STANDING COMMITTEE ON ESTIMATES AND FINANCIAL OPERATIONS

2011–12 AGENCY ANNUAL REPORT HEARINGS

DEPARTMENT OF HEALTH

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
THURSDAY, 04 OCTOBER 2012

SESSION ONE

Members

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

Hearing commenced at 9.38 am

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

AYLWARD, MR PHILIP
Chief Executive, Princess Margaret Hospital for Children, sworn and examined:

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

SALVAGE, MR WAYNE
Acting Executive Director, Resource Strategy, Department of Health, sworn and examined:

JEFFERIES, DR K. FELICITY
Acting Chief Executive, WA Country Health Services, sworn and examined:

MARK, DR PAUL
Acting Chief Executive, South Metropolitan Health Service, sworn and examined:

The CHAIR: On behalf of the Standing Committee on Estimates and Financial Operations I welcome you to the hearing this morning. Before we begin I am required to ask the witnesses to take either an oath or an affirmation.

[Witnesses took the oath or affirmation.]

The CHAIR: You have all signed a document titled "Information for Witnesses". Have you read and understood this document?

The WITNESSES: We have.

The CHAIR: The hearing this morning is being held in public, although there is discretion available to the committee to hear evidence in private either of its own motion or at a witness's request. If for some reason you wish to make a confidential statement during today's proceedings, you should request that the evidence be taken in closed session before answering the question. These proceedings are being recorded by Hansard and a copy of your evidence will be provided to you. The committee reminds agency representatives to respond to questions in a succinct manner and to limit the extent of personal observations. To assist the committee and Hansard, if you could please quote the full title of any document you might refer to during the hearing, and please be aware of the microphones and try to speak directly into them.

Members, if you could please assist Hansard when referring to the annual report and please indicate a page number in preface to the question.

Government agencies and departments have an important role and duty in assisting Parliament to review agency outcomes on behalf of the people of Western Australia, and we appreciate your assistance this morning. For the benefit of members and Hansard, I ask now that perhaps, Mr Snowball, you could introduce your advisers or they could introduce themselves to the committee.

[Witnesses introduced.]

The CHAIR: Mr Snowball, I understand you have opening comments you would like to make. I am checking whether it is short.

Mr Snowball: Shortish!

The CHAIR: I ask that you make that statement now, if you like.

Mr Snowball: I thank the committee for giving us an opportunity to do that. We really have three annual reports: one for the Department of Health; one for WA Country Health Service and one for the Metropolitan Health Service. It is important to give some context to the delivery of the health system as a whole, because I think in Western Australia we have a very high performing health system. I want to go through some of that before we get to the detail so the context is out there. I do that in two ways: one is in terms of its performance itself, but also comparing its performance with other states in some pretty key areas and measures. It is important also to put on the record the terrific work that our staff of over 40 000 people, who work in the WA health system in a variety of roles, perform for Western Australia. I will just put on the record a few key headline facts. Western Australians enjoy the second highest longevity in the world. Our health system is not just the public health system. It is private general practice, and councils and local government, who deliver for us health outcomes for our community that are, as I said, second only behind Japan. I think that is a terrific result.

In terms of our performance, some key measures that are often in the public eye are around the performance of our elective surgery and also the performance of our emergency departments. In both those counts, we have increased our delivery and our performance year on year, and 2011–12 was no different. We have seen continued improvement in performance around our four-hour rule, so much so that last financial year all states and territories in the commonwealth accepted and endorsed the four-hour rule model to be applied nationally. We can probably get no better recognition than have a reform of that type copied in that way. So we are really pleased about that. I think what sits behind that—we often get people saying that this has changed the work patterns and there is more work in these areas and different areas are getting pressure, but we did have a pretty key study of independent research done of what it has meant in terms of lives lost as a consequence of overcrowding in our hospitals. The study said that, over 12 months in our three major hospitals, 267 lives were saved as a consequence of reduced overcrowding in the hospital emergency departments. That is a pretty extraordinary outcome, I think, for Western Australia.

I will limit these other areas to really key areas before we go to key questions. In elective surgery, we are one of only two states that have seen increased admissions for elective surgery and a reduction in how long people wait for elective surgery. Not only has the Western Australian health system dealt with more cases, that is, more admissions for elective surgery, but we are now treating more people, more quickly. I think, again, that is a terrific performance result from our hospitals, surgeons, nurses and support workers. Just in those measures: What does that mean in terms of safety and quality? What are the key outcomes there? I think that all of the reports go to that. There are measures in our key performance indicators that reassure you around the safety–quality outcomes. In some of the key things, like infection control rates, we are well below national benchmarks; and mortality rates at our major hospitals are in line with other states. So our management of these large increases in demand coming through has seen that reflected, not in a diminishing quality or safety outcome; in fact, we have either held or improved our quality and safety. We have had a health system that is bearing the brunt of very significant increases in demand in both our emergency departments and elsewhere, not only as a result of population growth but also the rate of utilisation of our emergency departments. We have too few GPs in this state and too few residential aged-care places. Those things add pressure beyond the pressure we get from population growth. We have had a system that has managed that growth, managed the activity and is planning for it into the future, as well as maintaining and improving safety and quality.

I will make one final point. This is also in an environment in which we have had an extraordinary investment in infrastructure going forward. In particular, we have now an improved capital program of just over $7 billion. In the last financial year, 2011–12, we spent $1.75 billion on new infrastructure, so that is Fiona Stanley Hospital, development towards new kids, Midland, Albany, Busselton and Kalgoorlie, and so the list goes on. There are lots of other smaller-range projects that

do not always get the airplay the bigger ones do, but it represents a major investment in our health infrastructure, which we are following through to make sure that the services that occupy that new infrastructure are going to match the needs of our community into the future.

On that basis, this is the leadership team that has helped to deliver that outcome, and we are very happy to be here today.

The CHAIR: Thank you very much.

Hon LJILJANNA RAVLICH: Can I ask something in response to a comment made by the director general? In relation to having too few GPs, I wonder whether the director general could advise the committee how many GPs are we short in this state.

Mr Snowball: That is an interesting question. We have two ways of measuring that. One is a national average, which gives us a picture that if we were to be at the national average in terms of GPs, we would have about 300 extra in metropolitan Perth and we would have about 90 extra in country WA. There is a second assessment, which would make that number even higher. If you were to look at what is the benchmark, the level that all states aspire to in terms of GP to population ratio, that is higher again.

Hon LJILJANNA RAVLICH: How much would that be?

Mr Snowball: I have not got the exact numbers here. If we were looking at the national average, which is kind of a fair assessment, then that is the number you would be looking for. The absence of those GPs does mean that there is more pressure on our emergency departments. That is the flowthrough, I guess. It is not just people struggling to get in to see a GP. When you get a flu season like we did this year, there is an overflow because they just cannot accommodate the numbers and they come through to our emergency departments; hence the campaign, of course, last year.

Hon LJILJANNA RAVLICH: I wonder whether you could provide to the committee the national average or the figures. If you were to have figures based on the national average, what would that mean in terms of the current shortfall for Western Australia, and how many doctors would need to be funded in order to reach that national benchmark?

Mr Snowball: As you know, general practice is essentially funded through Medicare. It is basically: what is the shortfall of Medicare as a consequence of having, in metropolitan Perth, for example, 300 too few?

[*Supplementary Information No A1*.]

Hon PHILIP GARDINER: If I can just take that a bit further, what is the pathway that you see so that this shortage is going to be met by the supply of GPs coming through the universities and training places?

Mr Snowball: That is part of the solution. This state has seen an increase, obviously, with our medical student numbers over the past few years. In fact, we have almost doubled the number of graduates and interns coming into our hospitals over the past five years.

Hon PHILIP GARDINER: Is that because of the reduction of the years from six to five?

[9.50 am]

Mr Snowball: No, this is purely an increase in numbers. We have got Notre Dame as the new medical school, which fired up some years ago, and UWA increased its numbers. We have seen a doubling of the output from our universities of medical graduates, who in turn go into either general practice or other specialties in medicine. For us, there is a lead time for that, so we have got a bit of a catch-up. Not only do you have to maintain enough coming through to replace those who retire and resign, but we have a catch-up as well; this shortage has been with us for some time. It is about how to find a way to catch up in terms of those numbers. While that is one part of the solution, the other part we have been very reliant on is overseas recruitment, particularly for country areas of

WA, but also in the outer metropolitan area. We are in discussion with general practice. It is not just about the number of GPs; GPs are working less hours. As an average, over the last five to 10 years, it has steadily declined in terms of the clinical hours available to them. We are looking at ways that we can work more closely with them, whether it is in technology or exchanging information, so that we can actually make general practice more efficient and more effective as part of the broader network.

Hon PHILIP GARDINER: I know the NBN contributed to that. I was wondering whether I could just seek some supplementary information. Could you outline that pathway, based on the assumptions that we need to make about the demographics of Western Australia—the population growth—what the supply is coming through the current training schools, and maybe assuming that there are no migrant doctors coming in, so that we can make a statement to the public, for example, that by 2019 we are going to have a net deficit of 20 doctors or 30 doctors, so it is a minimal number rather than the 390 that we have got in the country?

Mr Snowball: I will just respond to that in two ways. In terms of the pathway, once you have done the internship—all graduates do the internship—then you choose a vocational path. General practice is a particular vocational pathway where you go on to do GP training and ultimately then practise as a GP. Just to give you a picture of the numbers, in 2002 there were 34 doctors doing GP training in Western Australia. That is now 106, so there has been a major step up. That is actually oversubscribed as well. We are producing many more GPs into the future, and we need them. The second part to that is that we do not just do this as a state in isolation, because obviously our interns move around too. We will have Victorian graduates doing internships in our hospitals, for example. There has been a nationwide study done by Health Workforce Australia that did just what you described. It said: if you wish to achieve sustainability by way of producing your own doctors—in other words, no reliance on overseas doctors—what would you need to train and educate in your medical schools? I do not have those numbers off the top of my head, but it is a publicly available document. They did a very thorough job in planning out the workforce. From memory, they were looking at bringing it to self-sufficiency in 2025. That was the target they had set. The question put to them was: tell us what we need to train in order to achieve self-sufficiency in 2025 in Australia. Those numbers are there.

Hon PHILIP GARDINER: Is it possible to get a summary of that—what did you call it—

Mr Snowball: The Health Workforce Australia report.

Hon PHILIP GARDINER: —as it applies to Western Australia, in a form that if we want to talk about it to our constituents, we can say that in 2025 we are going to have this, that or the other?

Mr Snowball: It is a prospective look at it, so it is an estimation. There are lots of caveats, I have got to say.

Hon PHILIP GARDINER: I fully appreciate that, but I think that would be a helpful, in a sense, pathway or final point of 2025—when I say "final point", it is always a progressive point, I know—to explain to people who have got great concerns about it.

[*Supplementary Information No A2.*]

Hon KEN TRAVERS: Can we go to page 70 of your annual report where it lists the average cost per public patient treatment episode in private hospitals? There is a figure there that shows the CPI adjusted and then the actual cost that was incurred. Are you able to explain to us why there was that increase?

Mr Snowball: Each year?

Hon KEN TRAVERS: Between 2010–11 and 2011–12 for both the actual and CPI-adjusted figures.

Mr Salvage: I will just talk generally about the basis on which the prices for those contracts are negotiated with the providers concerned. In the case of Joondalup Health Campus, that involves a benchmarking exercise. So the price that we negotiate and agree with the operators of Joondalup Health Campus for inpatient service provision essentially reflects the cost of delivering that service within our own secondary hospitals; there is a network or basket of secondary hospitals that we use to benchmark. The movement in price between years will be reflective of the movement in the cost of delivering services in the state's own hospitals. The differential between the CPI-adjusted figure and the actual cost I would have to take on notice.

Hon KEN TRAVERS: There is also the increase between 2010–11 and 2011–12—the fact that it has gone up even on a CPI-adjusted basis.

Mr Snowball: I will just take you through what these three lines are. The first line is the target that we should be achieving in terms of average cost and is set as part of the government budget statements process. That is outlined. What we want to see is both our estimated and our actual cost sitting below that number, which of course it does in 2011–12 and it is pretty much right on the money in 2010–11 in terms of the actual compared with the target. As you can see in the notes under "c", 2008–09 was the base year for the five-year CPI-adjusted series. What they have done is that they have sat a pure CPI-adjusted base as one line to give you a picture of where we are landing. Year on year we do, through our government budget statements, a target for that and then we compare the actual against both those numbers. It gives you a picture. Obviously, CPI is not necessarily a health-related CPI when we talk about a CPI adjustment over five years. That is why that will be higher than the CPI, because health costs rise at a faster rate than that. We are more interested in this chart between target and actual. That is what we should be looking at.

Hon KEN TRAVERS: Okay. You mentioned the benchmarking for Joondalup Health Campus. How do you do it for the other health campuses, like Peel? Are they on the same benchmarking or are they funded differently?

Mr Snowball: In terms of Peel, our chief executive who looks after Peel is sick today, so I am afraid we are turning to his proxy who is not able to talk with authority on that. I can provide that. I think we actually provided the formula that applied in previous years and I am very happy to provide that again if that is desired.

[*Supplementary Information No A3.*]

Hon KEN TRAVERS: Are you able to tell us how much you paid to Peel Health Campus in the 2011–12 financial year and how that related to the previous year's payments?

Mr Snowball: We can, but if we can take that again on notice.

Hon KEN TRAVERS: You would not have a figure?

Hon LJILJANNA RAVLICH: Do you have the info?

Mr Salvage: I do not have the value of the contract with Peel Health Campus in 2011–12. I do not have that information with me.

Hon KEN TRAVERS: All right.

[*Supplementary Information No A4.*]

[10.00 am]

Hon KEN TRAVERS: Did the department discover any problems with overcharging by Peel Health Campus during the 2011–12 financial year?

Mr Snowball: Sorry?

Hon KEN TRAVERS: Did the department discover any problems with Peel Health Campus in respect to the way they were charging the department for the services they provided?

Mr Snowball: As part of our contract management process, we go through and assess claims from all of our private hospitals in terms of the services. In my recollection, we undertook an audit of Peel in terms of their admissions and ensuring that what they were claiming effectively was the activity that they were undertaking, which we also do for Joondalup and all of our contracts. My recollection is that there were adjustments made as a consequence of that. It was recognised that some of the admissions should not have been paid for by the public—by the state—and those funds were subsequently recovered.

Hon KEN TRAVERS: Did you do an investigation into the background of how that arose—that overcharging for the services?

Mr Snowball: We did and that was part of the audit process. I do not have the detail of the audit with me here today obviously, so I am talking to you from my recollection. In terms of the process we have been through, though, it was very thorough, because how those counts of admissions were done within Peel became the issue. So we followed through on that to make sure that the definitions being used were consistent with the contract and that we were able to then validate and verify that work had in fact been completed. In terms of the process, we went through that to be satisfied that what was being reported as activity was in accordance with our contract and where it was out of kilter, following discussions, obviously, with Peel and the health campus management, it was agreed what was admitted activity that should not in fact have been met under the state funding arrangements, and that is what it was subsequently agreed to recover.

Hon KEN TRAVERS: Did you undertake any investigations to determine whether that was a deliberate attempt to defraud the government of money that they were not entitled to?

Mr Snowball: Yes, we did. We went through a very thorough process to establish that. With these contracts, there is some interpretation of the definitions and so on that you could excuse—if you get a changeover in staff or a new director of nursing or whatever, those things can occur. That is why we do the regular review and regular audit to make sure we are paying for what we are actually being delivered, and that is the work we went through and verified. The outcome from that audit was reported through to me. I was satisfied that there was an honest error, if you like, in terms of the process, and in my discussions with the head of the Peel Health Campus, I was satisfied they had recognised and agreed, and were refunding those funds that had in fact been charged erroneously.

Hon KEN TRAVERS: Did the audit talk about the fact that the Peel Health Campus had set up a specific scheme to pay a bonus to doctors who admitted people into the hospital because the hospital received additional money as opposed to just attending at the ED?

Mr Snowball: My recollection is no, it did not, but I would prefer at this point to take that on notice, because it was some time ago that that audit process was conducted. It was very detailed, so I do not carry that in my head, but I am very happy to provide that on notice.

Hon KEN TRAVERS: If you could take that on notice.

The CHAIR: Is that the audit document?

Hon KEN TRAVERS: I would like a copy of the audit document, but also whether or not the audit covered the issue of the hospital setting up a specific scheme that pays doctors an incentive to admit people into the hospital from the ED.

[*Supplementary Information No A5.*]

Mr Snowball: If I may take that on notice, but also to register that obviously this is a commercial agreement, too, so I will need to take advice on the extent to which a full report can be released and come back to the committee with that advice. In other words, if there are any elements of that audit report that related to commercial-in-confidence or other matters about individuals, I would like to be able to at least advise the committee of that.

The CHAIR: The process is that if you provide documents and indicate which, if any of them, you request to remain confidential, the committee will then make that decision.

Hon KEN TRAVERS: To maybe assist you in whether it helps you recollect that audit, would it surprise you if the hospital had been paying doctors a $200 bonus for every patient admitted into the hospital from the ED?

Mr Snowball: Yes, it would.

Hon KEN TRAVERS: Would it also surprise you if it was made aware to you that the doctors at the hospital had set up a scheme of arrangement around a company that then contracted doctors to the hospital who then received that $200 bonus for admitting patients into hospital itself from the ED?

Mr Snowball: Yes, it would surprise me.

Hon KEN TRAVERS: Who conducted the audit?

Mr Snowball: We undertook the audit. There were several levels to the audit, but it was basically to validate the information provided. It was undertaken and overseen by a senior public servant in the South Metropolitan Health Service, but we also used other supports to do the audit. I might add that part of that audit also looked at admission rates and so on compared to other sites, so it was not simply a look at definitions of admissions or what was claimed as activity; it actually did look at whether the admission rates for this level of activity in ED presentations were consistent with other similar hospitals.

Hon KEN TRAVERS: Did the audit go into inquiring, investigating or questioning staff at the hospital as to how that increase in admissions from the ED to the hospital had arisen?

Mr Snowball: To be frank, I cannot recall all that detail. I certainly recall the audit and I certainly recall the outcomes from the audit, but regarding all of the levels of detail you are going into now, I would need to remind myself by reading the audit.

Hon KEN TRAVERS: The other issue that arises is that—again, you may or may not be able to recall it if I present it to you—internally at the Peel Health Campus, the then director of nursing identified the concerns, raised them with senior management, and senior management ignored those concerns and continued to operate—that was in December 2010—until March 2011 undertaking the scheme that they were engaged in, at which point your officers started your audit. Are you aware of that?

Mr Snowball: In terms of the earlier reports?

Hon KEN TRAVERS: The fact that internally it had been identified and that the management took no action and in fact continued the scheme. The director of nursing, who I think was also in charge of the four-hour rule, raised those internally within management, but no action was taken; they actually ignored it. I understand that that director of nursing no longer works there and may have even been sacked from the hospital.

Mr Snowball: I cannot answer on the Peel Health Campus response if there was an internal raising of that issue, but I can say to you that sufficient information was brought to our attention for us to undertake the audit following a discussion with the Peel Health Campus. Once again, we are talking about 18 months ago in order to go through the chronology of those events. But I can say to you that, like with any contract, if there is any indication that we are not being delivered what we have contracted them to deliver, we make sufficient inquiries to satisfy ourselves first of all that we are getting what we paid for as a state—we are getting value for money for the taxpayers. That is the purpose of the audit. Using the analogy, that audit then goes back over time and picks up anything that has been overcharged, over-claimed or whatever, and that is what was returned to us as a consequence of this audit.

Hon KEN TRAVERS: I understand the audit process, but I guess I am more interested in whether you then engaged in any investigation to determine whether it was a deliberate attempt at fraud or an innocent mistake.

Mr Snowball: That is what I am saying to you. My recollection of the outcome of the audit was that it was not a deliberate defrauding, if you like, from the service; it was about establishing admission rates and how they had been applied in definition under the contract against the state that we validated and confirmed.

Hon KEN TRAVERS: What sort of process would you go through to determine that? If you send down the accountants—with all due respect, because I know your past profession; my father was one as well —

Mr Snowball: They are good men!

Hon KEN TRAVERS: Absolutely; I have a lot of regard for them! They will do an audit of the accounts, but they will not necessarily look behind that as to whether or not there was a deliberate scheme established within the hospital that benefited the hospital, but also that the people who established it for the hospital were personally benefiting from it, and whether or not there was any attempt to try to do that sort of investigation in this case.

Mr Snowball: It was a very thorough and well thought through process to undertake the audit. It focused very specifically on claims being made for activity undertaken. It was not just about ED admissions either; it was about elective surgery and all of the activity we were basically paying for in Peel. In normal circumstances, if you established from that that there were additional activities being claimed, yes, you would make further inquiries to establish the reason and the basis for that. But unless somebody was to come forward and say, "We think there has been a scheme here", or whatever, it is only as good as the information you are presented and investigating. It also involved interviews with, obviously, the senior management at Peel as part of that audit process. We needed to satisfy ourselves that we had, first of all, identified and got all the activity that we had paid for and, in the event that we had overpaid or over-claimed, there was an adjustment to it. That adjustment basically righted all of those issues as far as our end of the contract was concerned and, going forward, obviously continued scrutiny over claims subsequent to that.

Hon KEN TRAVERS: Do you know what the total overpayments were that had been made to Peel Health Campus that were recouped?

Mr Snowball: I cannot —

Dr Mark: I can, DG, if I may. Just to go back, members, the 2011–12 maximum payment was $89 807 754 compared to the 2012–13, which is $104 702 499. The amount that was recouped was, I think, initially 140 —

Hon KEN TRAVERS: Thousand?

Dr Mark: No, sorry; $1.4 million and there was an additional $400 000 on top of that.

Mr Snowball: In terms of those numbers, I am not sure where you have got them from, so can we just please take that on notice, because it is very important that that number is validated. I would appreciate for —

Hon KEN TRAVERS: Just to clarify what was just said then, it was $1.4 million and then an additional $400 000, but you are going to confirm that.

Mr Snowball: Yes, I would appreciate if we could validate that.

Hon KEN TRAVERS: It got confusing as to whether we were talking about thousands or millions then. So it is $1.4 million and then another $400 000 to be verified.

Mr Snowball: We will give you the exact figures.

[*Supplementary Information No A6.*]

The CHAIR: I would be interested to know with that overpayment, what percentage that was of the total contract as well in the answer.

Hon KEN TRAVERS: So, the matter has never been referred to any investigative agency, other than the audit, that you are aware of.

Mr Snowball: The audit was the investigation.

Hon KEN TRAVERS: The only investigation?

Mr Snowball: Yes.

Hon KEN TRAVERS: Just to clarify what I was trying to say earlier, as I understand it, two of the senior operators at the hospital also own a company called Locumforce—two of the doctors who established it—and Locumforce contract doctors to the health campus. So, as part of their payments for the work of those doctors, they were receiving that $200 bonus for having admitted the patient into the hospital rather than just treating them in the ED, which then led to the hospital receiving more money. So, that is not something that rings a bell with you at all?

Mr Snowball: No, it is not. Locumforce, as I understand it, is a group that basically provides locums for a whole range of services, including the public system, so it would not be an exclusive relationship in terms of my understanding of Locumforce. But, no, I do not know the detail of individual contractual arrangements that Peel would have with its doctors.

Hon KEN TRAVERS: I might leave it there.

[10.15 am]

The CHAIR: In that circumstance, would there be an expectation that there would be a formal declaration of interest in that relationship?

Mr Snowball: It goes to the nature of the contract with Peel. Without going into the detail of the contract, our contract with Peel is to deliver a level of service to a level of quality and so on. What subsequent arrangements they have to deliver—obviously they need to provide and achieve safety quality measures; they need doctors who are registered and qualified and so on—that they might have with them as employees or contractors is Peel's responsibility. We have an interest in those, but, as I said, I do not have the detail of the contract with me here today. If you have a question specifically around that, I would be happy to provide it where possible.

The CHAIR: Perhaps as supplementary A5, is there a requirement for a specific declaration of interest in that contractual arrangement?

Hon KEN TRAVERS: I raised a range of issues earlier about things like the bonus payment to admit someone from the ED to the hospital and you said it surprised you; I think you agreed with that being the case. Are you prepared to go away and have a look at those issues and maybe report back to the committee as to whether or not those issues were considered as part of the investigation? If they were not, are you prepared to commit now to ensuring that a further investigation is undertaken into Peel Health Campus to see whether or not there was a deliberate attempt to try to get money or defraud the state of money that they were not entitled to?

Mr Snowball: It would be helpful to us in any further work we might do to actually have the evidence of those arrangements before us; you have given me a scenario and I have responded as best I can to that scenario by saying that, first of all, I am unaware that that was in place in Peel—I would be surprised if it was—but I would like the evidence, if it is, to establish whether or not it impacts on our contractual arrangements with Peel.

Hon KEN TRAVERS: Can I suggest that one of the things the health department needs to do is talk to some—there is quite a list of them now—of the former staff of Peel Health Campus and ask them these questions to see whether or not they can provide any light on the ongoing operations of

Peel Health Campus and the things they may have identified, discovered and raised with management that have not been acted upon or investigated. That might be a good way of proceeding. Or we can get them in and ask them for you if that would help, where they would have the protection of parliamentary privilege, but surely you would have the mechanisms to give the former staff some protection—I think that is what their fear would be—from litigation from the company.

Mr Snowball: I need to make the point that the audit was a very thorough audit to establish that our contract with Peel had been honoured and the funds provided represented value for money and we were getting the activity that we had expected to be purchasing from Peel. Notwithstanding the other issues or matters raised as part of this, the central piece is that we are now confident as a consequence of the audit that those matters have been dealt with from the perspective of the contractual obligation. Notwithstanding that if there are other issues of evidence that we are able to provide, by all means we will be looking at that.

Hon KEN TRAVERS: I have two final quick questions. Has this issue not been raised with you by any of your media staff in the last few weeks—the issues around the Peel Health Campus?

Mr Snowball: Only in respect of the resignation of the chief operating officer.

Hon KEN TRAVERS: So no allegations regarding whether or not there has been fraud?

Mr Snowball: No allegations, no. With an ex-employee, you have got to look at the facts of that, too, because it can be a bitter separation, if you like, but I am aware of that person's resignation and, I think, the subsequent media coverage.

Hon KEN TRAVERS: I do not think they are the only one though; that is the problem, is it not, down at Peel?

Mr Snowball: That is right. The job we have got to do is sift through that to actually look at, from our perspective, the state government's interest in respect of the contract with Peel not being impacted in any way by that process.

Hon KEN TRAVERS: Are you currently undergoing a review into the extension of the Peel Health Campus contract—either the public or private components of it?

Mr Snowball: We are. Obviously, there is a process under the contract that allows that to occur. We also had Peel approach us in respect to an extension but also capital growth required in that area. Our view is that Peel is a growing area and will need an increase in terms of infrastructure and public services over time, but that is very much in its infancy. It is a case for us to satisfy ourselves about what will be required over time, where you might provide that service and in what way. Obviously, Peel is one of the options that we would need to look at.

Hon KEN TRAVERS: Is there an intention to renegotiate the contract without going back to a public process? The first option is: do you bring it back in-house? The second is: if you are going to keep it in private hands, would you not go back to a public process to determine who is the public or private operator of the hospital?

Mr Snowball: The point we are at now is there is a variety of options available to us under that contract and of all the three that you have just mentioned, we have neither reached a conclusion nor made a recommendation to government on which of those options we would be recommending. Our work right now is validating what will be needed in Peel over time in 2015, 2020 and beyond so that we are starting to build and make arrangements and use what is available to us either under those contracts or externally to those contracts.

Hon KEN TRAVERS: What is the time line for that process?

Mr Snowball: The current contract is due in 2017. Going back from there, you would need to make a decision around that by probably mid to late next year. You would have to have at least a position to government about it.

Hon KEN TRAVERS: About how you would move forward and whether you need to go to a tender process.

Mr Snowball: In the normal course of events, we would decide what activity needs to be provided at Peel, put our view and advice to government, which in turn would make a decision about how best to proceed, and that would be on the grounds of quality, safety, price, availability of services and so on.

Hon KEN TRAVERS: Just out of interest, what is the primary head of power you use to contract out health services?

Mr Snowball: The hospital and health service legislation. There are two avenues within health: one is where the Hospitals and Health Services Act provides for that and the other, as a public service agency, is through the minister as the Crown. You have a couple of choices, if you like, in how you contract. By and large, the department itself contracts the services. For example, where we might buy a public service out at Joondalup or Peel, essentially, the basic authority rests with the Department of Health as the funder and purchaser of health services in WA. Hospitals can subcontract their services to a degree, but only by approval of the board.

Hon KEN TRAVERS: As part of that process, can those private operators charge above cost recovery for the services they provide that you as the health department may not be able to do because it would be considered a tax rather than a fee or charge?

Mr Snowball: It depends a little on the service. In terms of hospitals, that is usually rolled up as part of—we have an obligation to provide services free of charge in terms of the public hospital inpatient services, so we would ensure that our contracts covered that. There are other arrangements, though, where you might have a private provider who provides a service. Sometimes they are provided in the private sector and sometimes in the public sector. Often the private sector will use Medicare or the pharmaceutical benefits scheme as part of their revenue, if you like. The kind of rule is that state funds do not subsidise services that are raising fees from Medicare or the pharmaceutical benefits scheme. The other way is we do not contract public hospital services that are noncompliant with our obligations under agreements with the commonwealth and other states around free access to an emergency service and hospital inpatient activity.

The CHAIR: Before we move off that, one final question I have is: has any action been taken in terms of additional controls since this auditing process?

Mr Snowball: Yes, in terms of the activity and reporting arrangements.

Dr Mark: I will talk to that through you, DG. The reason for this audit came to light when the admission rate at PHC increased, as it has in all our hospitals that introduced the four-hour rule. However, the increase at PHC was disproportionately large. That is what led to the beginning of the audit. The audit was based on whether or not the patients that were being charged for admission to PHC met the Department of Health guidelines on who can be admitted to a public hospital. There are ongoing audits. The admission rate and business is monitored monthly and there is a meeting between the management of Peel Health Campus and the senior executive of SMHS and there are ongoing audits into this issue of whether or not patients who were being charged for admission meet the admission criteria.

Mr Snowball: It is heavier scrutiny, effectively.

Hon LJILJANNA RAVLICH: Just on this, director general, did you advise the minister at any time about this audit and any other concerns that you might have had in relation to some of these matters at Peel hospital?

Mr Snowball: In the normal course of events, I would have alerted the minister that this was being undertaken. My recollection of that—again, I have to take that on notice in terms of the nature of that advice—is in the normal course of events, I would be alerting the minister and raising the issue.

Hon LJILJANNA RAVLICH: Can you remember having a discussion with the minister specifically in relation to Peel Health Campus?

Mr Snowball: Honestly, I cannot. You are looking at 18 months ago. My recollection is that I did. I cannot recall whether I did it verbally, by a briefing note or a combination of both. I would have to take that on notice.

Hon LJILJANNA RAVLICH: So you cannot remember ever having a discussion with the minister in relation to this matter and the Peel Health Campus?

Mr Snowball: No, I did not say that. I said I would need to check my diary and briefing notes and so on to validate the timing and what was said.

Hon LJILJANNA RAVLICH: Director general, I wonder whether you could provide to the committee the briefing notes, including whether they are contentious briefing notes, and any other correspondence, be it email, briefing notes and contentious issues, to the committee specifically in relation to this matter.

Hon KEN TRAVERS: Any correspondence between the department and the minister or his office.

[*Supplementary Information No A7.*]

Hon LJILJANNA RAVLICH: I have some questions about adverse events on page 12 of the Department of Health's annual report. I am wondering whether you can provide us with information on the number of adverse events during that financial year.

Mr Snowball: If we could come back to that—it is in our KPIs; we are just trying to find it.

Hon LJILJANNA RAVLICH: When you calculate adverse events, do you include deaths?

Mr Snowball: Yes.

Hon LJILJANNA RAVLICH: What I am really interested in is I understand that up to 10 per cent of hospital patients may suffer an adverse event. That is as at 30 June in a document produced by your agency "Improving Care …". Ten per cent seems pretty high to me.

Mr Snowball: If I may, that rate is actually lower than most other states.

[10.30 am]

Hon LJILJANNA RAVLICH: I am interested in the actual number of people that 10 per cent represents.

Mr Snowball: Okay. And it is important here, while my colleagues are finding the relevant piece of paper—the actual adverse events range across a whole variety of events. They are not always life threatening, nor are they always actual events. They can be near misses as well. But things like wrong medication would be a major adverse event. In terms of our rate of adverse events, as I mentioned before, we are actually one of the lowest of all states, and in my opening statement I talked about our safety quality being right up there in terms of comparisons to other states. This is one area that we compare very well, and are constantly improving. So that rate has been diminishing over time as well. I think the one that you are referring to is actually a report from AIHW, from memory, or from our own AIMS process.

Hon LJILJANNA RAVLICH: It is your own agency, the Department of Health.

Mr Snowball: Okay. So that will be our reports out of our AIMS system.

Hon LJILJANNA RAVLICH: Okay. I would imagine that giving patients wrong medications is actually at the fairly low end, so can you just give us some examples of —

Mr Snowball: It can be the bad end.

Hon LJILJANNA RAVLICH: Well, can you give us some examples of what sort of is on the quantum scale of adverse events, from lowest to highest?

Mr Snowball: Okay.

Dr Mark: The most acute ones, of course, lead to death or permanent disability. The lower acuity ones are ones that have potential to cause serious harm but have not caused serious harm. So, with the more serious ones, we tend to analyse each one; the lower acuity ones we tend to trend.

Hon LJILJANNA RAVLICH: Okay; but I was looking actually for some examples. We have wrong medications at one end and then we have got death at the other. What other sorts of incidents might occur?

Dr Jefferies: A bad one is if somebody has a fall in the hospital and fractures their neck of femur, so that is an adverse outcome that we always investigate and try and make recommendations how we can stop that. Things like putting the wrong label on a patient would be an adverse event, and we would actually investigate that because that can lead to really bad outcomes.

The CHAIR: Amputate this leg, not that one.

Mr Snowball: Yes, wrong side.

Dr Russell-Weisz: Yes, wrong side. Sorry; through the director general, you may have others. I mean, you can have wrong medication given. It may be that the wrong medication that has been given does not have a particularly detrimental effect, but it could have done if it was different medication, so you need to change the system, but also a very serious one would be operating on the wrong leg or the wrong arm. That is what Dr Mark referred to as one of our most serious ones. It has happened in health systems around the world, and those are what you call central events or what we call SAC 1s or SAC 2s—those very, very serious matters that would spark a much more in-depth investigation than maybe one of the ones we have just mentioned.

Hon LJILJANNA RAVLICH: Given that 10 per cent of patients may suffer one of these events, how many people does that involve here in WA?

Mr Snowball: We are happy to provide that. It does not look like I have got too much response to that. So, if I could take that on notice, we can provide that.

[*Supplementary Information No A8.*]

Hon LJILJANNA RAVLICH: Can I just ask: what is the cost of adverse events to the state health system?

Mr Snowball: And we can do that too, if I may, on notice.

The CHAIR: Also in A8.

Hon LJILJANNA RAVLICH: I am surprised if you do not know that.

Mr Snowball: Not off the top—we should have had it available to us, but apparently we do not.

Hon KEN TRAVERS: I want to go to page 44, the Friend in Need—Emergency scheme, or FINE. If you did a word search, you would probably think it was going to be about parking. Sorry; I had to get that in!

Mr Snowball: Yes.

Hon KEN TRAVERS: Since that has been established, has there been any assessment of the program undertaken and what was the outcome of the assessment?

Mr Snowball: In terms of the FINE scheme?

Hon KEN TRAVERS: The FINE, yes.

Mr Snowball: There has been a review that was undertaken. In fact, it touched on more than one review. In fact, one that was undertaken was part of the agreement that looked at evaluating the program in various locations and how effective it was—quite a thorough one. There was a second one that was not directly to FINE, but it was one undertaken by Professor Bryant Stokes, which really looked at our admission–discharge process within our emergency departments, and that incorporated a look at FINE as well as part of that response. So those two came back with quite useful information, and if I can just quote some of that information to you. Right now we are actually undertaking an independent evaluation of HATH, which is the Hospital at the Home, as well, which will be August 2012. So, we have had the one around FINE. It is a metropolitan-based partnership, as you know, between us and community care service providers, supporting the older and the chronically ill, and to provide an alternative to emergency department presentation or admission to a hospital. Both of those assessments were: do we make adequate and appropriate use of that service; and, secondly, how effective is the service in terms of patient care outcomes and the overall governance of that program? That review found—this is from memory, because it was set up, obviously, as a substitution, if you like, for providing the services within hospital settings. The equivalent hospital—it actually provided up to 500 hospital beds in community settings—that is, the hospital in the home. So, in that respect, it has helped to ease the pressure on our hospital beds, and our need for hospital beds into the future, as an alternative to hospitalisation.

Hon KEN TRAVERS: So there has not been a single review of that program?

Mr Snowball: Yes; there has, yes. Sorry; what I was saying is that there was one that was a specific review of the FINE program itself. There are review processes under the contract itself, and then there is a third one that arose as a consequence of a broader review of our emergency departments and admission there.

Hon KEN TRAVERS: Is it possible to get those as supplementary information?

Mr Snowball: I think so. Again, if I could take that on notice.

[*Supplementary Information No A9.*]

Hon KEN TRAVERS: You refer to it as a partnership with Silver Chain. Is it actually a contract and is there a time on that contract? I think when you established it, it was not through a public tender process. Is it your intention when that contract expires to go to a public tender process?

Mr Snowball: There is a contract, so there is a clear scheme of arrangement, if you like, with them, and the reason why I describe them as partners in this process is that, obviously, it is part of a network, just as we call the RFDS a partner and Silver Chain —

Hon KEN TRAVERS: No, no. I was not necessarily being critical for calling it a partner. You talked about it being a partnership—whether that meant that it had an ongoing relationship or whether there was a defined contract period. That was —

Mr Snowball: My understanding—and, again, I will take it on notice—is that it is a defined period, and we would seek to either renew or put it out to tender. I do not think we have got to that point yet, from my recollection—no, we have not.

The CHAIR: Maybe just as part of A9—do you want to clarify that?

Mr Snowball: So the timing —

Hon KEN TRAVERS: Yes. If we can find out what the timing is and whether or not the current contract has provision for an extension when the current contract ends and whether there are any provisions within that contract for an extension—a one or two-year extension or whatever—as well, that would be good.

The CHAIR: That is part of A9, yes. Just before we go on, I indicate that we might take a five-minute break at quarter to, so that we can stretch. Occupational health and safety breaks, I think, are very important.

Hon PHILIP GARDINER: I know that we have asked some questions on page 70 before, but can we go back to that page, please. My interest is just trying to get a gauge of some of these costings and how that compares within different hospitals perhaps, and also within different areas—city versus the southern inland health initiative in the country area. The first thing is the trends in that table 5. Activity-based cost management was introduced in the health department in the years 2007–08, or was it 2008–09?

Mr Snowball: No, 2010–11.

Hon PHILIP GARDINER: It was 2010–11, was it? It was that late.

Mr Snowball: That is right, 2010–11. So we are in the third year of the introduction of activity-based management.

Hon PHILIP GARDINER: Okay. Just looking at those targets that you have applied, and I see that the targets include the statewide overheads, which makes it even more relevant, there is quite a variation in the setting of those targets in percentage terms. In 2007–08—it changed in 2008–09 and was about 13.2 per cent. The next was about 4.3 per cent, which is quite low, but the last two years it was 11.2 per cent and 10.9 per cent. They are quite high numbers when you look at it on as CPI basis. I know that the actuals in the last year have come down below the target, and that is fine, but what is giving the biggest increase in costs of those 10 and 11 percentage numbers? Is it the overheads or is it the operations? That is really the basic thing.

Mr Salvage: The top line you are looking at is the number that would have appeared in the budget statements. What happens when health's budget is finalised each year is that we have to apportion total cost across our service structure. So we will take the budget that is available for each of those years and distribute the funding across the service structure. This relates to one of the services, which is the treatment of admitted patient services, which is the largest service that is available to us and reported through the budget statements. The movement between years will reflect two things. One is total availability of budget. So if we look at 2011–12, there was a significant increase in the budget to the Department of Health, and some of that related to the timing of commonwealth payments for initiatives like the improving public hospital national partnership agreement, and so when those dollars have flowed through in a budget sense, you will see a significant increase in the cost of the service done in that way. I think the more relevant line in that presentation is a comparison of the budget setting to the actual cost, which in 2011–12 shows that we were under what the target was.

Hon PHILIP GARDINER: That will be a little bit less than 10.9; it will probably be something like six or seven per cent—I will pick up another calculation quickly. So that is overall, is it, six or seven per cent? Now, the CPI—you have not got the CPIs listed here, but the CPI is about three per cent, or less than three per cent, I think it was at that time.

Mr Salvage: Trending at that level.

Hon PHILIP GARDINER: Yes. So what is the additional three per cent increase in costs a result of, given that you have got outcome-based budgeting taking place here and outcome-based management control on your costs?

Mr Salvage: I think, as the director general indicated earlier on, the price or the cost of delivering hospital services does tend to trend higher than the cost of delivering ordinary goods in the economy. I will just illustrate that by saying that there has been some work undertaken by a new body called the Independent Hospital Pricing Authority, which is setting the national efficient price, and that would look at the trends in the cost of hospital service delivery over a long period of time. We can provide you with their most recent report, which sets a price for 2012–13, and the

underlying cost growth in hospital service delivery identified in that report is around about the five per cent mark, from memory.

Hon PHILIP GARDINER: That would be useful, if we can just have just the relevant numbers out of that, which relate to what we are discussing.

[*Supplementary Information No A10.*]

Hon PHILIP GARDINER: When it comes to the breaking down of these numbers, let us say, between hospitals, do you use the numbers in terms of your own performance indicators, I suppose, between hospitals to compare what the costs are? I know that Royal Perth Hospital is quite different to Charlie Gairdner Hospital, and that always complicates things.

Mr Salvage: Sure.

Hon PHILIP GARDINER: But do you have the same table 5 there in relation to each hospital, and in particular Charlie Gairdner and Royal Perth?

Mr Salvage: We would have that.

Hon PHILIP GARDINER: Are they public numbers?

[10.45 am]

Mr Snowball: I will perhaps add a little bit to that. We have a weighted separation which has a cost to it, based around the average cost across the system. The reason our executive director for resource strategies raised the issue of the independent pricing authority is that we now have a national price for those particular weighted separations on an average. Across the state, when allocations go to area health services, we know what their cost profile is against the efficient price and against what we see as a state-adjusted price, if you like, because that efficient price does not always take into account key disabilities for Western Australia. For example, we have a widely dispersed set of hospitals in which for some services we provide very low numbers of patients, so the unit cost is higher than it is in other states. But they have to be there because of access to services and so on. Once you do all those adjustments, there is effectively a Western Australian price. Then when services are purchased from area health services, it is around that efficient price. The area health services have a need to make sure they are as efficient as they can be. We are setting what is a fair price; in other words, you cannot say, "Well, you're just trying to drive down our budget." We are pretty true to that price to make sure it is a fair price, but if you are operating above that price, you have got to look to your own cost profile: what are we doing differently from other hospitals that we need to do here? One of the benefits, in fact, when you look at that chart you are looking at now, which is public hospital patients who we contract private hospitals to do, we also learn a great deal in terms of what price we can achieve through private hospitals to deliver those services. Anecdotally, in a lot of areas, private hospitals are seen as more efficient, but they do not also do teaching and research and other things or provide a service that has low numbers of patients in which the public system does. You have to discount for all that. The beauty of the activity-based funding system is that everyone gets the fair price, but it pushes hospitals to look at whether they are inefficient and ask: why are we inefficient; is it something we can fix, or is it something we argue back to the health department and say, "We're inefficient because there are only 10 patients who we are delivering a service to when unit costs would be improved if we had 100, but there are not 100 in Western Australia"?

Hon PHILIP GARDINER: I think I understand what you said there, thanks, Kim. There has to be a spectrum of performance across hospitals. I am trying to get to the fact that health is such a difficult area because you need sufficient people to give the care, then you have to have sufficient cost control to ensure that there is not wastage—not the excessiveness. I would like to know how you deal with that in some rigorous way, if there is such a thing.

Mr Snowball: Look, there is. Through the Chair, ignore the hospitals for a minute, so you look at taking a particular case—say, orthopaedic surgery and a hip replacement. If you are going to provide that hip replacement at a safe, quality, best-practice level, what are all the costs that go into providing that? You need so many nurses along the way, a surgeon and an anaesthetist, and you cost all that. You also cost the overhead for providing a facility that can deliver that service. We go through that level of detail to arrive at a cost per case and we weight those cases. You will have patients who have other health conditions, so that will cost you more because they may need other support. We go through and do all that. That is now being done nationally as well. We have national cost weights for cases that we are able to compare to. There is all that level of detail. You are talking about thousands and thousands of calculations and assessments to arrive at that. It has been in the making not only in Western Australia but also in other states, so it has been in the making across the board.

On your question about relative performance, as part of the most recent health reform agreement, there is agreement to set up what is called the performance authority. So, across the board, there will be performance measures of hospitals and, indeed, primary care—general practice. You will get a picture of relative performance at a B2-hospital level across the system in their peer groups, if you like, so it will be like with like; you will not be comparing a country hospital with a tertiary hospital. You will be able to do that across the nation. It has been established and the legislation has been passed to set it up. In time, these performance measures will come out on a regular basis around hospital performance, cost, safety, quality, access and so on across the board.

Hon PHILIP GARDINER: Okay. Having had a little bit of experience within hospitals over the past 12 to 18 months—not myself—how do you assess how often the patients need to have the nursing and staffing to deal with their particular situation? I could be a very irritating patient or I could be a very easy going patient —

Hon KEN TRAVERS: The latter in your case!

The CHAIR: It is called medication, isn't it?

Hon PHILIP GARDINER: How do you judge what I should have in terms of the costings you have got to apply?

Mr Snowball: There is a professional overlay to this. In your example, we have nurse managers who make judgements as well. First of all, there is assessment that a patient with this condition will need this level of support. Somebody who is at risk of falls, for example, you will put in more dedicated resources to make sure that is prevented. There are adjustments there. There is that clinical professional assessment about what I need on my ward to manage the patients I have.

Hon PHILIP GARDINER: That is down to the micro level again, and, again, I understand that, but let us use the blunt instruments that governments use. We have a one or two per cent—whatever it is—efficiency dividend. How do you apply that when it comes in? Should it just be, "This patient over here, Gardiner, will have two per cent less time spent on him"?

Mr Snowball: No; we do not do that.

Hon KEN TRAVERS: What is the budget at the Moora health campus?

The CHAIR: Tape next to your name "member of Parliament"!

Hon KEN TRAVERS: "If he's grumpy be careful!"

Mr Snowball: Going to that issue, as a rule, we ensure that our clinicians have the capacity to make sure they are providing a safe service. Overlaying all of this about what sort of resource he needs, where do you find efficiencies and so on, is an underlying "We must ensure that whatever we do in our hospitals and services is safe." We take the advice of our clinicians and nurse managers and so on who are the experts in that area to provide that. We provide some guidelines over the top. It is more like that in 99.5 per cent of cases, this is what we need to deliver this particular service, but

there is always room for an individual clinician to say, "No; this person needs to stay in another day for these reasons." That is provided for. In terms of the efficiencies, we also look at things like adverse events, which have been raised. Adverse events cost the health system. The fewer adverse events you get in your hospitals, the fewer re-admissions, the less the length of stay and so on. You can reduce quite substantially your costs of providing a hospital service at the same level by removing any poor quality in that hospital. That is what we focus on. There is a variety of issues but let us say they have too many re-admissions because of infections. We would say, "To be more efficient, you need to get your infection control rate down so you are reducing your re-admissions so that you are not taking as many patients as you are currently taking." Improved outcome for the patient; improved cost of delivering—that is the sort of stuff we aim to do.

Hon PHILIP GARDINER: I have seen at one hospital, Charlie Gairdner, for example, and I forget the precise KPI, but in an area where the public could see—I have forgotten the detail—but it was the number of days to do something, which, in a sense, was a public demonstration of how the hospital was going. I thought it was a good thing to have because everyone knows what is aiming to be achieved and where one was at in terms of the hospital. I thought that that was a useful way of dealing with it.

Mr Snowball: That is good feedback. We try to do that in all our hospitals; namely, put up some key performance indicators realtime so that people working in the hospitals can see how they are travelling and how they are travelling compared to others. We now have that on our website, so you can see how long you would wait at Sir Charles Gairdner emergency department versus Fremantle ED. That sort of information is much more transparent and readily available to the community to not only see how we are performing but also to make their own judgements about where to go.

Hon PHILIP GARDINER: That is encouraging. I think something we raised here about three years ago was having some, in a sense, comparison that can inspire not competition—that's not quite the right word to use for health people, I know—so there is some benchmark. We are well past quarter to 11.00.

The CHAIR: I suggest that we take a break until 11.00 am and resume from where you are there.

Hearing suspended from 10.55 to 11.09 am

Hon PHILIP GARDINER: I will just change tack a little bit to look at the country hospital system, and recognising that they are quite a different service—every hospital is different, I know. How do you get a comparison of the efficiencies and activity-based outcomes, if you like, when you compare country hospitals with each other, so that we are confident that the efficiencies are being built in to how they operate?

Mr Snowball: Perhaps if I can answer that in brief, there is a bit of difference between the sizes of the hospitals. When you are looking at the very small rural hospitals, generally speaking, they are block-funded, so they are not activity-based funded because they do so few patients; they are more there for access to service because they are in a quite remote location and so on. So, we tend to look at a profile there of, "You'll have two nurses on 24/7, access to a doctor." It is actually quite a structured resourcing for those small hospitals, so the comparison then is across those small hospitals with basically a standard resourcing to run a small hospital, and those hospitals run regardless of the number of patients coming through. Then you go to district hospitals, which are kind of the next level up, and regional resource centres, which are more like our secondary hospitals in the metropolitan area. That is kind of your peer group. So, with the small hospitals, you are doing a comparison on what does it cost to run—what is an example?

Dr Jefferies: Boddington and Leonora.

Mr Snowball: Yes. So you would then look at, okay, they will have the same basic staffing structure, but there might be some differences; you might have different entitlements because you

are working in a remote location or in the north west and so on, so you make adjustments for that. But that is basically the approach we use.

Dr Jefferies: There are 70 hospitals in rural WA and only 21 actually form part of our activity-based funding for the state and only probably six of them will form the activity-based funding nationally, because they are very small, so there is a lot of community service obligation.

Hon PHILIP GARDINER: And the role is different—I can see that—because, really, it is an emergency role almost—to stabilise before moving on.

Hon KEN TRAVERS: You have mentioned it on page 13 briefly in the Department of Health annual report, but then it is also mentioned in more detail—the recruitment and staff development issues—under "Supporting Our Team" in your comments, director general. Then in more detail you have got your section on recruitment and staff development. Can you tell us how many nurses we are short at the moment?

Mr Snowball: I am trying to remember. In order to respond to that, we can come back to you on notice and say, "Here are the unfilled vacancies in our hospitals"; we obviously do not have that with us right now. The same Health Workforce Australia assessment was done—there was a question earlier about medicine—for nursing, so it is actually contained in the same report. That predicted the same prediction around nursing nationally and it has a breakdown state by state as well. That indicated a shortage in 2016 —

Dr Jefferies: There is a huge shortage—hundreds of thousands.

Mr Snowball: But that is nationally. What we are doing in this state is looking at what are our immediate needs. At the moment, as I said, it is down to what are the vacancies in our hospitals—we can provide that advice—plus we are training, obviously, record numbers of nursing graduates coming into our system. We are also looking at what reforms are required for the services of the future, so do we continue to provide exactly what we have provided for the last umpteen years or are we looking at a new model for delivering our service? This is a challenge for every state in Australia to look at: how do we ensure that we can continue to deliver the services, given our ageing population, the demographic that has shifted, who is going to look after that group of people going through the system at a time when we are going to be at most demand from that group and have an ageing workforce of our own? The short answer is I can provide that, which is essentially the Health Workforce Australia assessment, which is the national position, but I can provide you with our immediate issues with vacancies in our major hospitals—that is, unfilled vacancies, not ones that are filled with agency or locum services.

[*Supplementary Information No A11.*]

Hon KEN TRAVERS: My issue is whether you are doing any modelling on that and over the next two years what the shortage is going to be.

Mr Snowball: Very much, and what we are actually modelling is—we have got really good predictors of projections of activity in our system—how many people are going to need a hospital bed, how many ED presentations there are going to be, and that is pretty accurately forecast right out and we are doing the same with workforce. So, aligned with that: what is the requirement for us to either train or recruit the workforce that we are going to need over that period of time? It is the same for ICT; what ICT needs are we going to have in the future et cetera? We model that constantly so that we make sure that we are on track. It changes very quickly, so, as you recall the global financial crisis, most people who were going to retire around then did not; we ended up going from having a shortage of nurses to almost no expired nurses in a very quick time. So, this moves very quickly and pretty substantially over time. But our preparation is, all things being equal, to make assumptions about that workforce—that our retiring rates are not going to change too substantially, all of those things—to then arrive at how many more do we need either to recruit or train.

Hon KEN TRAVERS: So are you able to give us not just the vacancies here, but what you are currently projecting for the next two or three years—so over the forward estimates, for instance—your shortfall in nurses will be?

Mr Snowball: We can. Actually, I am not sure that you are going to see it as a shortfall in that period, but, yes, we can provide you with our projections.

Hon KEN TRAVERS: So, you are expecting that over the next couple of years you will not have a shortfall; you actually will be able to recruit sufficient —

Mr Snowball: That is right, but beyond that it starts to go the other way quite significantly. That is why I say things change very quickly. The outlook for the next two to three years, depending on the rate of population growth and the rate of utilisation and demand on our services—if you look at our CSF, we are able to accommodate that—we have got sufficient nurses for the next two to three years, including when we open Fiona Stanley Hospital, I might add. We do have some shortages in specialised areas—not nursing generally, but particular areas of nursing; particular skill areas—so we will recruit overseas for that. Of course, there is no point in identifying a shortage in two years' time because you are not going to be able to train them; you need more lead time than that, so we actually plan five, 10, 15 years out. So, we are then talking to the universities and others about how many we would like to see in their undergraduate years. As you know, we put out campaigns and we will say, "Try nursing; think about nursing" to our years 11 and 12 when we think it is time that we need more and we are able to offer a job when they graduate. That is how we kind of run our arrangements in terms of workforce.

The CHAIR: I think there was some additional information that will also come under supplementary information A11.

Mr Snowball: I might add—just your point about the shortage—to the point about how we are going to have a very major shortfall in about eight to 10 years' time. Right now we have got more nurses nationally than we need—so actually oversubscribed in terms of our nursing areas.

Hon KEN TRAVERS: Right, but not currently in WA.

Mr Snowball: Currently in WA we have vacancies. As I said, there are shortages in particular areas of nursing. The question is: is there a shortage of nurses? The answer is no. Is there a shortage of midwives or is there a shortage of perioperative nurses—that is, nurses with some additional skills to do particular jobs? Yes. So, it depends on the question you ask.

Hon KEN TRAVERS: I guess if we can get a breakdown. When you talked about vacancies, you made some comment about agency nurses, so is your shortfall for the positions where you cannot even get an agency nurse or are you saying that the shortfall is where you have got a vacancy and you are filling it with an agency nurse?

Mr Snowball: No; I am saying that a shortfall is where you are not able to put a nurse on the ward.

Hon KEN TRAVERS: So that is either an agency or a full-time employee.

Mr Snowball: Yes.

Hon KEN TRAVERS: All right, so if we can get a breakdown of currently how many nurses you are short and, in terms of going forward, what your predictions are, and also if you can break it down into those major categories of the different skill sets—so midwives and the rest. Did I also get you correct in saying that you expect that you will have sufficient staff to open Fiona Stanley Hospital without impacting on any of the other hospital or healthcare facilities in Western Australia?

[11.20 am]

Mr Snowball: You added the last bit there. What I said was we have sufficient nurses across our system to accommodate the activity that is going to be there when Fiona Stanley Hospital opens. So

what we are doing right now is in fact we put out a survey just recently, the employee intention survey, so that is to establish where people are thinking of working. So for us it is not necessarily an issue of the total number of nurses, or other staff for that matter; it is where they intend going. So if we find that three-quarters of the nurses at Charlies are saying, "We're going to work at Fiona Stanley", then we are going to have to manage that demand, that shift; so that, in short, it is how we manage where people go, against where we see the activity needing them to go. That is the challenge for us over the course of the next couple of years.

Hon KEN TRAVERS: How many bays or beds has Royal Perth Hospital under that modelling?

Mr Snowball: It goes down to —

Dr Mark: Four hundred and fifty in 2014–15.

The CHAIR: I am sorry, from?

Dr Mark: From 662 in 2011–12.

The CHAIR: From 662 down to 450?

Dr Mark: Yes.

Hon KEN TRAVERS: So when do you expect to be in a position to actually know where those shortfalls might be in terms of actual on-the-ground lack of nurses in different —

Mr Snowball: In different locations?

Hon KEN TRAVERS: Yes.

Mr Snowball: The staff intention survey will give us a pretty good picture of that. So we will have some pretty good ideas if there is any major shift at that time. The reality of that is that we still will be capable of responding in any event in the short term. So, for example, if we find nobody wants to go and work on midwifery at Fiona Stanley, well what do you do about that? So we would then look to strategies that get the nurses to those areas and those services. So there is a fair bit of work to be done. The first core part is: what does it look like globally? And that is what we get from our staff intention survey. What comes out of that will tell us how much more work we need to do to realign our workforce with our service profiles.

Hon KEN TRAVERS: So, in going to agency nurses, in terms of FTE numbers, how many agency nurses are there in terms of currently filling the system and what is the cost of those agency nurses?

Mr Snowball: We can take that on notice. We actually monitor them pretty much on a monthly basis. Our effort here is not to eliminate agency nurses, because they are required for us from time to time, but we do seek to minimise it because we would prefer to have permanent employees basically in those roles. But there is room for both. There is a higher cost. From memory it is about 1.25 of an FTE agency nurse compared with a permanently employed nurse.

Hon KEN TRAVERS: So the cost is 1.25 higher for an agency nurse?

Mr Snowball: Cash cost. So for an agency nurse you are not paying for leave and all those things; it is rolled up into a cash payment. So, 1.25 cash for an agency nurse compared with a permanently employed nurse. So the permanently employed nurse is still, obviously, accumulating leave entitlements and all those other things; whereas the agency nurse is not. And of course you are paying an agency fee on top of that.

Hon KEN TRAVERS: A premium, yes.

Mr Snowball: So we try to minimise that, and in fact you will see, if you looked at a trend line, a reduction over the time. Do we have the numbers there now?

Dr Russell-Weisz: For 2011–12 the number of agency nurses employed by WA Health was 251; and, to just put that in context, the number of employed nursing staff over that period was 11 897.

Mr Snowball: And that 251 is down pretty substantially from where we were a few years ago.

Hon PHILIP GARDINER: Do you have those numbers, what it was a couple of years ago, what that trend was?

Mr Snowball: No, but we can provide that.

Hon KEN TRAVERS: If we can get that as supplementary.

[*Supplementary Information No A12.*]

The CHAIR: And the last five years?

Hon PHILIP GARDINER: Yes, if that is not too difficult.

Mr Snowball: Yes.

Hon KEN TRAVERS: And that 1.25 additional cost, what is the average cost of a nurse? In actual dollar terms, what are we talking about? What is the average, all-up cost of a nurse employed by the Department of Health?

Mr Snowball: The average cost is a bit fraught in the health system because you have obviously got people on a whole variety of different rates, increment levels, allowances and the like. But to give you a rough idea, the average cost is around $105 000 as an FTE cost in Health; and nurses represent just over 70 per cent of our workforce. So probably a little less than $105 000; around $100 000 to $105 000 would be a reasonable rate.

Hon KEN TRAVERS: And that is across that full range of nursing from enrolled through to registered?

Mr Snowball: Yes, that is right.

Hon KEN TRAVERS: So for the full year your FTE count for agency nurses was only 251.

Mr Snowball: Yes, 251. And there has been a lot of effort put in too. Five years ago it was quite high, and a lot of reliance on a variety of nursing agencies. There was almost an industry running around that and it was a bit of a competitive thing too. So, some nurses preferred to have the cash and therefore would prefer to work for an agency. Because we have changed it now, we run our own agency. What do we call it?

Dr Jefferies: NurseWest.

Mr Snowball: NurseWest, sorry.

Hon KEN TRAVERS: And are they included in that 251 figure?

Mr Snowball: Yes. So that is our way of reducing, first of all, the agency costs but also providing another avenue. Nurses sometimes like to do a couple of days there and a couple of days somewhere else, and that suits their lifestyles. So we try to accommodate all of those within our employment sphere.

Mr Aylward: Further to the director general, just to comment on what he said on, say, neonatal nurses and, say, at Fiona Stanley, we have seen an increase in demand in relation to neonatal care throughout the state. There are neonatal nurseries now at Joondalup and Armadale peripheral hospitals, and it was difficult to actually get those nurseries staffed and we needed them staffed at all times. So there was a range of methods we could use to do that, and that was through rotating the neonatal nurses back through the women's and newborn health service at King Edward so that they did not get lost from, say, the tertiary sector but could also work in the secondary sector. So there are different models. It is not necessarily having those people just relying in the peripheral sector; there are different ways of doing that, and we would do that through a number of specialties if required.

Hon LJILJANNA RAVLICH: I am referring to page 121 of the Department of Health annual report. It deals with internal audits and I understand that sometimes you have ongoing audits and sometimes you initiate your own audits or special audits, which you then carry out or have somebody else carry out on your behalf. How many of the 29 audits were initiated audits or special audits by your measure?

Mr Snowball: Just to explain how we go about this, we actually set up an audit plan for the coming year, and they do that in two ways. One is they do a rotation, so there would be areas of audit risk, general risk—procurement, payroll, those sorts of areas—that you would routinely audit to different levels and degrees. And I get an opportunity as part of that to indicate where I would like to see any particular focus or an additional audit undertaken. So I am just quickly going through these. We will also align them with what might come from the Auditor General's reports and so on. So, where you see arrangement A and B in there, that was a consequence of a qualification we received. So this was an audit of progress to address that. From memory, I asked to be audited around webPAS, which was to look at the procurement arrangements for webPAS and to make sure that the product we were getting had gone through an auditing process. Alesco was one particularly I wanted, given that was putting in a replacement payroll system; so those three directly from my memory. I am sorry, four is the payroll under and overpayments as well, so that was about the AMA often raising concerns about HCN and errors in HCN and so on, so I asked for an independent audit of that area as well.

[11.30 am]

Hon LJILJANNA RAVLICH: In relation to the payroll underpayments and overpayments, do you have a quantum amount in terms of how much the department made in terms of overpayments?

Mr Snowball: Yes, we do. This is reported regularly from HCN. Often HCN are a bit of a scapegoat in this, too, I might add, because often it can be that late notification of roster changes or whatever means there is overpayment. So it is not an overpayment because somebody ticked the wrong box in HCN or put it through wrongly. The advice coming from hospitals might be inadequate. It requires confirmation or whatever, so you can get an overpayment simply because of late notification. When you extract those out, what we use—every other big payroll system in Australia uses it—is you look at the manual adjustments that you have made. In other words, there is a substantive change. We monitor that. The percentage, Phil, is actually quite low. We are happy to provide that on notice.

[*Supplementary Information No A13.*]

Hon LJILJANNA RAVLICH: Can you provide the figures for the overpayments and underpayments for 2011–12? Also, in relation to the controls over pharmaceuticals for child and adolescent health services, can you just give us a bit of an overview of what that dealt with and what that audit found?

Mr Aylward: This was a follow-up audit to a more broader audit that was done in subsequent years. It was an attempt to see what we have done in terms of putting control measures in place. So, in other words, did we follow through and put the controls in place? My recollection is that there were no adverse findings, there were no high recommendations in terms of needing to get on to or not to have done something of a previous audit. We got a clean tick to the control measures we put into place, but I have not got a copy of that here. Just to refresh my memory, I will get a copy of that, but it was a follow-up audit in relation to primarily the controls around the board in terms of dangerous drugs or scheduled drugs that need to have specific controls. So we put into place individual drug cabinets—I think most hospitals have done that now—that are locked and controlled by the clinical nurse manager or the coordinator on the ward at that time. Previously, those mechanisms were not in place. They just went to the drug area and there was not line of sight from the dispensing from the pharmacist through to the, I guess, drugs being taken by the patient or allocated to the patient.

Hon LJILJANNA RAVLICH: And how much has that been a problem in the past—the drugs being taken by the patient?

Mr Aylward: I think it was more of a case that there is not yet an end-to-end electronic system that can track accurately from dispensing to the patient. That is work in progress as one of the big ICT initiatives that we want to put into place. What we did is when the auditors had a look and said, "See where it was dispensed. Don't see where it comes out of the nurse drug area", and they had difficulty in seeing what the level of controls were with too many people coming in and out, we basically locked down, so to speak and figuratively, and had a single person with a key to access those drugs, so it actually eliminates a control weakness and remedies that problem for us.

Mr Snowball: If I can add, too, as you will see in the headline, it is "Completed audits or reviews", so there is a level of going back and just checking that a previous audit recommendation has in fact been completed. As well, for the reviews, I will ask them to look at a particular area, do an initial assessment and a scope to say, "Is this an area we want to do a more complete review on or are they satisfied the controls are in place and working adequately?" To that end, I will add to my list of the ones I asked for, the data integrity under EDIS, which is the emergency department information system. That is the system we use to provide information to us around the four-hour rule and triage performance and the like.

Hon LJILJANNA RAVLICH: Are these audits public?

Mr Snowball: I am not sure. I do not think they are, no.

Hon LJILJANNA RAVLICH: I am just wondering whether you might be able to provide to the committee the audit on the payroll underpayments and overpayments and also on the controls over pharmaceuticals.

Mr Snowball: Through the Chair, if I could also add that obviously I will take advice in terms of the readiness to provide that or any caveats we might need to put on that information for the committee to consider.

The CHAIR: There might be questions of confidentiality which you would be well aware of.

Mr Snowball: Names; that is right.

[*Supplementary Information No A14.*]

Hon KEN TRAVERS: If we can just turn to page 96, the patient evaluation of health services. How many FTEs are attached to the patient evaluation of services?

Mr Snowball: We will take it on notice, but my understanding is that we do not actually have any FTEs allocated. We get a company to do the surveying for us, so it is independent of us. One of the issues around assessment of patients is to get independent assessment and comparison obviously to other benchmarks around patient views of our system. A lot of them are in survey form. We post them out to individuals and ask them to fill in a survey form and it is returned to this independent group, who then give us an aggregated assessment of how patients view our service. The good thing in that is that we rate extremely highly. So for the people who actually use our hospitals, they rate our hospitals really well. In fact, we have only just seen the most recent information coming out of that. There has been a further improvement over patient assessment. Part of that is the four-hour rule has made a difference. People feel much more confident they are not waiting too long in emergency departments. Our rate of people just leaving emergency departments because they are sick of waiting has gone right down to one or two per cent. Those kind of responses just reassure us that we are on the right track.

Hon KEN TRAVERS: Do you break it down by health campus?

Mr Snowball: Yes.

Hon KEN TRAVERS: Is that reported anywhere where it is broken down by individual campuses?

Mr Snowball: We certainly feed it back to the hospitals.

Hon KEN TRAVERS: It is broken down by activity but not by campus.

Mr Snowball: Obviously we have it by campus as well, which we provide to the relevant hospitals. I would have to check that, but I think most hospitals use this information as well to feed it back. I have seen it in —

Mr Aylward: It is on the MyHospital website?

Mr Snowball: On the MyHospital website.

Hon KEN TRAVERS: So it is on the MyHospital website?

Mr Aylward: No —

Mr Snowball: You were speculating.

Mr Aylward: I was speculating just to my colleague there.

Mr Snowball: I do not think it is on the MyHospital website.

Hon KEN TRAVERS: What about we put it on the "My Parliament" website! Could we ask for that as supplementary information?

[*Supplementary Information No A15.*]

Hon KEN TRAVERS: Does it include the privately operated facilities—so, Joondalup and Peel?

Mr Snowball: Yes.

Hon KEN TRAVERS: Do you do any comparisons to private hospitals that provide similar services—so, in the privately run maternity hospitals?

Mr Snowball: Most of the private hospitals do this as well. They use similar survey instruments and report their survey results. In fact, they quite often put them on their own websites as well. So you are able to, if you wanted, have a look at, "How do patients rate St John of God Subiaco versus other hospitals?" You can access that. Most of the time they de-identify. Obviously, you end up with a scoreboard, too. While the hospital themselves will get their rating, they will see blind the rest of the ratings outside. So a hospital cannot say, "Oh, look; we are better than Cabrini down the road or Ramsay up the road." They do make it a blind instrument in terms of your benchmarking your performance with the rest. That is why I was kind of hesitating when we are saying whether we put the scoreboard of patient assessment of our hospitals. I do not think we do. We do in terms of performance on infection control measures and all of that, but not necessarily patient ratings, except, as you can see, in more of an aggregated form.

Hon KEN TRAVERS: I think it actually does come down to individual hospitals and allowing people to make those judgements. In terms of the survey, I think you mentioned you posted it out to the patients.

Mr Snowball: Yes.

Hon KEN TRAVERS: Is it just a matter of a voluntary return or are there any attempts to try to solicit returns from people? Do you do that sort of standard statistical comparison where you compare it back to so many people over 65, to so many women—the different statistical categories? Is there work done on that?

Mr Snowball: Yes, all of that is done. We survey about 10 000 patients over a particular period we are looking at. We have a return of between 85 and 90 per cent, so it is actually very high. People do like to comment and tick the boxes and so on. But the balance either will not respond or have moved address. I get to see why people did not respond. Most of the time it is "not at this address" or whatever. As you described, those 10 000 people are selected on the basis of their demographics and make-up in terms of the population.

Hon KEN TRAVERS: And then is there an adjustment to the figures to make sure they are reflective of the demographics at the end of that process?

Mr Snowball: There is. That is one of the reasons the risk in going down to individual hospitals is you will get a particular cohort that have used that hospital, and that is why the more aggregated it is, the more accurate your view of the performance of the system. As soon as you get to individual hospitals, you run the risk of losing the demographics because you get too small. Our smaller hospitals—even the integrated district health services, but certainly the other health services—are very small. You will have two and three staff on at any given time. It gets pretty pointed about patient satisfaction in that small town about Mary Jo who provides the nursing care. We try to avoid getting into that.

Hon KEN TRAVERS: I understand that, but is it possible to get them for the —

Mr Snowball: The big ones.

Hon KEN TRAVERS: — the larger hospitals where you will not be identifying down to individual staff—so, your major regional hospitals and your major metropolitan?

Mr Snowball: I have no reason to believe we could not, but I will take advice as well just to be clear.

Hon KEN TRAVERS: I can understand if you are getting down to you have only got two people at the Moora Hospital and you know Phil Gardiner was admitted that day —

Mr Snowball: And who ticked the box!

Hon KEN TRAVERS: Who the staff were and who complained!

Hon PHILIP GARDINER: Can we delete some of this from *Hansard*!

Hon KEN TRAVERS: Or at least include the laughter into *Hansard* to make sure people know it was jovial. If I could get that as supplementary.

The CHAIR: That is under A15.

Hon KEN TRAVERS: What is the total cost of that process in terms of the research company you use and the internal cost?

Mr Snowball: I will take that on notice, but it is not a substantial cost. But what it provides us, I can certainly say that.

Hon KEN TRAVERS: I was just going to turn to page 112, where you talk about your advertising costs. Was the department asked to contribute to the Bigger Picture advertising campaign?

Mr Snowball: In respect to? In what way?

Hon KEN TRAVERS: The Bigger Picture.

Mr Snowball: Right.

The CHAIR: You have not heard of the Bigger Picture?

Mr Snowball: Of course I have. But "contribute to" in what way?

Hon KEN TRAVERS: The advertising.

Mr Snowball: In what way—the cost of advertising?

Hon KEN TRAVERS: The cost of it or in any way.

Mr Snowball: The material and information?

Hon KEN TRAVERS: Yes, the material, the information, the websites. In any way were you involved in the development of it? Were you asked to make a financial contribution to the running of it?

Mr Snowball: No, but we provided information around the health infrastructure developments, particularly around Fiona Stanley Hospital, which obviously is featured as part of that education program.

Hon KEN TRAVERS: What was the cost to your agency of that campaign? Is there a cost to your agency of reporting that Bigger Picture campaign?

[11.45 am]

Mr Snowball: Obviously we are out there telling people what is happening at Fiona Stanley on a regular basis. So it largely drew on the existing information that we are putting out to the system, because we are contributing, obviously, to the bigger picture by saying, "Here is the health component." So the basic premise is that we provided information—largely it was information that we were already putting out to the broader community—and we were pleased to do so, because it will be part of the broader picture of what is happening across Perth. Lots of people drive past Fiona Stanley and see how much activity is out there—and QEII, for that matter. We are very pleased—to be quite frank and for the record—with the infrastructure investment that we have in Health. We think it is going to set up health services that will serve us so well into the future, and we are delighted with that. So as much as we can communicate that to the wider WA community, the better, because I think they can have confidence that we have a really good health service now but an even better one down the track.

Hon KEN TRAVERS: I do not disagree with that. I think the planning for that goes back a long time—it goes back to previous Ministers for Health getting all of that in order. But how does the information in the Bigger Picture campaign contribute, because I assume that you have your own Fiona Stanley Hospital website that is able to provide that information. Do you know how many hits you were getting on that website before the Bigger Picture campaign and how many you have been getting on it since the Bigger Picture campaign?

Mr Snowball: We obviously do not operate the Bigger Picture campaign.

Hon KEN TRAVERS: No, but you do have your own Fiona Stanley Hospital website.

Mr Snowball: Yes, we do; we have own websites and so on, and we also, as you might have seen, put material out in the community newspapers, and we will pay for that information to get out to inform the community. Midland is another example where we have done that more recently. I could not tell you offhand how many hits there have been on our websites before and after the Bigger Picture campaign. It has raised interest, certainly, because our campaign tends to be more about advising local residents about those changes that are happening. But having it represented in that bigger way for government has triggered interest, if I could register that. I could not tell you how many hits that is converted to, but I can say there is renewed interest in what Health is doing, which is, I think, a good thing.

Hon KEN TRAVERS: Are you able to take that as a supplementary, about what impact it has had on your own internal websites as a result of that Bigger Picture campaign and how many hits you were getting on your Fiona Stanley Hospital website pre the campaign commencing and how many you are getting now?

Mr Snowball: Yes.

[*Supplementary Information No A16.*]

Hon KEN TRAVERS: Are you quite sure that you were never asked to make a contribution towards the cost of running the Bigger Picture ads?

Mr Snowball: Well, I certainly was not. Sorry, I was on leave for a period, so that is why I am looking at my colleague for an answer; but, no, not that I can recall.

The CHAIR: Before we move off that topic, when this government came in, they had an intention of bringing in legislation for Royal Perth Hospital to basically fix in place, as I understood it, that it will always be a tertiary hospital. That legislation has not progressed, thankfully, in my humble view. I am wondering whether you can give any indication, but does the fact that that has not changed—that the status quo has remained—mean that RPH is being treated in the way that was planned under the Reid report.

Mr Snowball: No.

The CHAIR: Could you give us an update of where that is at, because in the big picture of the health budget, what is spent and in which hospital is obviously a critical decision, and I was certainly concerned that if we shift the general plan about what is going to happen with RPH, what that will do to the budget of other health campuses. This is a bit of a vague question, but I am trying to work this out now, because this is probably the last opportunity to do this process before we go to a state election. Where do we sit with Royal Perth? Has the fact that that legislation has not been progressed made a difference to your budget?

Mr Snowball: No, it has not. Obviously, we operate to the policy of the government of the day, and obviously the retention of Royal Perth in its form of 450 beds is what we are working to deliver. That is accommodated in our budget settings, so it is obviously within the current forward estimates as far as that covers that period. Our clinical service framework, which is really what we work to and are funded to deliver, describes all the activity. It does not describe where you are going to deliver it from. So what we have done to accommodate and continue to see Royal Perth operate is obviously adjust what all the other hospitals provide and operate. That is on our websites. We have put out the clinical service profiles for those hospitals. So anybody can look at that and see, post the establishment of Fiona Stanley, what Fremantle will be doing, what Royal Perth will be doing and what Kaleeya will be doing, and so on, and be clear about the service profiles for each, including Fiona Stanley Hospital, of course. So when so you say, "What are budget implications of not having that bill go through?", it is not so much the bill. The bill presumably would reinforce the continuation of Royal Perth as a tertiary hospital with 450 beds. If that were to be the case, it would not make any difference to the budget settings that we have in place.

The CHAIR: So continuing with RPH at a 450 capacity is maintaining its tertiary hospital status?

Mr Snowball: Correct.

The CHAIR: So in effect it has been operationalised without legislation? Is that what you are saying?

Mr Snowball: That is correct, yes. What that means is that the hospital continues to be a tertiary hospital, but it is operating with 450 beds. Some of the tertiary services that it provides now will go to Fiona Stanley Hospital—for example, the burns unit will relocate to Fiona Stanley Hospital. So there is a different configuration of services at each of those hospitals. We have gone through an entire planning process to deliver that for government. As I said, we get funded for activity regardless of where that activity is provided, so we have made those adjustments to accommodate Royal Perth.

The CHAIR: My understanding is that the previous policy setting under the previous government was that RPH would not be a tertiary teaching hospital, and now we are, under the new policy, maintaining it as a tertiary hospital. In terms of that kind of reallocation—whether it is slightly less, or however you do that figure—what does that actually look like now?

Mr Snowball: Okay. If I can go back one step, the Reid report recommended the closure of Royal Perth Hospital. That was in 2004. Where we are now is that we have accommodated and planned for that same level of projected activity across all hospitals, including Royal Perth, at 450 beds. I am trying to understand the question. Are you saying would it have cost less or more had we not closed Royal Perth?

The CHAIR: I will have one more go at it.

Hon KEN TRAVERS: Can I just clarify something? The Reid report recommended the closure of Royal Perth, but the then government did not accept that report; it was going to keep a hospital at Royal Perth.

Mr Snowball: The Reid report was the original blueprint, and there were some adjustments to that.

Hon KEN TRAVERS: So there is the adjustment between the Reid report and what is happening, and then there is also the difference between what was proposed to remain at Royal Perth and the tertiary hospital.

The CHAIR: Exactly, and I suppose that is the difference that I am trying to get at. Obviously there would be a difference in terms of money allocated. So the original plan was that RPH would have a lower level of service, as I understand it, and now it is going to be operating at a tertiary hospital level. Where will that additional resource come from?

Mr Snowball: Across the board, when we have Fiona Stanley in place, we will see—you have to bear in mind that this is the total thing as well, because there is Rockingham in that and there is Armadale in that. The Reid report said that we have too many tertiary beds and we have too many tertiary hospitals; we need to move to more of the secondary hospitals. So that is what we have been doing. We have opened Rockingham as a secondary hospital, and we are obviously going to Midland and other locations to build more beds into the secondary hospital system. That is what we have done. So regardless of which hospitals are providing tertiary and secondary, we have retained a scenario where you will have fewer tertiary beds and a lot more secondary beds to accommodate the activity into the future. So we have achieved what was set out to be achieved, but with a different configuration of hospitals.

The CHAIR: Which of the other tertiary hospitals have fewer beds?

Mr Snowball: Fremantle obviously has fewer beds. Part of this, too, is that since the Reid report, which was 2004—that is eight years ago—we have continually upgraded our projection of activity. So as that activity has changed, we have modelled our scenarios in each of those hospitals. So when you ask, "What supported Royal Perth's retention?", Fremantle, and also the smaller peripheral hospitals, like Fiona Stanley originally was not going to provide obstetrics or paediatrics, but it will now. So it has picked up some more of those sorts of services as opposed to the tertiary services. It is a quantum change from where we were then, with all of the scenarios that we have now. The population has increased substantially faster than Reid was predicting. In fact, if we had followed Reid, we would have had Fiona Stanley Hospital back in 2010, from memory. So the actual schedule for delivery has changed, too. So we have remodelled and replanned to make sure that we can accommodate those numbers. That is why Joondalup got additional beds sooner. We have made amendments as we have gone along in order to make sure that we have sufficient capacity for the population.

Hon LJILJANNA RAVLICH: Could we get a schedule of the services that will be lost from Royal Perth Hospital and transferred to Fiona Stanley or anywhere else, please? You can take that on notice.

Mr Snowball: Okay. If I could just mention, the clinical service profile for all of those hospitals is on our website. There are quite substantial documents for each hospital. That goes through the service, the role delineation, whether it is a level 5 —

Hon KEN TRAVERS: Are you talking about the clinical service framework now, or is this separate?

Mr Snowball: No; it is separate. The clinical service framework is the thing that predicts overall activity. The clinical service profile describes what is going to happen at each of the hospitals. The Fremantle clinical service profile will tell you what services are going to be provided and at what

level, so people will understand what is going to be there, and obviously that was needed before we even went out with the employee intention survey, because we had to say this is what is going to be provided at each of these facilities.

Hon LJILJANNA RAVLICH: But some people might make the assumption that the full suite of services that might have been provided at Royal Perth Hospital will still be provided and they will not know what has actually been transferred out.

Mr Snowball: So what is not there?

Hon LJILJANNA RAVLICH: Yes. But that is okay. You can take that on notice.

[*Supplementary Information No A17.*]

Dr Mark: The most obvious things that will be moving are the state rehabilitation centre, which will no longer be at Shenton Park but will be at Fiona Stanley Hospital, and obviously the cardiothoracic and advanced heart failure and lung failure units will be transferred from Royal Perth to Fiona Stanley Hospital, as will the burns unit. So those are the keynote services. Most if the other tertiary services will be retained at Royal Perth, particularly the state adult major trauma service.

Hon LJILJANNA RAVLICH: Is that the full list?

Dr Mark: There might be some other smaller services. I will not say it is completely exhaustive.

Hon KEN TRAVERS: The other impact is Joondalup Health Campus not becoming a tertiary hospital, because under your original clinical service framework —

Mr Snowball: That is true. The 2005 framework said that, I think.

Hon KEN TRAVERS: The tertiary hospital changing framework was also acknowledged in that.

[12.00 noon]

Mr Snowball: That is right. So, in that framework, we update and do a new projection. Every few years we go through a detailed assessment of the profile, and then each year we adjust it for population changes—just to update it; and then it rolls into our budget, workforce plan, infrastructure plan and so on.

Hon KEN TRAVERS: Fremantle Hospital also loses services to Fiona Stanley, but it is still a hospital.

Mr Snowball: It is still a hospital, but it will not be doing emergencies, so ED will be at Fiona Stanley and not Fremantle.

Hon KEN TRAVERS: What is the cost of the ED department at Fremantle?

Dr Mark: Not offhand.

Hon KEN TRAVERS: If we could have that on notice.

The CHAIR: On that one, I am quite interested similarly in what services are going from RPH, Fremantle and Joondalup.

[*Supplementary Information No A18.*]

Hon LJILJANNA RAVLICH: I refer to the WA Country Health Service annual report. Pages 33 and 34 provide a snapshot of population health for WA country areas. Specifically, on top of page 34, which is obviously from a sample size, it is stated that approximately 91.6 per cent of respondents were found not to be eating the recommended serves of fruit and vegetables; 47 per cent were found to not undertake the required amount of physical activity necessary for a healthy benefit, while one in three individuals, or 32.7 per cent, were recorded as obese and a significantly higher proportion of males than females were found to be overweight or obese, that is, 75.4 per cent versus 66.6 per cent. The only thing I can conclude is there is a crisis up there waiting to happen, if

it has not already happened. Director General, how much of the WA Country Health Service budget was spent in 2011–12 on promoting healthy eating and regular exercise?

Mr Snowball: There are two things with that. One is that we do run quite a large number of statewide campaigns, so we can narrow it down as best we can. It would be useful, perhaps, to acknowledge those statewide campaigns; for example, the obesity campaign we have just run. We absolutely share the concern about the rate of obesity in this state, and nationally I might add; but for us there are particular areas where nutrition and eating behaviours are leading to much higher risks for our community. That is identified across the state and I will ask Dr Jefferies to talk on that a little more. But bear in mind, when we do provide a response, it is not only directly Country Health but also statewide campaigns.

Hon LJILJANNA RAVLICH: Can you also provide what percentage of WA Country Health Service total budget is spent on programs, services and public education and promotion specifically related to eating and exercise?

[*Supplementary Information No A19.*]

Dr Jefferies: I was going to say that a lot of the Healthy Eating Healthy Lifestyle program is really primary health care, which is a responsibility of the federal government. General practice plays a big role in that area, and we do lack a lot of general practice in a lot of our remote areas, so people are not getting access like they would normally. So the general practice consideration that the director general talked about earlier does impact quite significantly in country areas. A number of issues, which I agree are really very significant, are statewide issues as well. The incidence of not eating fruit and vegetables is terrible across the state, while the country is a bit worse, but the state is not good. The big issues are smoking and obesity, and we have taken that on board quite seriously and we are working closely with the new Medicare locals to work out how we can actually promote some of this. It is really a partnership issue; the state is not an expert at prevention; it is more the not-for-profits. We have to work with those other people—general practice and primary care.

Mr Snowball: I will reiterate that in a lot of the messages we put out, which are often through the mass media and so on, it is really important to have one-on-one with a GP, with your family doctor saying, "You're getting overweight; you need to do something about your weight." Having that conversation is much more powerful than seeing an ad in a newspaper. That point of individual connection is important. We try to put that message, in the absence of GPs, but 80 per cent of people will see a GP in any given year, so it is a key point of a good prevention message and a good health promotion message. But outside that, we obviously try to run with our nurses, who do a fair bit of that—our community nurses in country towns; and we obviously try to do that as well, as do the Aboriginal medical services because there are particular issues and risk factors for Aboriginal people, particularly around smoking and also around nutrition. But it has to be a different message; it cannot be the mass campaign message.

Dr Jefferies: In the chart on page 25, 12.7 per cent of WA Country Health Service expenditure is on population health, which includes that kind of primary health care.

The CHAIR: We are going a little over time, but I will give Hon Philip Gardiner another question, if he wants one.

Hon PHILIP GARDINER: I think you said in your opening remarks that Western Australia has the second-highest longevity in the world, and that includes our Aboriginal population.

Mr Snowball: It does.

Hon PHILIP GARDINER: If you take out the lower socioeconomic sector, which unfortunately the Indigenous population mainly fits into, the longevity for the rest of us would be higher than Japan?

Mr Snowball: Look, I cannot vouch for the Japanese figures, but these are international rates. You are quite right. Western Australia actually enjoys better longevity, in fact, than most other states, so Australia as a whole is second to Japan and Western Australia is amongst the top in Australia. As you say, Aboriginal people do not enjoy the same level of health as other Western Australians.

Hon PHILIP GARDINER: It is much lower, really.

Mr Snowball: As you will have heard in the introduction that is a key, absolute priority for the health system, and we are working with Aboriginal medical services and not-for-profit sector, particularly around Closing the Gap, to focus in on these risk factors that have been identified to improve that longevity over time. We know, for example, that Aboriginal people smoke at a rate of about 50 per cent. We are down to 15 per cent, so it is a big differential. We know that just a five per cent reduction in smoking rates will have an incredible impact on longevity but it will be 10 and 15 years down the track. That is where a lot of our investment is in Closing the Gap, and $117 million over the forward estimates have gone into Closing the Gap, and that is where we will make the most gains in health outcome for the whole population but also bring the health outcomes for Aboriginal people closer to other Western Australians. That is our absolute aim.

Hon PHILIP GARDINER: I hope that in Closing the Gap that early child development from zero minus six months—so in the mother's pregnancy—and for the first three, four and five years is recognised as crucial.

Mr Snowball: In fact, there is a very specific agreement for the Indigenous early childhood program, and we work closely with Education in that, but we also have a very specific health focus within Closing the Gap, which is around maternal health, birth weights and so on. One of the challenges for us is not only improving longevity, but the other outcome that was agreed at that time was halving the infant mortality rates—I think it was in a generation, so there is a period to it. We have seen a really strong decline in infant mortality rates amongst Aboriginal kids over the course of that 10 years. I am very happy to provide the chart that shows that, and it is genuinely closing the gap quite substantially in the last five to 10 years.

[*Supplementary Information No A20.*]

Hon PHILIP GARDINER: Mind you, early childhood is just part of it; it needs a package of reinforcing factors as you go up the generations.

Mr Snowball: Health is not the only way to solve the problem; in fact, it cannot be the only way. It is as much about economic participation, housing, health and education as it is health; it has to be a package.

Hon KEN TRAVERS: I refer to pages 188 and 189 of the Metropolitan Health Service annual report and the qualified audit. There are a couple of qualifications from the Auditor General. I wondered if you have any general comments, and then I want to ask specifically what you are doing and how you are responding to that. My recollection is that the first qualification is not dissimilar to previous qualifications you have had. What is happening about fixing that? The second one is specifically around the KPIs about the percentage of emergency department patients seen within the recommended time.

Mr Snowball: So arrangement A —

Hon KEN TRAVERS: Has been around for a while.

Mr Snowball: Indeed, we had an excellent interview with the Auditor General following his audit. His observation, and I am not sure I am allowed to quote the Auditor General, but basically it was a recognition of substantial improvement in arrangement A and to a degree the expectation is that will be removed. Part of it is getting systems in place in HCN, and with doctors to achieve that outcome; but that was certainly recognised. We are on the right track and believe that will be lifted—certainly by the next annual report.

The other issue which is really about EDIS and the controls around reporting. I will just explain that EDIS is an emergency department information system. Its design is, effectively, to support clinicians to provide the emergency service. It was not designed to report on the four-hour rule, which is what we have asked them to do. The comments that have been made reflect on transposition of information on to EDIS and subsequent reporting, which raised issues about people's control over that. Secondly, it raised issues around access to it; that is, controls around people getting on and being able to manipulate information on our system. So we have obviously tightened up the controls around that. It was also identified in the report by Professor Stokes on the four-hour rule. So there are two issues for us. We do not have capacity at this stage to change EDIS into a system that will tell us what we need to know administratively. We believe the information remains reliable. We are concerned about the controls and we have taken steps to improve those controls over people's access to the system as well as data cleansing to ensure that we are picking up any errors or transposition errors that might have taken place.

Hon KEN TRAVERS: Does it not also mean that staff could be manipulating it to make it look like they are meeting the four-hour rule?

Mr Snowball: That was the question mark that Professor Stokes raised in his report six months ago, so we had the audit. In an earlier response, I said that I asked for an audit of the integrity of EDIS. The audit identified that there was a risk, however, there was no evidence there was manipulation occurring around that. But it is a difficult one, because we do not want to make it so difficult that people cannot get on and use the system as the clinical information system that it is there to do, and it does a great job as a clinical information system. So we have tended to accept that there might be some risks in terms of the data, but it is not going to be material in terms of outcome, but because we want to make sure that, first and foremost, people are treated effectively and well at the emergency setting, that has been our priority, and we talked that through as well.

Hon KEN TRAVERS: Does that system operate at Peel Health Campus as well, or how do you measure the four-hour rule at Peel?

Dr Mark: I think they do have EDIS, yes.

Hon KEN TRAVERS: Is it possible that, somewhere like Peel, it is manipulated in the other way so that people are presented as having been in the ED department for longer than they actually were to justify their admission so they can collect the $200 bonus that we talked about? Is there also the risk of manipulation in the opposite direction?

Dr Russell-Weisz: I cannot probably answer that because you put a hypothetical to me.

Hon KEN TRAVERS: I am not actually putting a hypothetical. I am suggesting that may be one of the allegations at Peel; that is, they were manipulating the hours that people were in the ED to justify their later admission and to collect their bonus. I am suggesting that it is not a hypothetical; I am suggesting it actually happened.

[12.15 pm]

Dr Russell-Weisz: Okay. What I can say for other sites that I am responsible for is that if somebody is actually admitted on EDIS, they have to change. The majority would be admitted to a ward in the hospital, so that would clearly in my view not be manipulated—or they can be admitted into ED. One of the things that we did clear up and did get consistent rules around was those patients who were actually admitted into areas within the emergency department, which is quite normal where you do not want those patients to be admitted into a ward but you do need to admit them for a little longer just to see and treat; there are those observation wards in the ED. Some of that data was cleaned up right across the system. As to manipulating it as a pure admission into the wards, I think that would be quite hard.

Mr Snowball: The key issue, if you are taking the scenario through, is that what was highlighted and what led to the audit was the percentage of admissions, so it is the admission rate as opposed to how long you spend in ED; that is, admission to the ward.

Dr Mark: To add to what my colleagues have said, I do not think there is anything in the Department of Health–approved reasons for admission to a public hospital that relate to a length of stay in an emergency department. It is not a case that somebody who, say, spent six hours in ED has to be automatically admitted; they can only be admitted if they meet certain other criteria. That was the substance of the audit.

Hon KEN TRAVERS: When we are talking about nurses, the other area is overtime. Do you know how much you spend on overtime for nurses across the department? I am happy for you to take that on notice. If you could break it down into the individual hospitals if that is possible, that would be good.

[*Supplementary Information No A21*.]

The CHAIR: I think we might call it a day at that point. The committee will forward any additional questions it has to you in writing in the next couple of days, together with the transcript of the evidence, which will include the questions that have been taken on notice. Responses to these questions will be requested within 10 working days of receipt of the questions. Should you be unable to meet this due date, please advise the committee in writing as soon as possible before the due date and include specific reasons as to why the due date cannot be met. If members have any unasked questions, please submit them to the committee clerk at the close of the hearing. Finally, thank you very much for your attendance and we will close the hearing now.

Hearing concluded at 12.17 pm