give the member a definitive breakdown.

The appropriations were recommended.

Meeting suspended from 6.00 to 7.00 pm