STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

ANNUAL BUDGET ESTIMATES HEARINGS 2010–11

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
FRIDAY, 2 JULY 2010

SESSION TWO

Members

Hon Giz Watson (Chair)
Hon Philip Gardiner (Deputy Chair)
Hon Liz Behjat
Hon Ken Travers
Hon Ljiljanna Ravlich

Hearing commenced at 12.40 pm

O'BRIEN, HON SIMON
Minister for Transport,
sworn and examined:

SNOWBALL, MR KIM
Acting Director General, Department of Health,
sworn and examined:

DILLON, MR ERIC
Acting Executive Director, Drug and Alcohol Office,
sworn and examined:

SALVAGE, MR WAYNE
Acting Director, Finance and Contracting, Department of Health,
sworn and examined:

SOUTH, MS JODIE
Acting Director, Central Infrastructure Unit, Department of Health,
sworn and examined:

WEERAMANTHRI, DR TARUN
Executive Director, Public Health Division, Department of Health,
sworn and examined:

MOFFET, MR JEFFREY
Acting Chief Executive Officer, WA Country Health Service, Department of Health,
sworn and examined:

AYLWARD, MR PHILIP
Chief Executive, Child and Adolescent Health Service, Department of Health,
sworn and examined:

RUSSELL-WEISZ, DR DAVID
Chief Executive, North Metropolitan Area Health Service, Department of Health,
sworn and examined:

FEELY, MS NICOLE
Area Chief Executive, South Metropolitan Area Health Service,
sworn and examined:

The CHAIR: I will open proceedings this morning. Firstly, on behalf of the committee, I welcome you to this morning's meeting. Before we begin, I am required to administer an oath or an affirmation.

[Witnesses took the oath or affirmation.]

The CHAIR: Thank you very much. You will have all signed a document entitled "Information for Witnesses". Have you read and understood that document?

The Witnesses: Yes.

The CHAIR: Great. These proceedings are being recorded by Hansard. A transcript of your evidence will be provided to you. To assist the committee and Hansard, please quote the full title of any document you might refer to during the course of this hearing. Please be aware of the microphones and try to speak directly into them; we have found that, when you get the call, wait till the light comes on—that will also assist us. I remind you that your transcript will become a matter for the public record. If for some reason you wish to make a confidential statement during today's proceedings, you should request that your evidence be taken in closed session. If the committee grants your request, any media and public in attendance will be excluded from the hearing. Please note that the uncorrected transcript should not be published or disclosed. This prohibition does not, however, prevent you from discussing your public evidence generally once you leave the hearing.

Government agencies and departments have an important role and duty in assisting Parliament to scrutinise the budget papers on behalf of the people of Western Australia, and the committee values your assistance today. Members, please remember to quote the page, budget item numbers and programs in preface to your questions. That will also assist the process. Just before we get started, we were thinking of breaking at one o'clock for lunch but this seems slightly keen. I am wondering: we could stop at one or we could go a little bit longer. I am perhaps seeking some indication from other participants. Would you like to do 15 minutes now and stop and have a break for lunch and come back?

Hon SIMON O'BRIEN: We are in your hands, Madam Chair. But I have organised for a lunchbreak for witnesses.

The CHAIR: In which case, I think it might be more appropriate that we do break at one so that we have a chance to do that. We will stay with that plan; we will do 15 minutes and then break for lunch.

Hon KEN TRAVERS: I am trying to identify where in the budget the operation costs of the Joondalup and the Peel Health Campuses are. Are they shown anywhere under the detail of controlled grants and subsidies; and, if not, where do they occur in the budget?

Hon SIMON O'BRIEN: I ask Mr Salvage to deal with that.

Mr Salvage: The answer is that they do appear under controlled grants and subsidies in that section of the *Budget Statements*.

Hon KEN TRAVERS: Under which particular item do they appear?

Mr Salvage: I beg your pardon; I will have to retract that first statement. They are captured under the "Public Hospital Admitted Patients" service on page 179 of the *Budget Statements*. They are also reflected in the "Grants and subsidies" line shown in the cashflow statement on page 205.

Hon KEN TRAVERS: If that is the case, why would they not then show up under the details of controlled grants and subsidies? If they show up in your cashflow statement as grants and subsidies, why would they not also then show up under that detail of controlled grants and subsidies?

Mr Salvage: I do not immediately have an answer to that question.

Hon KEN TRAVERS: The reason I ask—maybe you can take this one on notice—is that I would like to get a figure for how much is paid on an annual basis under each of those contracts for the administration of services at each of those hospitals.

Hon SIMON O'BRIEN: If we could take that question on notice.

[*Supplementary Information No B1.*]

Hon KEN TRAVERS: My next question continues on with respect to the Peel Health Campus and the contract with Health Solutions. As I understand it, there is a requirement under the contract for them to pay a rent fee. I am not sure whether it is to yourselves or whether it is to what used to be CAMS; it is probably works and services or somewhere else these days. I am just trying to understand what payments are made in respect to rent between the government and Health Solutions. As I understand it, in the contract there is quite a round-robin system of money being paid back and forth to people. I am just wondering if someone can explain to me how much is paid in each financial year and how much you expect to get for this financial year.

Hon SIMON O'BRIEN: I think, given the detail of that, that might be one to take on notice as well.

[*Supplementary Information No B2.*]

Hon KEN TRAVERS: With B1, can we get for the last three or four years how much has been paid under each of those contracts, if that is possible?

The CHAIR: That was referring to supplementary information No B1.

[12.50 pm]

Hon KEN TRAVERS: If we can then get an explanation of the contract payment arrangements with respect to the payment of rent—I think it is also referred to as an availability charge. Could we get a breakdown of what money has been paid for the past three years and is expected to be paid this year in respect of that?

Hon SIMON O'BRIEN: I understand that what we are taking on board for supplementary questions B1 and B2 is the committee would also like, if it is available—I assume it is—the previous few years of the same question, presumably for comparison purposes.

The CHAIR: Is that correct, honourable member?

Hon KEN TRAVERS: Yes.

Hon SIMON O'BRIEN: We will provide that.

Hon KEN TRAVERS: My next question is also about the Peel Health Campus. I understand that they are required to make provision for the maintenance and replacement of equipment. I wonder whether the department is able to provide any information on what monitoring they do to ensure that it is being complied with. How much is currently provided for? Do you maintain a reconciliation of how much has been provided for by Peel Health Campus? Where is the money held? How much is spent, and how much is currently in reserve for the replacement and maintenance of equipment? I understand that under the contract, that was originally provided for by the state government.

Hon SIMON O'BRIEN: I understand that the member is asking for the amount to be allocated via the Peel Health Campus for the ongoing replacement of equipment.

Hon KEN TRAVERS: Whatever they are required to under the contract in terms of the maintenance or replacement—what provisions they are required to meet under the contract.

Hon SIMON O'BRIEN: The provisions of what is required and —

Hon KEN TRAVERS: Whether they are complying with that and how much is in there for the reconciliation for the past two or three years of the money in that account.

Hon SIMON O'BRIEN: Again, this is asking for a level of detail beyond the budget papers that we have before us. I will have to take that on notice.

[*Supplementary Information No B3.*]

Hon KEN TRAVERS: Following on from that, has the department either last year, or does it on an annual basis, conduct an audit of the equipment at Peel Health Campus to ensure that the equipment is being maintained at a certain standard; and, if yes, when was the audit undertaken and what was the outcome of the audit?

Mr Snowball: Through the minister, yes, we do have regular and routine audits of the equipment. We also ensure that the equipment meets a standard and is compliant; there are compliance checks as well. That is routine, as is undertaken in the other hospitals in the state hospital system.

Hon KEN TRAVERS: My next question is a bit broader. What is the average cost per case mix adjusted separation for each of your hospitals? Do you maintain average costs per case mix adjusted separations for each hospital—the amount of money; and, if so, are you able to provide those figures for the last year and the coming financial year of what you expect to be the average cost per case mix adjusted separation for each of the hospitals funded by your organisation?

Mr Snowball: Through the minister, 2010–11 marks the first year we will move to an activity-based funding model in health. In the first year it will be relatively rudimentary in its form. It will look at average costs per weighted episode in our hospitals, with a particular focus on inpatients and emergency department attendances. We do collect the information that the member is referring to, but at present we do not actively use it in terms of our funding of hospitals; we use it as a means to look at benchmarking and at other states, and so on. It is not routinely reported either, on a hospital-by-hospital basis. Activity-based funding in 2010–11 will move to that arrangement. Over course of the next three years, it will go from looking at an average cost of peers in hospital groups, in terms of a cost per episode, to a weighted cost per episode—basically, the full refinement in terms of the case-mix approach to funding arrangements for hospitals. That will make it very transparent across our system; that is, first of all, what government gets for its investment in health, in terms of activity and also moving towards a clear efficient price for the services, hospital by hospital, that are delivered in Western Australia.

Hon KEN TRAVERS: If you do collect that information, are we able to get the information that you have for the last financial year and for the next financial year—or what you expect it to be in the next financial year?

Hon SIMON O'BRIEN: The information is not available as it has not been collected hospital by hospital. The aggregated amount though is something that I think we could source and provide readily to the committee.

Hon KEN TRAVERS: I apologise; I thought that Mr Snowball said that that information was collected at the moment. Do you only collect it on an aggregated basis across the whole of the health department?

Mr Snowball: That is right.

Hon KEN TRAVERS: In terms of the contracts that you have for both Joondalup and Peel, I understand both have variations on a theme in which you pay on the average cost of like hospitals. What information do you then use to determine the average cost of like hospitals when you fund those two campuses?

Mr Snowball: Through the minister, the arrangements are specific to the contracts for each of those hospitals, and it is through a methodology comparing two peer hospitals in our system, and particular hospitals have been identified as peers for Peel, for example. Any adjustment in costs associated with delivering those services in those hospitals are then fed through that methodology for the contract for, in that case, Peel.

Hon KEN TRAVERS: Yes.

Mr Snowball: I will perhaps ask Wayne Salvage to elaborate on that, but that is essentially the process we follow.

Mr Salvage: In terms of striking the contract price for services delivered by both of those units there is an internal benchmarking exercise, as the acting director general has referred to. We look at a basket of secondary hospitals in the system and we look at movement in the cost of delivering services in each of those hospitals, and the aggregate of those influences the contract price that is then struck for the coming year with those two providers.

Hon KEN TRAVERS: All right. I think you have already agreed that you will give us the payments that you make to those two campuses. But are you also able to provide us with the averages for the hospitals that fit within the basket that was used in determining their contract payments for the past two years?

Mr Salvage: We can provide information on that. If you are wanting an indication of the price range for hospitals, there are nationally published data that provide costs by hospital groupings—that is, principal referral hospital such as a Royal Perth or secondary hospitals such as a Midland hospital. We could provide that information to you as an illustration of what the cost range is for those different types of hospitals.

Hon KEN TRAVERS: I would like to actually know what the cost range is in Western Australia rather than a national figures, to be honest with you.

Mr Salvage: We can provide Western Australia's comparative information, if you like; that is, compared to other jurisdictions' peer group levels.

Hon KEN TRAVERS: Right. And with somewhere like the Peel Health Campus, how do you then monitor whether you are getting value for money under that contract, compared to those services being provided in-house by the department?

[1.00 pm]

Mr Salvage: In terms of the operation of the contract, my understanding is that we look at whether the prices that we want to pay for the services at that facility are comparable with our own providers and use that as an internal benchmarking process.

Hon KEN TRAVERS: That would suggest that you are paying the same cost as if it had been delivered in-house and there is no saving from having it contracted out. Is that correct?

Mr Snowball: In terms of working out the value of the project, it is the totality of the project, including the capital component. Depending on the construct of the contract, you have to look beyond just the price per service. Certainly in Joondalup, there is a benefit to the state in terms of the capital outlay from the state for that service. If you just honed in on price per case, we are getting the price per case you would expect to get from a peer hospital. The benefits may well come from benefits associated with not having to outlay the capital involved in that contract. The question I am reading is: how are the private contracts more cost effective and in what way? Are we simply applying the same peer cost to our other hospitals? The answer to that is you have to look at the contract in its entirety.

Hon KEN TRAVERS: I understand the point you are making, although I never quite understood how people could expect the private sector to be able to access capital cheaper than the government and we still have to pay it for the capital it uses. If you hive out that capital side—we can have the debate about the capital—and then bring in an operator to operate the capital, do we make any savings in either Joondalup or Peel from having contracted that service out? From what I am hearing, you are telling us that you do not make a saving; you are just paying those operators the same price that the department would have paid if it provided them in-house. Is that correct? If not, what is the saving that we are achieving?

Mr Snowball: We do make a saving in those contracts. I will ask Dr Russell-Weisz, who looks after the Joondalup contract, to give more of the detail around that contract arrangement.

Hon KEN TRAVERS: I have a bit of knowledge about Joondalup, and it does a pretty good job, but I am more interested in Peel. I am happy to hear the information about Joondalup. If somebody can give us information about Peel, that would be good.

Dr Russell-Weisz: As Mr Salvage has said, a benchmarking process with peer hospitals occurs every financial year. I will just talk about Joondalup because I do not know the details about Peel. In that benchmarking process, there is not a price paid for a certain volume of services, which is determined in an annual notice between Joondalup and the state. That volume of service is predetermined. Depending on what we purchase, there is a discount on a certain volume of those services. We do get a saving on our recurrent costs in comparison with whether the state had provided those services itself on the actual operating costs in relation to Joondalup Health Campus.

Hon KEN TRAVERS: And Peel?

Hon SIMON O'BRIEN: The same level of detail for Peel is not immediately available but perhaps we could take that on notice.

[*Supplementary Information No B4.*]

Hon KEN TRAVERS: Could you indicate the estimated saving in each year for the last, say, three or four years under the Peel contract?

Hon SIMON O'BRIEN: The substance of the question is that the member wants to know not only whether there are savings but also the quantum of those savings.

[*Supplementary Information No B5.*]

The CHAIR: We will formally take a break now and reconvene at two o'clock.

Proceedings suspended from 1.05 to 2.01 pm

The CHAIR: I think Hon Philip Gardiner had a question.

Hon PHILIP GARDINER: I did. Hon Ken Travers was talking about the activity-based budgeting and the outcomes and some of the developments there, which I find particularly exciting, and I note that a little bit later than this time last year was when we first talked to the previous director general about zero-based budgeting—the same thing. In the budget papers and appropriations have you assumed any potential savings that may emanate from the developments that you are undertaking in this 2010-11 financial year in relation to activity-based budgeting?

Hon SIMON O'BRIEN: In the absence of a specific target, we are in a position to talk to this, I think, in the general terms that the member was requiring, and I will ask the director general to do so.

Mr Snowball: Through the minister, I guess one of the key features of the activity-based funding is that it makes absolutely transparent to the hospitals, to the department and to government more generally the relative efficiency of the hospitals in the performance of their services. The reason why we have not set a specific target of savings from that is that efficiencies can come in different forms, or inefficiency can come in different forms. There are some examples in the country, in particular, where we have to acknowledge very small economies of scale, therefore the general cost per service is expected to be higher purely because you are not getting the benefit of a large number of patients in those areas; it is similar for the high specialties in the metropolitan area and some of our teaching hospitals. We have also got some structural efficiencies associated with building, building design and so on. The intent behind the introduction of activity-based funding is to establish that, so that we can then discover, with the hospitals in the area health services, the nature of the inefficiency related to that particular hospital. Where it is clearly a management inefficiency, then we will work with the hospital about how you recover that in terms of savings. Others that we identify very clearly are structural inefficiencies that need to be addressed in other ways. So we see the introduction of activity-based funding primarily as a means of achieving clear efficiency in the way our hospitals deliver services.

Hon PHILIP GARDINER: Thank you very much, acting director general. I could not find it in the documents I have in front of me, but I recall seeing somewhere that there was cost allocation that you were attributing to the activity-based budgeting development of $7 million or $8 million. Am I correct in my recollection of that?

Mr Salvage: You might be referring to the fact that there was a specific allocation from the commonwealth government as part of the signing of the national partnership agreement. There was an amount of $13.3 million cashflowed over a period of four years. We received that revenue in 2008–09 with an expectation that we will receive more revenue in the next couple of years but not in 2010–11.

Hon SIMON O'BRIEN: The acting director general might like to add to that, too.

Mr Snowball: To elaborate on that: as you are aware, the commonwealth is looking through the reform program to go to activity-based funding arrangements nationally in 2013–14. It is important for this state to have a clear position around our own costs of delivering hospital services in this state, particularly as so much of it is around rural and remote areas where we know we have cost disabilities around having to provide housing, additional costs for leave and turnover and so on in those small and remote communities. We need to have a very good picture in this state around the cost of delivering our hospitals so that when we do look at a national price that the commonwealth has been flagging it will seek to set, then we are able to make clear our position in this state and influence that, if you like, for Western Australia.

Hon PHILIP GARDINER: We previously had a hearing with the Mental Health Commission. We understand the service provider funding model that we talked about on that occasion. There is a line that you will probably not have in your papers—not this amount anyway—of $446 million under "Other expenses" which I understand will be for programs and services provided by the health department to the Mental Health Commission. As I read your papers, I read the number as being a little bit less—$440 million. Is the $6 million difference as a result of the activity-based budgeting process or is it a difference for some other reason?

Mr Salvage: The difference between $440 million and $446 million relates to other payments that will be made by the Mental Health Commission. It is not a saving on the budget that will be allocated to the Department of Health. It is another matter that we will have to get further advice on to give you the composition of that $446 million. It is not a saving attributable to an activity-based funding regime.

[*Supplementary Information No B6.*]

Hon PHILIP GARDINER: The other thing, which may be more difficult to answer, is in the same context as activity-based budgeting because it is outcomes we are trying to achieve. We all understand that is the whole reason that activity-based budgeting can work. Where the Mental Health Commission is hiring services from the health department, the best model is where there are competitive services from which they can choose. That helps the efficiencies come under a competitive environment. In the absence of a competitive environment, which will probably be the case in most programs—and health has them as a sole provider—will the activity-based budgeting be focused on working to make those programs more efficient at realising the outcomes that are being asked for by the Mental Health Commission? Will you be putting your efforts into that area as a first stage in this whole process?

Mr Snowball: There are two parts to that. Activity-based funding is very focused on the efficiency side. It is about how many occasions of service you can provide for a given allocation of funds.

[2.10 pm]

The next part of that, though, is about: is that the right work to be doing to improve, in this case, mental health outcomes for Western Australians? It might go to access as much as it goes to the quality of those services. So, in answer to your question, the initial introduction of activity-based

funding is rudimentary from 1 July 2010—so, yesterday. Over the next two and three years, we will be expanding the sophistication of that activity-based funding to look more at activity-based management; so not only are we getting services that are reasonably value, we are also getting the right services. In other words, in health it is: do you invest in dialysis units to provide for those with end-stage renal failure, or do you put your money into prevention programs—good nutrition and so on? So there is then a decision about: what is the return for the investment in those various areas for the health outcomes for Western Australians? That is something that is going to be, over the course of the next three years, developed more explicitly in health. And it goes to mental health; mental health is very much the first one with the formation of the commission.

Hon PHILIP GARDINER: Thank you very much.

Hon LJILJANNA RAVLICH: I just want to refer the minister to page 179 of the budget papers, which shows the appropriations, expenses and cash assets. I refer specifically to the line item that deals with total appropriations provided to deliver services. We see that over the forward estimates there is an additional $817 million required. I am wondering whether that increase over the forward estimates has been calculated based on the current level of service, or has this been calculated based on the increased projections of the increases in services across a whole lot of areas in the health system?

Hon SIMON O'BRIEN: Can I just clarify what you are asking about?

Hon LJILJANNA RAVLICH: Yes.

Hon SIMON O'BRIEN: You are talking about the total appropriations provided to —

Hon LJILJANNA RAVLICH: Deliver the services.

Hon SIMON O'BRIEN: — deliver services. You mentioned an amount, I think, of about $817 000.

Hon LJILJANNA RAVLICH: Million. I think from $4.322 million in 2010–11 to an increase in appropriation to $4.642 million in the following year—that is an increase of about $3.2 million. The following year it goes up to —

Hon SIMON O'BRIEN: I see. You are looking at the prospective increase of $800 million-odd over four years, yes.

Hon LJILJANNA RAVLICH: Yes; absolutely—over the forward estimates period. I am asking: are these increases in funding allocation based on the current levels of service, or do they take into account the increased pressures on the health system over the forward estimates?

Hon SIMON O'BRIEN: Okay. There are elements of both. Of course, the "total appropriations provided" is also impacted on by the sources of the funds that go into that table. I will ask Mr Snowball to address your question.

Mr Snowball: Through the minister, that appropriation has two elements to it. One is that it recognises the additional costs going forward, so there is a projection of estimated cost increases year on year, as well as projected activity demand year on year going forward, drawn basically through the clinical services framework, which is a framework established in Health to plan and make expectations around activity demand right through the system. So this reflects both the cost element—so cost indexation—as well as expected activity increases over that time.

Hon LJILJANNA RAVLICH: The reason I ask that is that I am pretty sure that when Dr Flett appeared before the committee last year he made the point that an additional $200 million would be needed for every year over the forward estimates to maintain the level of service delivery. Can Mr Snowball just comment on that?

Hon SIMON O'BRIEN: What comment is the member looking for?

Hon LJILJANNA RAVLICH: Let me put it another way. Can the minister give an assurance that there will not be additional pressures to provide additional funding for health and that these figures over the forward estimates are pretty accurate for what the funding requirements will be?

Hon SIMON O'BRIEN: I understand what the member seems to be driving at, particularly with reference to some remarks by Dr Flett last year. The government, through its forward estimates, is seeking to address the projected growth in moneys required to fund services at the appropriate level. That is what I will tell the member as a minister, but given the thrust of her question, which I think is to contrast the answer with the comments of the director general last year, I will ask the present director general to confirm that that is the case and, therefore, the member can be reassured at an administrative level as well.

Mr Snowball: Through the minister; the projection of activity has been set through a very detailed process within Health, and it is based upon estimates around population growth, demand and where the population growth will rise. It has a lot of assumptions to it as well. The best I can say is that we have used our best endeavours to project that activity into the future, and this budget is based around those projections. Should year on year there be—I do not know—a sudden influx of huge numbers of people into Western Australia, we would obviously be looking for some recognition of that within the normal budgetary process. But right now we have the best estimate from health for the demands going forward, and they are reflected in the forward estimates.

Hon LJILJANNA RAVLICH: I just want to go to some of the WA Health performance report indicators and just maybe get some comment from the minister on some of the drivers of health costs to the system. The minister may not have it with him, but he may have a briefing note along these lines, because these are, after all, the key WA Health system performance indicators at a glance. They are from January to March 2010 for that quarter. I am assuming that these are the latest and that we have not got them from March through to June. That information is not available yet. If we look, for example, at more acute medical admissions to hospital, there is a 3.8 per cent increase across the system, but in the country it is actually a 4.5 percentage increase. If we look at renal dialysis admissions, it is a 2.7 per cent increase and in the regional areas it is a 6.7 per cent increase. If we look at people admitted for mental health services, we find that across the board it is an 8.1 per cent increase.

The CHAIR: I wonder, member, if you could give us an indication of what you are quoting from?

[2.20 pm]

Hon LJILJANNA RAVLICH: The document is the "WA Health Performance Report: January to March 2010 Quarter". All I am doing, Madam Chair, is going through some of the key indicators of this agency's performance outcomes. If we have a look at patients on the elective surgery waitlist, we have a 14.3 per cent increase compared with January to March the previous year. The waiting list for elective surgery in regional areas has an increase of 15 per cent. So you would have to say that there are some serious pressures on the health system. You are telling the committee that these pressures are accounted for in terms of the forward estimates budget—is that correct?

Mr Snowball: Yes, that is correct. I can perhaps elaborate on that by saying that during the course of 2009–10 those numbers that you have quoted, when all of that is aggregated in terms of inpatient-weighted activity—so, weighted for length of stay and acuity of the patients—it went to about a three and a half per cent increase and emergency department-weighted presentations were nearly six per cent and we have been able to deliver that within a blanket increase of seven per cent in our budget growth over the same period. That gives you an illustration that year on year, Health gets lots of additional activity, and that has been happening year on year. What we are able to do through not only support from the state government to fund that activity, but also our own productivity improvement and efficiency measures in health, is meet that sort of activity growth. A good example of that is when you bring in new technologies that are able to reduce a patient's length of stay. All of those are efforts that Health undertakes constantly to deliver against the sorts

of demands that it has to meet. So it is a combination of being able to achieve productivity in what you do, as well as support, obviously, from government in terms of meeting those demands going forward. But that demand is contained and our best estimate of that demand is contained in our forward estimates.

Hon LJILJANNA RAVLICH: Dr Snowball, I wonder whether you could provide the committee with some actual figures because what I have in front of me is the increase compared with January to March 2009, but it does not tell me how many people in total are, in fact, on the elective surgery waiting list. It does not tell me, for example, how many people in total are on —

Hon SIMON O'BRIEN: Madam Chair, if I might assist, I am just wondering if we could get this down to what the specific question is. For example, there is a range of matters here that the member is raising that I could discuss but I do not want to use up the committee's time in ways that you might not want me to. What is the question? Is it how many people are on the waiting list at such-and-such a date? Seeing as today is the second day of this financial year that the budget estimates are covering, is that what you want to know?

Hon LJILJANNA RAVLICH: I want to know a number of things and I think that these are fair questions given that we are dealing with appropriations and the key performance criteria —

Hon SIMON O'BRIEN: I am not suggesting that they are not appropriate questions; I am just asking what the questions are.

Hon LJILJANNA RAVLICH: Here are the questions, honourable member: how many people as of today's date are waiting to be admitted to hospital?

The CHAIR: Let us just deal with them one at a time; I think that would be easier.

Hon LJILJANNA RAVLICH: You can just take them on notice.

Hon SIMON O'BRIEN: The latest figures available at this time are those as at the end of May—a month ago. At the end of May 2010, there was a total of 16 127 cases on all the public hospital waitlists, of which 14 475 or 89.8 per cent were within boundary. Out of those 16 127 cases, 12 466, which represents 77.3 per cent, were on metropolitan waitlists and, obviously, the other 3 661 or 22.7 per cent were on the WA Country Health Service waitlists. Does the member want to know the median times?

Hon LJILJANNA RAVLICH: Yes, thank you.

Hon SIMON O'BRIEN: I have more information on the elective surgery waitlist: the median wait time for all cases on all waitlists was 2.24 months, with a median wait time of 2.2 months and 2.4 months respectively for metropolitan and country hospitals. I understand that is about the second-best performance nationwide. Hon Ljiljanna Ravlich was alluding just a few minutes ago to some figures back in the first calendar. If we contrast those with the previous year, we will see this department has made significant strides in bringing costs and workloads under control, and they deserve to be congratulated.

Hon LJILJANNA RAVLICH: That is not what the AMA says, but we will leave that till later.

Hon SIMON O'BRIEN: Go to the AMA estimates next time!

Hon LJILJANNA RAVLICH: They were the minister's friends, with all due respect. How many patients in total are currently on the elective surgery waitlist for both metropolitan and regional public hospitals? And, also, if I can have the split between regional and metropolitan that would be handy.

Hon SIMON O'BRIEN: That is precisely the information I just provided. Does the member want another figure?

Hon LJILJANNA RAVLICH: My first question was how many more admissions were there to hospital. How many people have we got on the waitlist generally?

Hon SIMON O'BRIEN: For admissions?

Hon LJILJANNA RAVLICH: Yes.

Hon SIMON O'BRIEN: I will provide the figures as at the end of May 2010, which are the most up to date. I have given the member figures for elective surgery waitlists. By definition, that includes the waitlist figures for admissions, if she gets my meaning. They are one and the same thing because the only other admissions would be from incidents of illness or accident arising.

Hon LJILJANNA RAVLICH: Did the minister break that up into regional and metropolitan?

Hon SIMON O'BRIEN: Yes, I did. I was about to give Hon Ljiljanna Ravlich the total number of admissions for May. I do not know whether that is what the member asked for, but would the member like me to read that into the record?

Hon LJILJANNA RAVLICH: Yes, I would.

Hon SIMON O'BRIEN: In May 2010—this is not up to May 2010, but for the month—there was a total of 7 056 admissions from all public hospitals waitlists, of which 6 302 were within boundary. Of those 7 056 admissions, the figures for metropolitan and country admissions respectively are 5 683 and 1 373.

Hon LJILJANNA RAVLICH: How many people who need admission for renal dialysis cannot get it? Is everybody who requires renal dialysis able to access it?

[2.30 pm]

Hon SIMON O'BRIEN: My advice is that everyone who requires renal dialysis receives it. Obviously, if a person did not, the result would be disastrous, so patients do receive it.

Hon LJILJANNA RAVLICH: Does anyone die waiting for it?

Hon SIMON O'BRIEN: I will ask the director general to answer that.

Mr Snowball: Through the minister. We can clearly say that we are able to provide dialysis to those people who require it. It depends also what form of dialysis the member is referring to. There is peritoneal dialysis and haemodialysis. So the form of that dialysis is different. Some of it can be undertaken in a home environment. Someone who is with a trained carer can receive dialysis in that way. We try to encourage and support that wherever we possibly can. Other individuals can have a range of co-morbidities such as heart conditions and other conditions that influence their health outcomes. Those cases, more often than not, require dialysis within a hospital setting. We do have people in metropolitan teaching hospitals from very remote parts of Western Australia, purely because of that tertiary level need.

The member asked whether people are dying while they are waiting. Some people choose not to receive that treatment. That, though, is a personal decision they make. I can say that we have very clear plans for dialysis services. We are establishing services in the Kimberley, for example; in Derby and Kununurra, and in Broome, where there is already a major dialysis centre. Wherever we can, we are providing dialysis services close to where people need them. I have to say that we are able to provide dialysis in Western Australia to anyone who needs it.

Hon LJILJANNA RAVLICH: Through you minister. What do you say to the claim by the AMA that doctors at the coalface are saying that, because of the budget constraints, they are struggling to provide best-practice care? In fact, they rate the state government's performance in health as being average to poor.

Hon SIMON O'BRIEN: What is the source of that quote?

Hon LJILJANNA RAVLICH: It is from the AMA—the "Budget squeeze hammering patients" survey of February 2010. I am sure the director general will be aware of the survey.

Hon SIMON O'BRIEN: He is now that you have identified it.

Mr Snowball: I think that survey was a survey of junior doctors in the system.

Hon LJILJANNA RAVLICH: Part of it was.

Mr Snowball: It was also a survey designed by the AMA. We would not agree with a number of those outcomes at the moment. That does not necessarily hold true for what we see in our system. The message we would really like to get across to junior doctors and others is that, when they identify issues of that type, there is a process within the hospitals through which to raise them. We do not want to think that our doctors feel that they are providing second-rate or poor quality services. We want to hear about them and seek to address them.

Hon LJILJANNA RAVLICH: One of the concerns is obviously the pressure that the four-hour rule is putting on medical practitioners. We know that has been abandoned in the UK. Is there any view to perhaps abandoning it here in Western Australia because of the pressure it puts on doctors?

Hon SIMON O'BRIEN: What is the basis for asserting that?

Hon LJILJANNA RAVLICH: I read it in an article on the internet. I am sure it has come up before. I am sure Mr Snowball has heard of it.

Mr Snowball: Through the minister, whilst the four-hour rule in Western Australia has a base around the UK, there were important differences in the way in which the four-hour rule was introduced in Western Australia. There is much more of a focus around quality and safety around those changes, so it is not just a flat rule that says, "You've got to get your patients out of ED within four hours." There is a whole process in WA that goes to all elements in the hospital—for example, discharge processes in the hospital and so on, and improved processes so that we can seek to get patients through the system more quickly. To draw a direct link between the UK four-hour rule and the four-hour rule in Western Australia, you need to look at those particular differences.

Hon LJILJANNA RAVLICH: But with all due respect, Mr Snowball, I have heard from nurses whom I have spoken to directly that the four-hour rule puts incredible pressure on nursing staff in hospitals. They say that they cannot deliver the same level of care that they did prior to the introduction of this four-hour rule. I can only go on what I have been told. As good as you would like to paint it, I am sure that even you have heard criticism, whether it be from the doctors' fraternity or whether it be from nurses, about the sorts of pressure that the four-hour rule is placing on them.

Hon KEN TRAVERS: Or—I have got to declare an interest—on ward clerks.

Hon LJILJANNA RAVLICH: Ward clerks too.

Hon SIMON O'BRIEN: Are you moonlighting as a ward clerk?

Hon KEN TRAVERS: No, but my partner does—and I see the direct results of a hard day in the office!

Hon SIMON O'BRIEN: I am sure we all appreciate the work that she and others in that position do. I think all members, just by virtue of our roles, understand the pressures that emergency room staff and related colleagues are under all the time. You will also be aware of the concerns and needs of patients and their families to ensure that attention is received as promptly as possible or within a reasonable time frame when they seek treatment at an emergency room. I think the opposition and other observers would be justifiably critical in asking questions if patients were remaining in emergency departments for excessive periods of time without seeing anybody, without being treated, without being discharged, or without being transferred to a ward or whatever subsequent action was necessary. The four-hour rule is intended to meet the needs of patients without compromising the interests of staff who we know are under pressure. The purpose of the four-hour rule is not targeted at placing pressure on our health professionals or ward clerks or others; it is about having a system that works better, and that includes a system that works better for those who work within it. The health department is following this policy in a very positive way to try to seek

the outcomes. In any changes of regime or standard, I guess that does put some perceived pressures on some people just by the nature of a change in routine and regime and standard. But I would assure all members that the department and, indeed, the government are not blind or unsympathetic to the pressures that all our health employees are under and we are not seeking, through any policies that are being pursued, to try to increase that pressure or ignore the concerns that may raise. I think the acting director general might want to offer some other observations from his particular vantage point about the issue that has been raised.

Mr Snowball: Through the minister, I should point out that this program is in implementation; it is a three-year program. We have a lot of areas where we are getting staff together to talk about what changes are needed in the process, as well as monitoring that as it goes. Where there are particular pressure points as a change is implemented then it is managed within that hospital.

[2.40 pm]

We absolutely want to know from our staff what it means to the workloads—where those workloads have moved—so that we can respond properly to it. Perhaps I can ask Dr Russell-Weisz to make an observation on the north metropolitan area where they have introduced some fairly significant changes as part of the redesign process in those hospitals, and the sorts of avenues people have to raise those issues through that process.

Hon LIZ BEHJAT: Before the doctor answers that question, I have some specific questions about the four-hour rule. Perhaps if I could ask those questions, they can be incorporated in the answer you are about to give, if you do not mind.

The CHAIR: Sure.

Hon LIZ BEHJAT: I note that our stage 1, 2 and 3 hospitals are at different stages of implementation and that it is a three-year program. I want reassurances from the department today that the underlying factor in relation to the four-hour rule at all times will be the outcome for the patient. What I am afraid of sometimes is that with these efficiency indicators—we want to see a 98 per cent success rate with the four-hour rule, which is all well and good—the patients might be seen too quickly and then be taken out of an emergency department where they have the best medical attention available to them in terms of the specialists and machinery that might be needed. They might be taken from the ward and they might not have been properly diagnosed with an underlying factor because you have found one thing, which is great, and matched the four-hour rule and you get them out into the ward and then they are put somewhere where they do not have the best facilities available to them. I am looking for a reassurance that that will not happen when we see this implementation in Western Australia.

Hon KEN TRAVERS: If I could add, the next level down is that people are not being discharged out of the wards to make beds available prior to their clinical needs allowing them to be discharged, and what mechanisms are in place to ensure that that does not occur.

Hon SIMON O'BRIEN: These are all legitimate questions and concerns. I am sure that at all levels that is recognised, and there is a need to have safeguards against any of those sorts of symptoms. I am sure that Dr Russell-Weisz, who I am about to throw to, will be able to assure members on this point. It is a very valid point. Patient safety and avoiding any compromise of care is the bottom line at all times in the four-hour program; it is not about just improving the stats or league tables.

Dr Russell-Weisz: I would like to reiterate what the minister and acting director general have said. This program in Western Australia is about safety for patients. I think if we look back to maybe two years ago and at what our emergency departments were like, we had in those days, and we still do, a measure called "access block", which measures the percentage of patients who waited greater than eight hours to get into a bed. At times during the height of the winter seasons, we had figures of

around about 50 per cent. That was an unacceptable level of those patients waiting to get into inpatient beds.

We know from some work done here in Western Australia, and it has been mirrored around the world, that there is an increased rate of morbidity and mortality of patients who spend too long in emergency departments. The four-hour rule in the UK—in the original one in the UK and the one here, but specifically the one here—has been based on improving quality outcomes for patients and not just chasing data and making sure that patients get pushed through the emergency department too quickly. The stage 1, 2 and 3 hospitals—I am talking on behalf of the whole state—went through a whole clinical redesign process to look at what were the areas where we can, in a sense, reduce waste—where patients were being kept in emergency departments for too long, and where either they could be discharged quicker to make departments less busy, or they could get to wards quicker. Some of the focus has been on discharging patients, as has just been mentioned. We found that patients were being discharged late in the day. Patients who could be discharged in the morning were being discharged at three or four in the afternoon, when, at no detriment to their care, they could have been discharged in the morning. We are trying to shift that curve forward; that releases the beds for not only emergency patients, but also elective surgery patients. The change process has been tough at times. There is no doubt that this change process has problems, but we have seen some huge improvement in our outcomes. In March and April this year, our access block figures reduced from 50 per cent to below 10 per cent in a lot of our hospitals. They are dramatic figures. On specific days just this week, Royal Perth and Fremantle Hospitals were tracking at about 81 per cent and 76 per cent respectively—within the four-hour rule figure. All the three main teaching hospitals have tracked between around about 65 and 75 per cent over the past couple of months. But I would like to reassure members that this program is about safety and quality. There is the ability for staff, through a very rigorous program, to bring up what we call "breaches". Breaches are patients who have not made the four-hour rule and also those patients who were pushed through too quickly to wards or who should not have been discharged. They will be looked at on an individual basis and an analysis will be done to see what can be improved.

Hon KEN TRAVERS: Is that based on a staff member reporting it? Is that what you are saying?

Dr Russell-Weisz: Through the minister, we have made it available through staff members to report it, but it is also on the data. On a weekly basis, we get broken down data from the hospitals that looks at the percentage of patients who were discharged within four hours and those who were actually sent to the ward within four hours. Then we can look at those patients who did not get to the ward within four hours and who were not discharged within four hours. We would look at those as breaches. It might be very appropriate that they were not discharged, because they were getting appropriate care, or that they were.

We have had some feedback that some patients may have been sent to the wrong ward. Those instances have been looked at and remedies put in place. There are real areas that we know of. As the acting director general said, this is the implementation phase. We are learning through this phase, just as the UK did. The latest information I have from the UK is that they are still setting a target. Their target has been modified slightly, but only from 98 per cent to 95 per cent at four hours.

The CHAIR: Is there anything further on this?

Hon LJILJANNA RAVLICH: On the four-hour rule.

The CHAIR: Hon Ljiljanna Ravlich.

Hon LJILJANNA RAVLICH: There is an issue in relation to the four-hour rule and the underpayment of doctors at Bunbury Regional Hospital. I am wondering whether the director general is aware of that.

Hon SIMON O'BRIEN: Can you elaborate a little more on the issue and the nature of the problem?

Hon LJILJANNA RAVLICH: Apparently, the junior doctors employed at Bunbury Regional Hospital have had a significant underpayment of wages. With the new four-hour rule, they were required to work 80 hours per fortnight, but they have been paid for only 76 hours per fortnight. Apparently, Health Corporate Network has been deducting four hours from the roster for each fortnightly pay period and there is money owing to a whole lot of junior doctors at Bunbury Regional Hospital. Given that this has been an issue or is an issue for the AMA, I would have thought that perhaps the department and the director general may have been across it.

[2.50 pm]

Hon SIMON O'BRIEN: Now that you have outlined it, the specific point is that there is an allegation that doctors required to work 80 hours a fortnight have been getting paid for only 76 hours.

Mr Snowball: The payment arrangements for junior doctors are specified for the state. It is probably not necessarily reasonable to attribute that change to the four-hour rule specifically. I am aware that the issue has been raised with us by the AMA, and we are in the process of investigating that claim. Bunbury has fairly recently gone into stage 2 of the introduction of the four-hour rule and I think it commenced the diagnostic process late last year, which is before you actually do anything. It would now be around the implementation phase. We will certainly be looking at responding to that issue.

Hon LJILJANNA RAVLICH: Have any other hospitals reported similar incidents? What is the magnitude of the amount of moneys that may well be owed to these junior doctors? Can it be quantified at this stage?

Hon SIMON O'BRIEN: In response to the question of whether other hospitals have reported this, my advice at this time is no. In relation to Bunbury, I would be most concerned on behalf of the government if people are required to work or are rostered to work for 80 hours and having their pay docked down to 76 hours. For that reason, as the director general said, the department is investigating this.

Hon LJILJANNA RAVLICH: I ask the director general how many complaints it has had from junior doctors or from the AMA on this issue.

Hon SIMON O'BRIEN: I am advised that the only one that we are aware of is the one from Bunbury. As Mr Snowball indicated, the department is seeking to establish the veracity of that claim. There is no question that we are underpaying our staff for the hours that they are required to work. We will sort that out.

Hon LJILJANNA RAVLICH: I do not know whether you got me right. I am asking whether the department has received any complaints from the doctors in relation to underpaying them that you are aware of at this stage.

Hon SIMON O'BRIEN: The answer is no.

Hon KEN TRAVERS: I understand that the staff at Albany health campus were advised today that you do not intend to contract out non-clinical support services. Can you explain to us why that decision was taken?

Mr Snowball: As you are aware, it is part of the redevelopment of the new Albany health campus. As part of that process, we are looking at all of the services that are provided, both clinical and non-clinical. In a moment I will ask Jeff Moffet, the acting chief executive of country, to talk specifically about what occurred yesterday and today. We are running a process where we look at capacity in the public sector. We end up with a public sector comparator. In moving from an old facility, which Albany hospital is, to a new one, how will the public sector deliver the support

services in that environment with a new hospital? With that information, we then look to the private sector and ask whether it is able to provide the service in a more cost-effective way than we can provide it as a public sector. Normally we would go through an expression of interest and establish, firstly, whether there is a market to do it and, secondly, whether the private sector was capable of doing it at a more cost-effective rate within the quality parameters that are set. Having gone through that process, we have established that what has been worked through with the staff in Albany in terms of the support services, the level of efficiency they are able to deliver in the new facility is such that we do not believe it is necessary to go to the private market because we have already established good benchmarks and quite a significant productivity improvement has been offered through that process. We are not bound to go to the private market when we have established that we are getting good value for money from the support services within Albany hospital.

Hon KEN TRAVERS: Before you pass it over for the specifics, when you talk about the public sector comparator, does that also include a requirement that any private sector operator ensures that the wages and conditions are the same as they currently are in the public sector, or are they able to achieve savings by driving down the wages and conditions?

Mr Snowball: Through the minister, when we go out for a bid, if you like, if you were to go to the extent of seeking tenders for those services, they would be all part of the evaluation of those tenders to ensure that they are compliant with the normal industrial conditions and circumstances and so on. By and large, if you were to do that, you would ensure that staff had an opportunity either to move to the new provider, if there was a new provider, or, alternatively, seek redeployment within the local health service if they would prefer to stay in the public sector.

Mr Moffet: I think the director general has covered a few points in relation to the reason for the decision. There are a couple of distinct advantages in terms of retaining those services in-house. One of those is that the new build of the hospital will allow for more efficient design; that is, a much more efficient floor space and much more proximity of services to delivery sites than is currently the case at Albany health campus. On top of the design efficiencies and the technology efficiencies available inside the design, new service models in terms of catering will be implemented, and we will be delivering meals much closer to the wards and processing meals much closer to the wards. We will be using what we call PSAs—patient service attendants—who have got combined functional roles that allow for a more efficient utilisation of staff and allow the efficiencies in the public sector that meant it was a value-for-money proposition in terms of keeping those services in-house.

Hon KEN TRAVERS: Following on from that then, have you done the same exercise with respect to that for Midland health campus and the new Fiona Stanley Hospital?

Hon SIMON O'BRIEN: Nicole Feely will talk about Fiona Stanley Hospital, and then perhaps if we could go to Dr Russell-Weisz for some comments about Midland.

Ms Feely: Through the minister, if I understand the question correctly, it is in relation to whether a public sector comparator has been determined in relation to the Fiona Stanley FM process.

Hon KEN TRAVERS: Yes, for the non-clinical support services at Fiona Stanley.

Ms Feely: In answer to that, I can say that there has been an extensive process put in place in relation to the public sector comparator that has been based around looking at the prices available for example, say, at Royal Perth and Sir Charles Gairdner Hospital, and also comparable hospitals interstate. That, without having all the details of that in front of me, is the basis of what the public sector comparator for a tertiary hospital like Fiona Stanley will be into the future. In relation to the private sector element of it, there has been an independent assessment done again in relation to similar projects interstate and overseas by an independent consultant. The element of price will be determined by what is currently under review as part of the tender process, so from the public sector actually putting its responses into the tender proposals.

Dr Russell-Weisz: In relation to Midland, obviously it is a slightly different PPP in that we are not talking about what we would call a DBFM—design, build, finance and manage. Midland is what we would call a DBFO PPP—design, build fund and operate. It is a slightly different PPP.

Hon KEN TRAVERS: Sorry, the funding being by whom?

Dr Russell-Weisz: The funding in relation to the Midland PPP will be potentially, at this stage, by the private sector.

[3.00 pm]

Hon KEN TRAVERS: You have got commonwealth money.

Dr Russell-Weisz: Yes, there is. What has happened at the moment, in relation to the PPP, the likely procurement option will be a DBFO where the financing can be provided by the private sector with the money through the commonwealth and the state being paid over a period of years as an availability charge, or the financing can be paid by the combined moneys of the state–commonwealth governments to actually fund the construction of the hospital. There are two potential options in relation to that. What has happened in relation to Midland is that the initial procurement analysis, which was done in 2009, showed that the best form of a PPP was the DBFO. That is being updated as we speak. The work that was done at that time showed that the outsourcing of non-clinical services was clearly the preferred procurement option.

Hon KEN TRAVERS: Is that analysis able to be tabled with the committee as supplementary information?

Hon SIMON O'BRIEN: It is in the process of development or redevelopment at this stage, Madam Chair. No, it is not ready to be tabled.

Hon KEN TRAVERS: Has the decision been made to definitely go down the path of contracting out Midland and Fiona Stanley Hospitals?

Hon SIMON O'BRIEN: I understand that, in the case of Midland, we are still going through a deliberative process. Ms Feely might be able to tell us about Fiona Stanley Hospital.

Ms Feely: My understanding is that until we are in a position to have a final recommendation of the FM process, so we go through this tender process, no decision is final in relation to whether or not we will or will not outsource. We have been given in-principle approval to go through this process to determine whether or not it is the most cost-effective way for the delivery of these services. In addition to cost effectiveness, is there a different model in relation to outputs et cetera that can be considered by government as an effective way of delivering these services? Until we have been through this process, which is an extensive process, I would not be in a position to make a recommendation to either the director general or ultimately the minister as to whether or not an ultimate decision should be made about which way to go on this process.

Hon KEN TRAVERS: I hear what you are saying. What I am still a bit perplexed about then is the process you have gone through in Albany where you have not gone out to the marketplace; you have made an assessment. For a range of reasons—most of which seem to be around the design and the fact you were building a new facility—you could get efficiencies that meant you would keep it in-house. However, for Fiona Stanley and Midland, even though you are building brand-new facilities for both of those, you are saying that you are still going to test it in the marketplace. I cannot quite reconcile those two explanations that I have had. Maybe you could explain to me how one should reconcile the two explanations that have been given.

Hon SIMON O'BRIEN: It is perfectly straightforward, Madam Chair, as Mr Snowball will now demonstrate!

Hon KEN TRAVERS: I am glad the minister is as confused as I am!

Hon SIMON O'BRIEN: I am not at all confused!

Hon KEN TRAVERS: Feel free to explain it to us then, minister.

Hon SIMON O'BRIEN: I do not want to show off!

Mr Snowball: The processes we are going through here, in all of those cases, is to establish the most cost effective and best quality way of delivering the services—in that case Albany, and in other cases Midland and Fiona Stanley Hospitals. With Albany, we have reached the conclusion now that that is capable of being done in-house, cost effectively and with good quality in terms of the service. We have not established that in either Midland or Fiona Stanley. We are going through a process now of establishing just that by having public sector comparators formed in both cases to test the market to establish whether in fact that is the most cost-effective way of doing it. In the case of Albany we have got some good comparisons that we have been able to use. Basically, the hospital is a 100-bed hospital. We know what it provides to the region. So we have got enough confidence that we think that we have got a service. We have already asked and tested the market. It is a variety of areas. It is not just one service; it is laundry, catering and the like. So, is there a commercial laundry in town that could do it? Yes or no. So we have gone through those sorts of steps ourselves as a service to reach that —

Hon KEN TRAVERS: When you say "test the market", what do you mean by that, though?

Mr Moffet: Through the minister, one of the key differences is that Albany is at a more advanced state in terms of its procurement. We have gone out to an expression of interest early last year in terms of the available market for Albany. What I guess arose was a range of respondents that put in submissions, some of which were PPP in style. We went through an extensive internal assessment process, complemented by a procurement analysis process through Ernst and Young, and that determined that it was not a value-for-money proposition to go down a PPP pathway in a regional environment with lower volumes. So it is a very different project to the proposed PPP projects in, for example, the Fiona Stanley and Midland. What ultimately was decided upon by government was an early contractor involvement project, which would see us still testing the market on some unbundled elements, such as parts of support services and parts of some of our clinical services as well. For each of those unbundled elements, we have actually tested it against internal efficiencies. We are still actually going through a phase of testing the clinical markets. We are about to go out for a request for proposals for particular respondents in terms of chemo, dialysis and radiology, for example, and they will each be subject to analysis in terms of value for money and quality for the state. So it is at a more advanced stage than the PPP assessments or options in terms of Midland and Fiona Stanley. The decision was not to proceed with the PPP, but to go with an ECI contracting approach, where we will see a full public sector build and partnering around small, unbundled interest in the Albany regional environment as far as service providers go.

Hon KEN TRAVERS: I will just go back in terms of the Midland hospital and the model that you are looking at using. Would you say it is the same as the Peel or the Joondalup model? Which one is the closest and what are the variations on that model?

Dr Russell-Weisz: It is certainly more like the—I am not that familiar with the Peel model, but it is similar to the Joondalup-type model, and this goes into the other answer you sought in relation to what we have done over the last year. As I explained in my last answer, the procurement analysis was done, but we also have been out to market, sounding to show that there is a market out there of either healthcare providers or financiers who would be interested in the Midland development. It is showing the similarity with the Joondalup Health Campus, and if it is what I explained, a DBFO, where the financing is from the private sector—if that is the case, that is very similar to the initial Joondalup build, the one that was done in 1996. If it is where the financing is provided by government, then it will be similar to the latter redevelopment of Joondalup.

Hon KEN TRAVERS: I have two final questions on this point. Firstly, have you got the Commonwealth's agreement that you can hold on to their money and use it to pay over a period of time as an availability fee? Secondly, in terms of the difficulties with the contract at Joondalup,

what changes will you make to ensure that we do not face the same problems that we faced at Joondalup, where you, as a department, often have to renegotiate the terms of that contract almost on an annual basis in terms of the amount of money? Also, when it comes to upgrading—which I think was one of the issues that was originally highlighted by the Auditor General in their assessment of that contract, and then we have lived through it for the last four years—there are immense complexities when it comes to seeking to upgrade that hospital at a future stage, and the complexity of the negotiation. So what are you going to do to ensure that you do not actually have those same problems for any future contract at Midland?

[3.10 pm]

Dr Russell-Weisz: In relation to the first question, yes, the commonwealth has given the state government approval to procure this under the PPP–DBFO route. Secondly, in relation to the problems with the Joondalup contract, although there may have been some problems with the Joondalup contract, the Joondalup contract does work—as does the contract manager—quite efficiently. We will learn from how the contract has evolved over the past 10 to 12 years. One of the areas we make sure that we address is the ability to expand the Midland health campus in future years, as the demand has shown that there will be a requirement to build extra capacity at the Midland health campus over the next 10 years.

Hon KEN TRAVERS: I have to say that I think one of the only things that saves Joondalup is that we have quite a responsible operator out there that is willing to enter into negotiations. I am not sure that always occurs with some of the operators that we get under a privatised model—without naming them, but I am sure we know whom we are talking about. I would be interested to know the amount of time and resources that the department has had to spend on monitoring and having negotiations with Joondalup over the past three or four years, both on the expansions and on an ongoing annual basis, discussing contract issues and payments of the services provided. What sort of cost is that, and is that factored into the department's public–private comparator for both compared to Midland and Fiona Stanley, I might add. I would suspect that the CEO spends a bit of time—certainly over the past four years, the previous CEO spent a bit of time on Joondalup issues. At the rate that we pay the CEO, that would add a fair bit of cost each year, not to mention the other staff. I am not having a go at the salary; I am just pointing out that a lot of the time of very senior and highly paid officers is involved in those negotiations.

Mr Snowball: Through the minister, there is no doubt that these contracts are a complex, complicated and difficult exercise, as is running a major tertiary hospital. The reason why we are, I guess, through both Midland and Albany, and Joondalup in the past, is making sure that we squeeze every dollar that we possibly can out of the funds that we have —

Hon KEN TRAVERS: Tell me about it! They complain to me all the time.

Mr Snowball: Every dollar that is wasted the health system is a dollar that we cannot push towards a service gap or a priority health need. I see that role, as part of the role of our management and leadership group, is to chart that course, as it were, and to provide advice to me, and in turn to government, about the choices that are available and the best one for this state's health services.

Hon KEN TRAVERS: Do we have an idea of what that costs, and does the department try to estimate that to put it into the public–private comparator when these decisions are made?

Mr Snowball: Through the minister, this is my own perspective on it: I see that cost as being part of the role of a chief executive to look at and negotiate those arrangements. Just as if we had our own public sector employee, we have got to negotiate our industrial way through that. Service models, structures and all of those things are the responsibilities of a leader–manager in the health system. So it would be very difficult to say how much of that is assigned to negotiations with the AMA or the EBA or the Joondalup Health Campus over the next contract. It is just all part of the executive and management costs of running Health.

Hon KEN TRAVERS: Except that the department is already doing it once with the AMA, and that can then be applied across the rest of the health system. It has to be repeated. As part of the contract, particularly if it is funded on the basis of other hospitals of a similar size, as we talked about before lunch, the department is actually paying that internal management up-front as part of that contract payment and then it is having to provide its own resources again to manage that contract. In fact, if we read most of the reports about PPP, it is actually the contract management side, which is where governments end up incurring losses, so I am surprised it is not something that the department tries to quantify and put into the public–private comparator.

Mr Snowball: Certainly we apply specific resources to that work. I was trying to respond to the question of whether if we were using a chief executive to negotiate, we would say it was five per cent of his time. No, we would not do that. However, we certainly do that with the specific resources that are applied. We have people working up the contracts and the expression of interest and all that goes with that, which is defining the service and getting it to a level of definition to be able to test the market and, in time, forming a sensible contract. That is part of the lead-up costs. I agree with the member that that can be identified. I find it more difficult to then apportion pieces of senior personnel against that sort of work.

Hon KEN TRAVERS: I know that somewhere in the department there is a contract officer who manages the contract for Joondalup and Peel. Perhaps a question you can take on notice is: for Peel Health Campus, how much have you spent on legal fees in the past two years to get advice on the way in which you manage that contract?

Hon SIMON O'BRIEN: The member wants to know how much has been spent on legal fees for the Peel Health Campus in respect of contractual and related matters.

The CHAIR: That is what I understood the question to be.

[*Supplementary Information No B7.*]

Hon LJILJANNA RAVLICH: Can we get a copy of your public–private comparator framework? There must be an instrument that you put over these projects when you assess whether the indicators tell you to go one way or the other.

Hon SIMON O'BRIEN: We will take that on notice. Obviously, we do not have the model to hand. We will respond by supplementary information.

[*Supplementary Information No B8.*]

Hon LIZ BEHJAT: I turn to the budget papers, specifically to item 7 "Prevention, Promotion and Protection" on page 193 and also item 10 "Drug and Alcohol" on page 195. Under "Prevention, Promotion and Protection" reference is made to specific areas of service, including genomics, the management and development of health information, Indigenous health et cetera. Nothing there relates to specific areas of prevention and promotion around alcohol and drug problems. I notice under item 10 "Drug and Alcohol" a range of prevention programs. I am not sure whether my question comes under items 7 or 10, and the minister might have to provide the answer on notice. If we look at item 10, "Drug and Alcohol", the net cost of service is $52.755 million. Can we get a breakdown of how that money is expended? I am trying to drill down to find out how much we are spending on prevention and education awareness programs for drug and alcohol problems in this state.

Hon SIMON O'BRIEN: Drug and alcohol programs?

Hon LIZ BEHJAT: Does it come out of the drug and alcohol item or the prevention, promotion and protection item.

Hon SIMON O'BRIEN: We have a specific drug and alcohol category and I suspect that it is a stand-alone item. I will ask Mr Dillon to comment on it in a moment. I am sure we can provide the

breakdown that the member is seeking as well as identify which of the two broad areas it falls into. We do not need to take it on notice. We can probably provide that information now.

[3.20 pm]

Mr Dillon: A key component of the prevention work that drug and alcohol performs is our campaign work, and the expenditure on that for 2009–10 is approximately $1.5 million. The total expenditure in relation to all of our prevention activities is approximately $6 million out of the totality of our budget, which includes the corporate overhead in relation to our prevention work. Our work is broadly aligned prevention or treatment and the component for our prevention capacity is approximately $6 million out of that.

Hon LIZ BEHJAT: Thank you.

Hon SIMON O'BRIEN: Does that meet your needs?

Hon LIZ BEHJAT: That is fine, but I would still like to get the information about the programs, the line items and that.

[*Supplementary Information No B9.*]

Hon SIMON O'BRIEN: What were the specifics you wanted there? What was the breakdown?

Hon LIZ BEHJAT: I would just perhaps like it broken down as to the drug and alcohol prevention programs that we have running and the amount of money that is expended in each of those areas.

Mr Dillon: I can tell you that in terms of our campaign work, in 2009–10 approximately $840 000 was spent in terms of alcohol, and in relation to illicit drugs, it was approximately $620 000. That comprises a total of $1.46 million for 2009–10. In the totality of the prevention spend, within that we have a workforce development element. I do not have a specific figure available to me here, but I could provide that separately. There is general prevention work, which involves community development, liquor licensing and advice to communities in terms of alcohol management. That is a separate component also.

Hon LIZ BEHJAT: Great, because if we could try to find out as well the demographics that we are targeting in relation to these programs, whether it is Indigenous, non-Indigenous, youth, people like that, so some specifics of the programs that we have running.

Hon SIMON O'BRIEN: I am just wondering how we might best help the member here, Madam Chair. Maybe almost a briefing on the area might be better, or is it just the raw data that you are after?

Hon LIZ BEHJAT: A briefing; that would be fine.

Hon SIMON O'BRIEN: That would obviously involve the conveying of that data as well so, Madam Chair, rather than a supplementary answer, perhaps we could undertake to follow up out of session and provide that briefing. The member obviously has a strong interest.

Hon LIZ BEHJAT: I would be happy with that.

Hon SIMON O'BRIEN: Great.

Hon PHILIP GARDINER: On page 185, under "National Healthcare Agreement (NHA) and National Partnership Agreements (NPA)" there is reference to closing the gap in Indigenous health outcomes. Further down the page there is a fair bit of money that has been outlaid in relation to the closing the gap in Indigenous health, but I do notice that in the outcomes and key effectiveness indicators on the following page and onwards for two or three pages, there is no reference to the closing the gap programs. I would have thought that that was a very important program in which to actually assess the outcomes. Is there a reason for the exclusion or is it just that we are getting wound up to really do those programs now?

Hon SIMON O'BRIEN: I might ask Mr Snowball to just describe it. It is as you partly surmised, as we shall see.

Mr Snowball: Closing the gap is part of the national partnership agreement, which in turn has specific outcomes described in it in terms of the partnership agreement itself, which has then funds assigned both from the state and the commonwealth. Both ends have agreed what the priorities are and the outputs and outcomes from those priorities as per an implementation plan, and that is what is being rolled out and described in these papers.

Hon PHILIP GARDINER: I will go on to a different topic on the same page. I refer to page 185, "Value for Money Audit". The minister would be aware that some remarks were made in the Parliament earlier this week about information systems in the Department of Health that relate to a program called information communication technology or information health alliance on which a fair bit of money was being spent—$300 million, I gather. Where does that program currently stand? Am I correct in understanding that was a contract with the company Fujitsu?

Mr Snowball: Through the minister, the $330 million relates to a wider ICT program across health. It has a number of component parts to it. Part is replacement of ageing infrastructure and support systems—data centres and the like, which service our hospitals. We have one system in the metropolitan area, which is TOPAZ, which is some 20 years old at least, and which needs replacement. In the country, there is a system called HCARe, which also needs replacement. There is a program under that $330 million to upgrade and replace that infrastructure. There is a second component to it, which is upgrading our technology through that infrastructure, and which includes things like eHealthWA programs servicing new developments like Fiona Stanley Hospital and the like. Within that $330 million is a series of programs and projects that relate to those two broad areas that I have described. If the member needs more detail on that, I would need to take it on notice, but that gives a broad-brush answer. Fujitsu was a contractor in a number of the projects as part of that process. I do not have any detail around the issues that were raised in Parliament during the week. On any issues or allegations around the Fujitsu contract, I would need to take those allegations to be investigated. I do not have any indication there is anything untoward in those contract arrangements. If information is brought forward, then I can follow through on that.

Hon PHILIP GARDINER: Has Fujitsu's contract been completed—I am not sure of the details—or has Fujitsu completed what it was obliged to do contractually?

Hon SIMON O'BRIEN: I wonder if the member might be able to pin down his question, because we may have to provide an answer by way of supplementary information and we need to know precisely. There is an ongoing relationship between the Health Department and Fujitsu in the sense that it has done work in the past that is concluded, but there is also some more work that I understand is proceeding. Can the member give us a time frame or a scope of what it is he is inquiring about?

Hon PHILIP GARDINER: The best I can offer, minister, is a time frame beginning around 2005–2006 and I presume it would have concluded by 2009-ish, but I cannot be any more particular than that. Does that help?

Hon SIMON O'BRIEN: Probably not, because it would to be for a specific body of work. The person who might be able to provide an answer on the spot is not with us today, which is why we are seeking to get it on notice and why I want it to be precise. If we cannot get it precisely on notice there is another mechanism, and I would be delighted to receive a question with some notice when the Parliament resumes, or there might be some other way we can assist the member, if necessary.

[3.30 pm]

Hon PHILIP GARDINER: Thank you minister. I will follow that through.

Hon KEN TRAVERS: You can make a ministerial statement at the beginning of the day rather than waste question time!

Hon SIMON O'BRIEN: I will display my customary brevity at whatever part of the proceedings.

Hon PHILIP GARDINER: You may not be able to answer this, but there is a suggestion that there was a $20 million gap somewhere where money was lost—not misappropriated.

Hon KEN TRAVERS: I think the term used the other day was "unable to be accounted for".

Hon PHILIP GARDINER: Thank you Hon Ken Travers. It is a lot of money. Can you give any elucidation to this committee of what you understand that misallocation to be—whether it has been found or whether that whole misallocation does not exist?

The CHAIR: I think the question is: have you found $20 million?

Hon SIMON O'BRIEN: If I found $20 million I do not know that I would want to share the information!

Hon KEN TRAVERS: Before 30 June last year I know what would have happened to it!

Hon SIMON O'BRIEN: There is a general allegation that $20 million may have gone missing or not been allocated. It certainly has not come to the department's notice that such is the case. One would have reasonably expected it to have done so, if that were the case. I am not sure whether this really relates to the current estimates process, with respect, even though I am more than happy for the agency to entertain the free-ranging questions we have answered. I do not want to restrict things in any way. Without having a specific question, I do not know that I can really respond.

Hon PHILIP GARDINER: We will try another medium to get a response. The question came out of the value-for-money audit on page 185. I wondered whether such an audit would have discovered whether $20 million may have been misallocated.

Hon SIMON O'BRIEN: I understand what the member is saying. A value-for-money audit is probably a different mechanism than that which would have been intended. A more traditional audit might have uncovered a $20 million deficiency. I think the allegation raised the other day is perhaps best pursued as a separate matter.

Hon PHILIP GARDINER: I will come back to that.

On the issue of governance and contractors, it is very easy—I have seen this in the past—for someone to do a scoping study for a project, and because of the knowledge and money one has spent with such a corporation or consultant to do the scoping study, and, along with others, that consultant applies to do the ongoing work, it is very tempting, to say, "Yes; we will award the next project to the same entity". Is that governance dilemma recognised for what it is in the health department, in the way one should consider what to do if that circumstance arises again?

Hon SIMON O'BRIEN: Of course, across government with so many contracts and so many tenderers, these are matters of great importance. We have some sophisticated mechanisms to ensure that there is appropriate treatment based on equity and probity across all agencies. In relation to the health department, I might ask the director general to defend his own agency's honour in this matter and invite him to add some specific comments.

Mr Snowball: Through the minister, while I cannot speak for the processes going back, I can certainly talk for them now. We have very strict processes around procurement. We have a relationship now with DTF, which undertakes what is known as their health cluster, who support the procurement arrangements in Health, so there is a level of separation in that respect. We also have very strict processes in terms of the gathering of tenders, the evaluation of tenders and so on. For the more substantial contracts, we will have probity auditors as part of that process to guide us and to provide advice to our managers in terms of acceptance of contracts. We have clear levels of authority in terms of signing off on significant contracts; anything over, in the case of the ICT area, $4 million needs to come to me to be approved as a contractual arrangement. We try, along the way, to have good separation of those processes and individuals in that process. No one person, if you like, is responsible for every element of the procurement process. I am very comfortable that there

are good controls and systems in place now right across Health in terms of its procurement arrangements.

Hon PHILIP GARDINER: I wonder whether I could ask, if they have been formalised, whether just the principles of that process could be provided to the committee as supplementary information.

Hon SIMON O'BRIEN: As supplementary information, we will provide guidelines on procurement along the lines that you have indicated.

Hon PHILIP GARDINER: Just the main principles, yes.

Hon SIMON O'BRIEN: We will probably give you even more than that.

Hon KEN TRAVERS: Can I just finish off on that Fujitsu thing? I wanted to ask a question following on from the questions about the Fujitsu matter. I assume the department has a media monitoring unit. Have the allegations that were raised in the Parliament and reported in the media been brought to your attention, either through that mechanism or as a result of a contact from the minister's office; and, as a result of that, what actions have you taken as the director general?

Mr Snowball: Through the minister, yes, they were brought to my attention through *Hansard*, so we have got a clear picture. In fact, we had already initiated an assessment of all of our ICT projects, not specifically to respond to that issue but more broadly, and that preceded those matters being raised in Parliament. I actually have an individual who is under contract to go through and look at how we are managing our governance arrangements in ICT more generally to be satisfied that we are on track, on budget and on time with those projects I talked about earlier under $330 million. On top of that, as a consequence of what was raised here, it will also be part of the focus of that individual to report to me around that allegation.

The CHAIR: I propose that we take a break until a quarter to four just to allow people to stretch their legs. We will reconvene at a quarter to four.

The DEPUTY CHAIR: Hon Giz Watson has offered her apologies; she has had to depart. We will proceed. We will finish at five o'clock.

Hon LJILJANNA RAVLICH: I refer to page 179 and the total appropriations provided to deliver the service. Have the new EBAs for new doctors and nurses been factored into that 2010–11 budget estimate, given that the doctors' EBAs expire in September? I am not sure when the nurses' EBAs expire. Perhaps you may be able to give us that information when you give us the response.

Mr Salvage: I will talk to the assumptions that were made in the department's bid to the 2010–11 budget process, which resulted in the additional $1.116 billion that you see in the table at the bottom of that page being allocated for total cost and activity pressures. As the acting director general referred to earlier, as part of that process we took the activity profile from the department's clinical services framework and applied a costing methodology to that framework to arrive at our estimated budget requirement for the forward estimates. In doing that, we had to make some pretty critical assumptions around costing and demand growth. One of them related to the extent to which we would need to factor into the budget at this point growth for meeting an increase in costs of salaries. It is critically important for us as an agency because about 60 per cent of our total expenditure relates to salaries and wages growth. In the modelling that we put forward, there was an assumption that the EBAs for those staffing groups would be settled within the parameters of government wages policy.

Hon LJILJANNA RAVLICH: I understand that five industrial agreements for doctors are due to expire on 30 September. I do not know how many expire for nurses, but you might give that information to me. I understand that the doctors have submitted a log of claims. No doubt the director general may well have seen that log of claims. Could the director general provide the committee with the essence of what that log of claims includes, because the government wages policy is about 2.5 per cent, 2.75 per cent and three per cent, in three phases I understand? I am

assuming they have asked for more than that. Could you give us the percentages of what they have sought from their end?

Hon SIMON O'BRIEN: We might take that on notice to make sure we have the figures right.

[*Supplementary Information No B11*.]

Hon LJILJANNA RAVLICH: I want to make sure we have it right. Can you provide to the committee the log of claims that was presented to the minister and through the minister to the director general for the following industrial agreements that will expire on 30 June: the Department of Health Medical Practitioners (Metropolitan Health Services) AMA Industrial Agreement 2007; the Department of Health Medical Practitioners (Director General) AMA Industrial Agreement 2007; the Department of Health Medical Practitioners (Drug and Alcohol Office) AMA Industrial Agreement 2007; the Department of Health Medical Practitioners (WA Country Health Service) AMA Industrial Agreement 2008; and the Department of Health Medical Practitioners (Clinical Academics) AMA Industrial Agreement 2008? Can you provide the committee with the relevant agreements that cover nurses, and give the committee an indication of when they expire; and, also, whether you have received a log of claims from the Australian Nursing Federation in relation to what they seek as part of their EBA?

Hon SIMON O'BRIEN: Mr Deputy Chairman, what was indicated—this was, I think, identified by you as supplementary notice B11—was a request for us to identify what percentage pay rises were being sought by the doctors and the nurses in the current round of pay negotiations with respect to some EBAs that are due to expire—hopefully fresh EBAs will be entered into from 30 September this year—and how that impacts, thereby, on the cost of services. That then relates this matter back to the budget estimates, which is what this hearing is about, and I undertook to provide that information. The member, in wanting to make explicit what the actual question was, has actually changed that quite dramatically to ask for a log of claims for all of those matters to be tabled, and then some other information as well.

Hon LJILJANNA RAVLICH: No, let me clarify.

Hon SIMON O'BRIEN: That is exactly what you said.

The DEPUTY CHAIR: I think the honourable member is after what the potential increase might be to the health department for the workforce, which is 60 per cent of the total expenditure; and I think she wants to know how that might be different to the budget, based on a log of claims that has been presented. Is that the issue you are driving at?

Hon LJILJANNA RAVLICH: That would be good to know, but I am really after a copy of the log of claims that were sent to the Minister for Health on 26 March. That will identify what the percentage increases are that are sought by the AMA on behalf of their members. What I have also said—quite explicitly, minister—is that there are a number of nurses agreements that I understand are also due to expire some time this year, and no doubt the ANF would have been in contact with the minister, or with the director general, and it, too, would have lodged a set of claims. I am asking you to provide those sets of claims to the committee, because, no doubt, they will have a financial implication. You have already told me that the budget is predicated on the government's policy in relation to wages at 2.5 per cent, 2.7 per cent and three per cent; I am anticipating that in the case of both the AMA and the ANF, they will not be satisfied with that level or the government wages policy and they will seek a higher increase in wages. I am asking for the government, through you, to table the relative logs of claims.

Hon SIMON O'BRIEN: There may be considerably more to a log of claims than a percentage pay increase.

Hon LJILJANNA RAVLICH: Yes, I understand that. That is why I would rather see the whole log of claims rather than just the percentages.

Hon SIMON O'BRIEN: The initial question that we agreed to provide supplementary information for and which is relevant to this hearing, is for the percentages that have been put forward for consideration in the course of the EBA negotiations. I have said, yes, we will provide that. I think I can undertake, on behalf of the health minister, to provide that. In connection with the further matter that has been raised—because it is a further matter—I will also take on, as a supplementary question for referral to the Minister for Health, the question of whether we can table all of the logs of claims that have been referred to and provide them to the committee. We will take that on notice. It is something that will have to be taken on notice because I cannot commit the Minister for Health necessarily to do that because I, in my representative capacity, am not party to the receipt of those logs of claims or party to the negotiations. I can only take it on notice and ask the Minister for Health to respond.

[4.00 pm]

The DEPUTY CHAIR: I accept that. If there is any commercial sensitivity in the negotiations, the minister would reserve his right to table them. If there is no commercial sensitivity, and if he sees that it will not damage either party in the negotiations, then the tabling of all logs of claims should be numbered B12 based on clearance with the minister.

[*Supplementary Information No B12.*]

Hon SIMON O'BRIEN: That is now clear. There are two questions—B11 and B12.

Hon LJILJANNA RAVLICH: Can I clarify something to the honourable member: the reason I have sought the log of claims and not just the percentage wage increases that are being sought is because there are a range of other issues, apart from the salary component, which have a dollar value attached to them. They also become important when you look at the total cost of an EBA agreement. That is why I have gone broader than just the percentage increase in salary component.

The DEPUTY CHAIR: I think that has been accepted.

Hon SIMON O'BRIEN: That is accepted and understood. Again, the fact is the initial thing that was agreed to and was recorded in your record is the percentage increase. If you want to change that, then we acknowledge you want something different than what you asked for, to make sure that we take on board everything that was asked for.

Hon KEN TRAVERS: Can I suggest that the way we should handle it is that we request they be provided as supplementary information. Should the department believe that they need to be kept confidential when they provide that to us, they indicate that to the committee and provide the reasons as to why they believe they should be kept confidential. That is how we have handled these matters in the past. That is probably the best way to proceed on this occasion.

The DEPUTY CHAIR: Hon Ken Travers is right—if there is any commercial sensitivity of any kind and they are required to be kept confidential, they should be given to the committee in camera only and will not be released to the public.

Hon KEN TRAVERS: That will be a decision of the committee. We would accept a submission from the department as to why they should be confidential.

Hon SIMON O'BRIEN: I thank Hon Ken Travers for his suggestion. It is not actually my concern. The Deputy Chairman is quite right in saying that considerations of perhaps commercial sensitivity or whatever may well apply. That is a matter for the minister who will be fielding this supplementary question. I am not alluding in any sense—even though it has been said now—about withholding anything. Hon Ken Travers is quite right; documents can be provided in camera and then it is a decision of this committee as to whether or not they choose to make them public. The committee has absolute discretion to make the documents public. That is something we have to rely on. My desire to see this as a separate question is actually more mundane than that—it is simply

because I do not know what has been received because I am not the minister that receives these logs of claims.

Hon LIZ BEHJAT: I want to go back to page 193 of the *Budget Statements* under the heading "Prevention, Promotion and Protection". I notice that in the second dot point under "Explanation of Significant Movements" the 2009–10 budget is less than 2008–09 due to a reduction of $7 million in commonwealth funding for Gardisal. Does that mean that the Gardisal vaccine program has come to an end? I would have thought that that was an incredibly successful program for young women to ensure that they are vaccinated against cervical cancer. Can you throw some light on that one for me?

Hon SIMON O'BRIEN: No; but I hope Professor Weeramanthri can.

Dr Weeramanthri: The Gardisal program continues. The reason that extra funds were allocated in the first few years was to get over the introduction of the program for a particular cohort of young women. Now we have established that, there is an ongoing basis to the program, which now continues with commonwealth funding. So the program continues as originally intended, but there was an initial hump for funding to deal with the introduction of the program and catching up with the first cohort that had to go through.

Hon LIZ BEHJAT: Is that 100 per cent subsidised?

Dr Weeramanthri: The full cost of the vaccine is borne by the commonwealth, and then given to us, but the arrangements for that will change in future years. At the moment the vaccine is bought by the commonwealth, but actually in future years none of it will appear on our balance sheet. So there is a transition to a different form of funding, but the full cost is borne by the commonwealth, yes.

Hon LIZ BEHJAT: Do you have any data surrounding the uptake of young women who are having this course of vaccinations? Is it successful?

Dr Weeramanthri: Through the minister, yes, we have got good data. We are pleased with the uptake. It is in the order of 60 to 70 per cent in the initial years. Clearly, there is a choice for parents, discussing this with their children, and we would expect that the uptake will increase in future years as the program becomes embedded and better understood.

Hon LIZ BEHJAT: And is there any work in particular being done in this area? We have obviously had an increase over recent years of migrants here who come from a CALD background—culturally and linguistically diverse. Do you have any statistics surrounding whether there has been a good uptake in that group as well?

Dr Weeramanthri: Through the minister, I do not have figures on that particular subgroup, no.

Hon LIZ BEHJAT: Would it be available anywhere, do you think?

Dr Weeramanthri: I take advice, but I am not aware of such a breakdown of figures.

Hon LIZ BEHJAT: Okay.

Hon KEN TRAVERS: I was wondering if we could get—and I am happy for it to be taken as supplementary information, but I want to make sure that your department is able to answer it—the bed capacity that you have; that is, the number of beds that are potentially available in each of your hospital facilities. I will actually put on a supplementary question at the end of the day for all of your facilities in terms of general, but I am particularly asking at the moment about mental health beds—the bed capacity—so the number of beds you potentially have available at each of the hospitals or facilities, and broken up into both open and secure beds, and the number of beds that are actually staffed at the moment on a similar line, along with the number of —

Hon SIMON O'BRIEN: Can we just take one category at a time? Ms South will be able to respond in respect of the mental health beds.

Ms South: Yes. Through the minister, with respect to mental health beds, we currently have around 640 mental health beds in the metropolitan area and 51 in the country area. That is our total physical capacity at the moment. I do not have the breakdown of secure and non-secure on me, but we can provide that; and just noting that does include also mental health beds at the children's hospital and the women's hospital, as well as our other facilities.

Hon KEN TRAVERS: Is that the potential bed capacity or is that the number that you have staffed?

Ms South: That is the physical bed capacity.

Hon KEN TRAVERS: Do you know how many you actually have staffed at the moment?

Ms South: I do not have that information at the moment.

Hon KEN TRAVERS: That can be supplementary information then.

[*Supplementary Information No B13.*]

Hon SIMON O'BRIEN: So that was not only the number staffed, but also you want to know the breakdown of secure and non-secure?

Hon KEN TRAVERS: Yes, and what facilities.

The DEPUTY CHAIR: Open and secure bed numbers for mental health. Have I got that correct?

Hon KEN TRAVERS: Yes.

Hon SIMON O'BRIEN: You also mentioned that you wanted to obtain the general bed numbers by supplementary —

Hon KEN TRAVERS: The similar figures. I am happy to put it on notice now, then. I would like the same numbers for the general bed numbers by facility—in regional Western Australia, maybe by region rather than by individual facility, so Goldfields, South West et cetera—the potential bed capacity and the number that are actually staffed. If it is reported on the first of the month or the thirtieth of the month, then I am happy for it to be the last reporting date.

[4.10 pm]

Hon SIMON O'BRIEN: Given the number of facilities, even if we have the information now, it would probably be easier for the committee if we provided it in a tabular form by way of supplementary information.

Hon KEN TRAVERS: The capacity and the number of staff, and what I would also like, if the department has it, is when the current asset investment program is completed, what is the expected bed capacity; and, if the department has it, how many of those beds it expects to be staffed at the completion of the asset investment program.

The DEPUTY CHAIR: Is that on the same supplementary information request?

Hon KEN TRAVERS: As I say, for the WA Country Health Service, I am happy for it to be by region rather than individual facilities.

Hon SIMON O'BRIEN: It might be useful to mention, too, that on the department's website I understand there is information for each facility, each hospital, the total bed capacity and the most up-to-date information available of the occupancy, which is how many are available. I just mention that because it is a related matter that the member might find interesting.

Hon KEN TRAVERS: That is one of the things I am interested in. When the minister says "occupancy", does he mean those beds that are occupied or those that are actually staffed? I suspect there is a subtle difference but probably not a big difference between the number that are staffed and the number that are occupied.

Hon SIMON O'BRIEN: No, indeed. The figures, as I understand it, are for the capacity of a hospital—that is the total number of beds—and, at the time of posting, the occupancy, which is the number of those beds that are occupied by a patient. I also understand, as the member has just acknowledged, that in most cases that figure is synonymous with the number of beds funded or staffed. I will just seek advice as to whether or not that is not the case.

Mr Snowball: Through the minister, on that website there is actually a definition for each of those areas, so it would be very clear what it is we are reporting. In fact, I have just got the definitions. It includes the bed occupancy rate per hospital and what we are now calling available "active beds". An active bed means that the bed is available and staffed and it can be occupied—for metro hospitals, for example, the same day during the week, because weekday, weekend and multi-day beds are categorised differently. So this is a very comprehensive list of those beds on the website.

Hon KEN TRAVERS: Where in the website? I must say, the department's website is very extensive and one can get lost in it at times.

The DEPUTY CHAIR: Maybe we should change the supplementary information to a request for the website address rather than the definition!

Hon SIMON O'BRIEN: Mr Deputy Chairman, if I may, I think you had your tongue firmly in your cheek there. I was about to offer that as a serious suggestion. I am prepared to provide all this information.

Hon KEN TRAVERS: If it is on the website. The other question was that at the end of the current asset investment program, because I know that on the website, for instance, will be the clinical services framework through to 2020 now, but that probably will not reconcile itself with the current asset investment program that is in the budget.

The DEPUTY CHAIR: Hon Ken Travers, are you happy to have a website?

Hon KEN TRAVERS: If it contains the information.

The DEPUTY CHAIR: If it contains information, can we have the supplementary information request as being the website?

Hon KEN TRAVERS: I am happy for it to be electronic rather than more paper.

Hon SIMON O'BRIEN: I think that the matter has been clarified. There will be a wealth of information provided and suitable directions to the website so that members have access to the full range of like information.

What will be provided in summary by way of supplementary information will be our existing capacity and our proposed capacity through several out years. In addition, we will address those questions we just discussed about hospital capacities relating to individual facilities, total bed capacities, the occupancy rates and the available active beds which are synonymous with what the member asked for in terms of staff beds or funded beds. If further clarification is required after that supplementary information is provided, we will provide that as readily as we can.

Hon KEN TRAVERS: The final area in terms of information I am interested to find—again, if it is on the website I am happy to be referred to that—is information for each of the hospital facilities in regions in country WA and the number of filled positions and vacant positions for both medical and nursing staff. Do you have a composite list showing that information? Are you able to quickly say that at Sir Charles Gairdner Hospital there are X number of filled medical staff positions and X number of vacancies?

Hon SIMON O'BRIEN: I understand what the member wants. We would have to freeze it in time, for starters. This literally changes from day to day.

Hon KEN TRAVERS: I am happy to have the most recent information. If the department's internal reports are done, for example, on the first of each month, then I would be happy to have the most recent one. I do not expect it to be made up as of today's date.

[*Supplementary Information No B14.*]

Hon SIMON O'BRIEN: We will take that question on notice. The sense of what the member is after is clear. We will do our best to provide all that information. It must be understood that it will only be a snapshot in an ever-changing scenario and it will be the most recent data. I think we can satisfy the member's query on the basis of what information is already collated as part of regular returns into headquarters, whereas if it transpires that some of this would require going out to every facility, that might make it a bit more problematic. I suspect we can give the member something that will satisfy his query.

Hon KEN TRAVERS: I accept the minister's point that it will be a snapshot in time. I imagine that throughout the year the department tracks its FTEs on either a weekly or monthly basis. Can the minister provide information on the number of FTEs that were tracked on a weekly or monthly basis over 12 months, so that we can get a sense of that snapshot in time? There might be high or low number of FTEs. If a similar sort of tracking on a monthly basis of the activity levels within the department could be provided at the same time, it would be useful as well.

[4.20 pm]

Hon SIMON O'BRIEN: Okay, I think we can also provide again a snapshot comparing perhaps a year to date with the previous year to date of the FTEs across the various categories of employee—these are totals—for example, nursing staff, agency staff, medical salaried, medical sessional and so on and so forth. We can also provide it in another way by area health service—north, south, country and so on. That will also give a dimension; you will see the percentage change, absolute numbers and so on, although obviously we cannot provide that latter bit of information, which I am offering, broken down across every institution —

Hon KEN TRAVERS: No, you have your snapshot in time across the institutions, but then anything that is tracking is more aggregated. As I say, if it is possible to do it on sort of a monthly basis of what your FTEs were over the last 12 months, that would be fantastic.

Hon SIMON O'BRIEN: We have the sense of what you need and we are keen to provide something from the existing records that our management team use, so we will provide that.

Hon KEN TRAVERS: I am not expecting the department to go out and generate a whole new set of reports for me. I assume that they have reports of that sort of nature in terms of their own internal management to track things, so that is what I am asking for, not something to be specifically created in terms of those —

Hon SIMON O'BRIEN: Okay, we will provide the data and we will also provide any notes as necessary to explain any sudden changes or variations in the figures, if they need explaining.

[*Supplementary Information No B15.*]

The DEPUTY CHAIR: That is the FTE comparison from year to year, but month to month.

Hon SIMON O'BRIEN: Yes, and just before we perhaps move off that—we will provide that—it might be helpful, too, for the sake of today's session, if Mr Snowball just qualifies some of the data we will be providing; there are some interesting patterns emerging that might be useful to explain to members now as we look at it, because the committee is involved in looking at the emerging, changing situation of our finances.

Mr Snowball: I mentioned right at the very beginning that one of the things that health has been able to deal with during the course of 2009–10 has been increasing growth in activity and demand. We have sought to match that with both productivity and support from the state government. I would like to be able to report that, for example, we have made a substantial change in the way we

staff our hospitals, so we have actually reduced by almost half our reliance on agency nurses in the system. That has allowed us to in fact invest that money into permanent and casual nurses, so we now have more registered nurses as a consequence. I should point out that an agency nurse is 1.3 times the cost of a permanent nurse, so I think that is a substantial achievement by the health system and the executive here.

The other area has been to pay particular attention to the admin and clerical areas of the department. We have seen a three and a half per cent reduction in FTE numbers in admin and clerical, to over 230 FTE—this is the year to date in terms of our FTE numbers—which again has meant that we have been able to refocus our effort from those admin and clerical areas more into the direct service delivery areas over the course of 2009–10. So I would just like to recognise that particular piece of work. We have similarly invested that in staff in the system, particularly medical and nursing staff.

The DEPUTY CHAIR: On behalf of the committee, congratulations; that sounds good.

Hon LJILJANNA RAVLICH: I refer to page 188, "Outcome 2: Improved health of the people of Western Australia by reducing the incidence of preventable disease, specified injury, disability and premature death." I am specifically looking at the chart that deals with the loss of life from premature death due to identifiable causes of preventable disease or injury in Western Australia. The first question is: why are there no figures for 2008, 2009 and 2010?

Dr Weeramanthri: These were the latest available figures. There is a delay in coding of deaths, so clearly we have to wait until the end of the year before we code and then there is a period over which coding will take place. There is a lag in providing complete mortality figures for prior years. These would have been the latest figures available at the time of the preparation of the report.

Hon LJILJANNA RAVLICH: How long is the lag, given the latest figures are 2007 and this is the 2010-11 budget?

Dr Weeramanthri: The lag is between one and two years

Hon LJILJANNA RAVLICH: That still does not make sense, with all due respect.

Dr Weeramanthri: Through the minister, we have more up-to-date figures as they come in. I am sorry, I cannot give a better answer than that.

Hon SIMON O'BRIEN: We all want up-to-the-minute figures but there is a significant and necessary lag in compiling this. Until the table is up to date in all categories, we do not have the complete picture. It is not as far behind as one might think, because when we are talking about financial year we are talking about a different thing than the calendar year, which I believe is what is displayed here—no? Apparently these are for calendar years, which gives a six-month lag for starters. Even though we are considering the 2010–11 year, that is a financial year and not a calendar year. The 2010–11 financial year started yesterday, and 2010 as a calendar year is still in progress. We are, in fact, only waiting on the finalisation of the 2008 calendar year, which is only 18 months gone and apparently it takes some time to assemble these figures. It is not as if they are being hidden; they are a useful tool for all of us.

Hon LJILJANNA RAVLICH: How can they be useful when they do not mean anything, given they are so old?

Hon SIMON O'BRIEN: This is explained in the document. My understanding is that it is based on long-term outcomes. In this case, what is shown in the budget document is a 10-year table so that we can at least perceive a trend, which has to be gradual. It would be remarkable if it were not gradual, as it takes years for trends to become apparent. Indeed, I would have thought that even a 10-year table is not showing quite as wide a snapshot as we would need, but we can only go on the data that is available.

Hon LJILJANNA RAVLICH: The one thing that most of these have in common, be it heart disease, breast cancer, lung cancer, cervical cancer or melanoma, is that if detected early and if

treatment is successful, means that people are probably not in the health system for as long as they otherwise would be if these disease were left undetected and left to grow, if you like, and therefore people become very, very ill and become very dependent on the public health system. The real issue here is the cost efficiency of early detection of these diseases and therefore the saving to the public health system. Having said that, I am concerned that women with breast cancer are having to wait longer than they have in the past to be screened by BreastScreen WA and then after that are waiting up to 40 days for an appointment at either Royal Perth Hospital or Sir Charles Gairdner Hospital, and then waiting probably a month and a half, two months or whatever it is for the appropriate surgery. When we take those time frames and put them together, women can be waiting for up to six months before any practical action is taken on their disease. Mr Snowball, I see you nodding your head. If you can guarantee me that that is not the case, I will be most pleased. Can you first of all tell me how much of a blow-out there is in the waiting times for BreastScreen WA?

[4.30 pm]

Hon SIMON O'BRIEN: I hope we can both please and reassure the member. As to whether we use terms like "blow-out" remains to be seen. I do not accept that.

Hon LJILJANNA RAVLICH: You can use whatever you like.

Hon SIMON O'BRIEN: There is no need to be combative.

Hon LJILJANNA RAVLICH: I am not being combative; I am just saying there are a lot of women whose lives may be at risk, and that is serious.

Hon SIMON O'BRIEN: Indeed; it is very serious. As you well know, my own wife is a breast cancer survivor, thanks to the treatment she received. In terms of the general trends you are talking about in breast screening and what movement there has been in availability—let us avoid terms like blow-out—I think we can get a general overview. I think both David Russell-Weisz and Nicole Feely are both in a position to advise us.

Ms Feely: Through you, minister, I can advise that, as of today, from advice I have received, there is one patient at Royal Perth Hospital who is over-boundary from a category 1 perspective. Her surgery has been booked as of 12 July. I am trying to check whether there was a 14 or 16-day overrun on that 30-day category. There is one patient at this stage.

Hon LJILJANNA RAVLICH: How many did you have a month ago?

Ms Feely: I understand two others were completed as of yesterday.

Hon LJILJANNA RAVLICH: Every woman who wants a breast screen at BreastScreen WA can now have one?

Ms Feely: I will hand over through the minister to my colleague, Dr Russell-Weisz in relation to BreastScreen. I am talking about surgery.

Hon LJILJANNA RAVLICH: I am talking first of all about the breast screen and then we will go to surgery.

Dr Russell-Weisz: Through the minister, we found that the actual demand with women attending BreastScreen is that mammography screening has increased by 58 per cent between 2000 and 2009–10.

Hon LJILJANNA RAVLICH: How much is that in real numbers?

Dr Russell-Weisz: In 2000 they used to screen 60 000 patients; they are now screening 94 000 patients annually. Basically, the clinics have been slowly increasing at Royal Perth Hospital and Sir Charles Gairdner Hospital over the years to treat those patients. But that has been quite a significant increase in demand.

Hon LJILJANNA RAVLICH: How long do they wait for an appointment, on average, to access that screening service?

Dr Russell-Weisz: I may need to take that question on notice to advise, generally, how long they wait to access that service. But I can say that in the metropolitan and country areas, the majority of patients will get into that screening service quickly.

The DEPUTY CHAIR: The member wants as supplementary information —

Hon LJILJANNA RAVLICH: From the time a person applies to have a screen and the length of time it takes to get that screen. I want days, weeks, years—whatever it is.

The DEPUTY CHAIR: You want the waiting time for breast screening.

[*Supplementary Information No B16.*]

Dr Russell-Weisz: BreastScreen WA is a successful program, which has the highest level of accreditation in the country. It was recently accredited—being accredited measures how successful it is in seeing patients in a timely fashion—with a commendation because of the quality of clinical care it was providing. They have also had some success in relation to getting further grants from the commonwealth and they have recently got $13.3 million for a digital mammography implementation grant for the next three years. We will also open our first Bunbury clinic. There will actually be a fixed clinic in Bunbury within the next two years as part of the comprehensive cancer centre and there is a van out there at all times.

Hon LJILJANNA RAVLICH: With all due respect, I do not doubt that they do a very, very good service. But the point that I am making is that the demand for that service seems to exceed the available resources to be able to deliver the service in a timely fashion. What we are dealing with is a disease which, if not picked up and detected very early, can and often does lead to very dire consequences, which may include that women with breast cancer actually end up being long-term users of the health system, whereas if it was picked up and dealt with quickly, it may well not be the case. You are telling me all the great things. You have already told me there are 94 000 and the demand has increased.

The DEPUTY CHAIR: Thank you, Hon Ljiljanna Ravlich. I think the question is clear. It is about the prevention —

Dr Russell-Weisz: I will provide the supplementary information through the minister to the member. But I would say that where our pressures are are not necessarily in BreastScreen; they are actually once patients have been seen in BreastScreen and actually getting them into the clinic and actually being seen in the clinic and operated on. Even in those clinics our performance is very good. My colleague has said between one and two patients may be over boundary; so that is our category 1 patient who should be seen within 30 days. I would say at Sir Charles Gairdner Hospital our performance is the same. The majority of patients will be seen in boundary—so actually meet the in-boundary targets of being seen—but there is burgeoning pressure on the system and we will have to increase our clinics at both Royal Perth and Sir Charles Gairdner Hospitals, which is planned.

Hon LJILJANNA RAVLICH: Can I get a clarification on what we mean about the boundary?

The DEPUTY CHAIR: Good question.

Hon SIMON O'BRIEN: Mr Deputy Chairman, that is what I want to clarify here. I think the key point that the member is asking for is about delays in our 94 000 patients accessing breast screening. Then, of course, there is the consideration of what happens for those women who have been screened who then require follow-up and access to other services. There are two separate areas.

Hon LJILJANNA RAVLICH: The minister seems intent on telling me what I am just saying.

Hon SIMON O'BRIEN: There are two areas here and I want to make sure that they are both covered. I might ask Mr Snowball to comment on this as well, and then we can go back to the other matters that are raised. But there are two distinct things here. My understanding is that there is no real booking system for the screening; it is a case of a broad-based service provided to those people who come along, and they are actively encouraged to come along and have it. Then we have got the question of, if there are follow-up clinical services required, how long that takes. Just to confirm that, I will defer to Mr Snowball.

Hon LJILJANNA RAVLICH: I am really wanting to clarify this period of a month, because I am told that all, with the exception of one person, are dealt with within the month. I want to know how that month is determined. Is it from the time they go to the breast-screening clinic, have the scan and then, if there are biopsies that need to be done or whatever, they go and get them and then they can go for surgery all within a month?

Dr Russell-Weisz: No; I can clarify that. Through the minister, obviously the treatment modalities are slightly different so you may get a patient referred from BreastScreen to the clinic. At that clinic time, there might be a decision to provide surgery—potentially a mastectomy—or to do a node biopsy or a lumpectomy or some other sort of treatment. It really depends; there are different methods of treatment. But the date you are talking about is the date from screening. Day one kicks off at the date from referral—so, the date that the screening doctor has referred the patient—and then the 30 days kicks off from when that referral is received, which is probably a day later, to 30 days from then.

[4.40 pm]

I can give you some stats for 2008. Even though we are seeing a massive increase, as I said, from 69 000 to 94 000 in 2008, 65.4 per cent of women requiring assessment attended an assessment clinic within 28 days of their screening episode. Sixty-five per cent got in within that time, but in 2009—I do not have the 2010 figures to date—78 per cent of women requiring an assessment attended an assessment clinic within 28 days of their screening episode.

Hon LJILJANNA RAVLICH: Is the medical fraternity at all alarmed at the fact that we have seen an increase from 60 000 up by more than 30 000 or over such a short time frame?

Hon SIMON O'BRIEN: We are delighted. The whole idea is that —

Hon LJILJANNA RAVLICH: You cannot be delighted.

Hon SIMON O'BRIEN: The whole purpose of this preventive, or early intervention, program is to encourage as many women as possible to actually seek out and have the benefit of breast screening. It is actually good that we are getting that increased response, even though it is an extra workload.

Hon LJILJANNA RAVLICH: But are you seeing an increasing number of women detected with breast cancer? If you are, surely that would be a cause for concern. Would that indicate that there is a greater prevalence of breast cancer or that it has always been around but just because of the detection methods, it is being picked up. Surely those questions have to be asked.

Hon SIMON O'BRIEN: I will ask our experts for departmental advice on that. If it is more prevalent or there is a greater proportion being detected because of more preparations, either way, the more people in the system, the greater hope we have of avoiding the more severe development of adverse cases.

Dr Russell-Weisz: I would like to clarify one point. Once a patient had been referred from the screening clinic—that is, seen by the surgeon or the breast specialist—and if a decision is made at that time to refer the patient for surgery, that patient, if they are a category 1 urgent patient, has to be operated on within 30 days of the decision of that surgeon. That is the information we were both referring to. We believe that the number of patients who fall outside that date is very minimal.

In relation to the increase in the breast cancer rates, or those patients presenting for screening, we are seeing this not just in breast cancer, but also a number of cancers right across the board. There are a number of reasons for that. I am probably not the expert. If the minister is happy to pass on to Dr Weeramanthri, he may be able to comment further on the general increase in cancer throughout the population.

Hon LJILJANNA RAVLICH: That is good because I was going to ask you for some statistical data in terms of the growth of these respective breast, lung, cervical and melanoma cancers.

Dr Weeramanthri: Through the minister, you can see from the table you referred to that the long-term trends are all positive in terms of declining mortality from all of those cancers, including breast cancer, which is obviously good news. The target age group for women in terms of breast screening where the screening produces the best returns in terms of picking up disease and preventing mortality, is between 50 and 69 years. As you know, as the population ages, what we are seeing is a greater number of women going into that age group. One of the causes of the greater detection now is simply a demographic feature of the ageing population and the baby boomer phenomenon, but also a greater success in encouraging women to get regular screenings over that period. The best return is regular screening of people in that group of people between 50 to 69 years. I do not know of any evidence that there is an actual increase in the age-specific incidence of breast cancer. In fact, I think that is pretty steady, but we are seeing more women moving into the age group that is most at risk, good health care screening and, in fact, a decline in mortality over time.

The DEPUTY CHAIR: You said that when you have detected a serious case—I forget the term you used—they will be operated on within 30 days, and that is one of the measures. What is the mortality rate of women who are operated on within those 30 days? What if they are identified as being serious? If it was my wife, I would want the operation to be done tomorrow. I want to know whether that 30 days is too long a period to have as your benchmark.

Dr Russell-Weisz: The 30 days is a standard across-the-board target for category 1 patients in a number of areas, not just breast cancer. I take your point in relation to urgency. Also, there does need to be planning with a lot of patients not just in relation to surgery but also in relation to radiation and chemotherapy that needs to be planned in that time so the patient gets the best suite of treatments rather than potentially just surgery. A lot of patients will get treated well under that 30 days; they may get treated within seven days. Some may be out towards 30 days. One statistic is that the 2008 BreastScreen Australia evaluation showed, to back up Dr Weeramanthri's point, that screening in Australia as a cost-effective intervention has led to a 28 per cent reduction in breast cancer mortality despite a rapid growth in the actual disease.

Hon SIMON O'BRIEN: That is very encouraging.

The DEPUTY CHAIR: I want to remark on that table. One of the absences from that table is colon cancer. I understand we have a particular program to raise the awareness of the early detection of colon cancer. Should that be added next time?

Dr Weeramanthri: We actually publish a range of departmental publications, including one on colon cancer. If that is requested, we are certainly able to provide it.

Hon SIMON O'BRIEN: One of the things about the budget papers is that they are specific to the budget. They give a useful snapshot in so many ways but there is a colossal amount of other material, which in most cases is freely and publicly available. There is no attempt or failure to provide that. It is just that there is a limitation to how much material, interesting though it is, can be provided.

The DEPUTY CHAIR: I understand that.

Hon KEN TRAVERS: I want to go to the issue of medical equipment. Back in May the minister issued a media release indicating that additional funding of $120 million over three years will be used to replace priority clinical and diagnostic treatment.

The DEPUTY CHAIR: What page are you referring to?

Hon KEN TRAVERS: I am referring to a press release first. Where in the budget does it occur? I see the ongoing line item for equipment, which I think is on page 198. The minister announced that there would be $120 million over three years to replace priority equipment, and that would be additional funding. I am trying to reconcile that with the budget figures that show for the next two years there is a total of $80 million, not $120 million. It is shown as works in progress. I would have thought it should have been shown as new works if it is additional money. Is it just that the cost of the equipment you were going to buy last year became more expensive, otherwise it should be listed as new works? I make that comment because it becomes very difficult for us to reconcile the media statements. As the Under Treasurer pointed out to us once, a ministerial statement does not necessarily mean it is a government decision.

[4.50 pm]

Hon SIMON O'BRIEN: I will just seek some advice. The media statement, I think, was made on 19 May 2010.

Hon KEN TRAVERS: Correct.

Hon SIMON O'BRIEN: It referred to "new medical equipment" and —

> More than $120million over three years will be used to replace priority clinical and diagnostic medical equipment for patients in Western Australia's hospitals …

Hon KEN TRAVERS: And in the next line he mentions "additional funding", clearly indicating that $120 million was additional funding.

Hon SIMON O'BRIEN: The funding is made up of $40 million in the 2010-11 year and the 2011–12 year. Also, the missing portion is not through escalation; it was contained in the 2009-10 year, so it is part of an ongoing program.

Hon KEN TRAVERS: But that is works in progress; that is not additional money. That includes money that was already allocated in previous budgets.

Hon KEN TRAVERS: The phrasing of the statement is—I do not debate what you are saying about your observations of the budget papers that are before us and are the subject of this hearing—that is what the budget says. The media statement was commenting that —

> More than $120million over three years will be used to replace priority clinical and diagnostic medical equipment for patients in Western Australia's hospitals to improve care.

This is part of an ongoing program—I am not sure when it commenced—and the budget papers also show a total estimated cost of $306.775 million.

The DEPUTY CHAIR: Where is that?

Hon SIMON O'BRIEN: The first line on page 198. The estimated expenditure to the end of June 2010 will be $225 million.

Hon KEN TRAVERS: We are back to the $80 million really, are we not, not the $120 million.

Hon SIMON O'BRIEN: No, we are. Then the out years of 2012-13 and 2013-14 are yet to have their allocations placed in them, quite obviously. I would not guess at what they might be. That is something —

Hon KEN TRAVERS: They are in never-never land, so we cannot count them.

Hon SIMON O'BRIEN: We are not seeking to; that is in the future and that will rely on future decisions. But the announcement was about the progress of the funding and the provision of new medical equipment, and over these three years: 2009-10; 2010-11; and 2011-12.

Hon KEN TRAVERS: How much new money has been allocated to the department for the three financial years 2010–11, 2011–12, and the 2012–13? How much new money has been allocated to the department? If it is new money and it is for a new program, why is it not listed under "New Works"; why is it fudged in under "Works in Progress"?

Hon SIMON O'BRIEN: You are using the expression "new money for a new program".

Hon KEN TRAVERS: Minister, if you have a program to buy 65 buses and you suddenly get the money to buy 85, in next year's budget you will not list it as "Works in Progress", you will list it as you will have your 65 buses and you will have 20 new buses.

Hon SIMON O'BRIEN: Indeed.

Hon KEN TRAVERS: The same issue should happen here.

Hon SIMON O'BRIEN: Hang on; we are in agreement on what the budget actually says, and you are wanting to —

Hon KEN TRAVERS: Reconcile it with the minister's claim.

Hon SIMON O'BRIEN: — reconcile on what the minister has said in a press statement from May, talking about medical equipment that is going to be purchased and provided.

Hon KEN TRAVERS: You have still got to get onto the equipment for Fiona Stanley. This might be a case of the Under Treasurer being correct—that the ministerial announcement was not necessarily a cabinet decision, it was just spin.

Hon SIMON O'BRIEN: I am advised that the new money that you refer to was allocated, for the three financial years we are talking about, in last year's budget. My advice is that the new money of $120 million was indeed added to the budget and out years for the three years we are talking about; that is, the year 2009–10 in which Minister Hames released this statement; year 2010–11 and year 2011–12. That is $120 million of new money, if you wish to call it that, or additional funding, as is mentioned here. I do not have last year's budget figures in front of me. I do not have the budget papers in front of me but where we have the total of the equipment replacement program currently shown as $306.775 million—can you see that?

Hon KEN TRAVERS: Yes.

Hon SIMON O'BRIEN: I am advised last year that was $186.775 million, and that $120 million of new money was added to that. That is the amount that Minister Hames is referring to in his media statement. That is why it covers the three years 2009–10, 2010–11 and 2011-12.

Hon KEN TRAVERS: If that is the case, minister, why is that additional money not listed as new works? If it is new money, then it should be included as new works. I presume that when the budget was created last year, there would have been a list of —

Hon SIMON O'BRIEN: I understand what you are saying. I do not know why. It is a mystery of Treasury as to why it might be shown there. It could have been shown as 186 there, and then it finishing or being completed and then new works. I do not know why. Perhaps it is treated by —

Hon KEN TRAVERS: Maybe if you let one of the officers answer the question, they might be able to tell us.

Hon SIMON O'BRIEN: — Treasury officials as an ongoing rolling program.

Mr Salvage: I am happy to add a comment there. I think we are constrained in terms of the construction of the budget statements about how we can classify these issues. Essentially the

$120 million was a refresh addition, if you like, to an existing program. That is why it appears under "Works in Progress" rather than as a new item.

Hon KEN TRAVERS: Is it to buy equipment over and above what was allocated in last year's budget, or is it to buy the same equipment and the price has just gone up? If it is to buy equipment that was not included in the program last year, then surely that is new works. It would make it a lot easier if we actually had new works listed to be able to reconcile that with the statements that are made by ministers.

Hon SIMON O'BRIEN: Through the answer, we now can reconcile it. It is additional funding, as Mr Salvage has said.

Hon KEN TRAVERS: That is your claim.

Hon SIMON O'BRIEN: My advisers have advised me that is the case; that it is part of an ongoing rolling program. That is why it is shown as an addition to that rather than having its own line item under new works.

[5.00 pm]

The DEPUTY CHAIR: Hon Ken Travers, do you want to ask a supplementary question on this?

Hon KEN TRAVERS: On equipment, there has been some confusion about whether the equipment that will be installed at Fiona Stanley Hospital will be new equipment or old equipment that is transferred there. Can you give us clarification as to what will happen, how much of the equipment at Fiona Stanley will be new, and how much will be transferred from other hospitals; and is there any budget allocation, or is the government reconsidering a budget allocation, to purchase equipment for Fiona Stanley Hospital?

Hon SIMON O'BRIEN: I am going to refer this to Ms Feely, but I will just indicate to you that, in general terms, there is going to be a mix. There is going to be a lot of new equipment for a new tertiary hospital, as you would expect; but also, where we have got some perfectly good existing equipment that is fully serviceable. It would be ridiculous to discard that rather than transfer it to a new location, and for the detail of that, I will —

Hon KEN TRAVERS: Yes, but I guess my question is: where is it going to come from? If it is coming from an existing hospital, which hospital is it going to come from?

Hon SIMON O'BRIEN: I will pass it over to Ms Feely.

Ms Feely: Through you, minister, we put the Shenton Park redevelopment to one side. Of the $1.76 billion set aside for Fiona Stanley, there was a figure of $167 million set aside for FF&E. Part of the original business case, when it was prepared under the previous government, included a 20 per cent contribution to FF&E from Royal Perth, which at that stage was to be closed. So in relation to that 20 per cent, what we are saying is that we are currently reviewing it in light of the CSF and the hospital delineation, and FF&E that is, of course, in good working order will be transferred to Fiona Stanley from Royal Perth in areas such as the burns unit, which will be transferred holus-bolus out of Royal Perth down into Fiona Stanley. As we look at what services—and we are doing all this transition work at the moment—move from Royal Perth, where there is a reduction in service or something, or from any other hospital in the south as such—so if we have an emergency department from Fremantle closing prior to the opening of Fiona Stanley, and there is, again, good working equipment—we would be looking and taking a value-for-money approach at what equipment is in good working order and will not be used at the existing facility which may be used elsewhere. But in relation to specifically the business case on Fiona Stanley, there is that 20 per cent that was allocated to come from Royal Perth. The ultimate percentage that will be coming from Royal Perth is yet to be determined.

Hon KEN TRAVERS: I am assuming, when you made those decisions, that the 20 per cent was based on—that was the usable equipment that was suitable to be transferred over at the time. I

assume you were not planning on just throwing out, as the minister says, good equipment under the original proposal to close Royal Perth. Now that Royal Perth is remaining open, I would have thought a significant amount of that equipment will still be required at Royal Perth, so you must have some idea, as a result of the decision to keep Royal Perth Hospital open, what impact that is going to have on the equipment that you need for Fiona Stanley.

Ms Feely: Through you, minister, I am not trying to be obtuse on the answer. I was not part of the business case built up in 2004, so I can only assume that, looking at all the equipment in Royal Perth, with the hospital then closing down, that a 20 per cent figure was taken as—probably when you close an entire hospital down, that is what you have left to be moved. It was also, as I understand—and no higher than that—simply as a way of offsetting the overall demand on the Fiona Stanley budget. The extent to which a 20 per cent figure is a definitive figure in 2010, or by the time of 2014, I am not in a position to answer that, which is why we are looking at it as we go through the transition process and look at the clinical services framework, as we look at what services will transfer. We will have to make that decision at the relevant time down the track.

The DEPUTY CHAIR: Noting the time —

Hon KEN TRAVERS: Sorry; can I just follow on with one more question in terms of that?

The DEPUTY CHAIR: Yes, if you have one more.

Hon SIMON O'BRIEN: When do we finish? I thought we were finishing this at five.

The DEPUTY CHAIR: Yes, we are. I just have one question from Hon Ken Travers to wind up this one, and then one from Hon Liz Behjat, who has been keenly waiting, and then we will close. Can you bear with me for that?

Hon LJILJANNA RAVLICH: Yes, I can.

Hon KEN TRAVERS: Yes, I can.

The DEPUTY CHAIR: It will be just three or four more minutes.

Hon KEN TRAVERS: I am just trying to find the bit of paper that I need, so if Hon Liz Behjat wants to ask her question —

The DEPUTY CHAIR: Okay; Hon Liz Behjat.

Hon LIZ BEHJAT: You do not even have two answer this question. I just wanted to actually pass on some information to you. With Hon Ljiljanna Ravlich's line of questioning with regard to BreastScreen WA, it prompted my memory that I actually needed to make an appointment for myself to go and have a mammogram.

I just left the chamber to do that. The minister will be pleased to know that, as a secret shopper, the first available appointment offered to me at the clinic closest to where I have my office is Thursday next week, but with the proviso that if I have any concerns at all or want it to be sooner than that, another appointment could be found for me on Monday at any other clinic in Perth. I just thought the minister might like that feedback.

Hon KEN TRAVERS: I thought the member might suggest that the minister needed to open the Joondalup clinic on Sundays now that we have extended trading up there!

The other issue is on the decision not to close Royal Perth Hospital. I note that as a result of that, Joondalup Health Campus is now not going to have a cardiothoracic service, which was originally proposed in the 2015 clinical services framework, and this has now been removed. In answer to a parliamentary question I got the other day, I was told that that was because it was inefficient to operate more than three, and so there would be one that Fiona Stanley, one at Sir Charles Gairdner and one at Royal Perth—noting that Sir Charles Gairdner and Royal Perth are five kilometres apart. That is another example of a service that is going to be missed out on and going somewhere else as a result of keeping Royal Perth. What other implications are there of keeping Royal Perth Hospital

to services being provided across metropolitan or regional Western Australia? Why was the decision taken to keep the cardiothoracic service at Royal Perth and not move it to Joondalup?

Hon SIMON O'BRIEN: That is a pertinent question. To give it a proper decision deserves, I will take notice.

[*Supplementary Information B17.*]

The DEPUTY CHAIR: Ladies and gentlemen, members, we have finished the hearing for today. The committee will forward any additional questions that it has to you in writing in the next couple of days, together with a transcript of evidence, which will include the questions you have taken notice. If members have any unasked questions, I ask them to submit these to the committee clerk at the close of this hearing. Responses to these questions will be requested within 10 working days of receipt of the questions. Should the agency be unable to meet this due date, please advise committee in writing as soon as possible before the due date. The advice is to include specific reasons as to why the due date cannot be met. On behalf of the committee, thank you very much for your attendance today.

Hon SIMON O'BRIEN: Before you wrap up, Mr Deputy Chairman, I have just two very quick things. With any questions being forwarded, as it is sight and quantum unseen, could I ask that they be relayed electronically, and that will greatly facilitate our compliance with your requirements—so how you receive them from your members, but if we could receive them electronically, please?

The DEPUTY CHAIR: Yes, that is fine.

Hon SIMON O'BRIEN: I thank you for that. I also express, on behalf or witnesses here today, our appreciation of your committee staff for their assistance provided to us in our attendance here today and the conduct of this hearing.

The DEPUTY CHAIR: Thank you. That is very much appreciated.