Division 23: WA Health, $5 539 719 000 —

Mr S.J. Price, Chair.

Mr R.H. Cook, Minister for Health.

Dr D. Russell-Weisz, Director General.

Mr R. Anderson, Assistant Director General, Purchasing and System Performance.

Mrs E. MacLeod, Chief Executive, East Metropolitan Health Service.

Mr P. Forden, Chief Executive, South Metropolitan Health Service.

Mr J. Moffet, Chief Executive, WA Country Health Service.

Mr A. Dolan, Acting Chief Executive, North Metropolitan Health Service.

Dr A. Anwar, Chief Executive, Child and Adolescent Health Service.

Mr R. Toms, Chief Executive, Health Support Services.

Dr J. Williamson, Assistant Director General, Clinical Excellence Division.

Dr A.G. Robertson, WA Chief Health Officer.

Dr R. Lawrence, State Health Incident Controller.

[Witnesses introduced.]

The CHAIR: This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day. The Chair will ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The estimates committee's consideration of the estimates will be restricted to discussion of those items for which a vote of money is proposed in the consolidated account. Questions must be clearly related to a page number, item, program or an amount in the current division. Members should give these details in preface to their question. If a division or service is the responsibility of more than one minister, a minister shall be examined only in relation to their portfolio responsibilities.

The minister may agree to provide supplementary information to the committee rather than asking that the question be put on notice for the next sitting week. I ask the minister to clearly indicate what supplementary information he agrees to provide and I will then allocate a reference number. If supplementary information is to be provided, I seek the minister's cooperation in ensuring that it is delivered to the principal clerk by Friday, 30 October 2020. I caution members that if a minister asks that a matter be put on notice, it is up to the member to lodge the question on notice through the online questions system.

We are on division 23, Department of Health.

I give the call to the member for Dawesville.

Mr Z.R.F. KIRKUP: My question relates to "COVID-19—From Response to Recovery" on page 313 of budget paper No 2. In previous hearings with the Deputy Chief Health Officer and the Chief Health Officer, we have spoken at length about the health advice provided to the state and, indeed, some issues about the border arrangements in place for Western Australia. One of the questions put was on the border arrangements in other states or territories and whether Western Australia would look at instituting a smarter border approach or a travel bubble, as I think it has been called publicly. Has that work been undertaken by the state to look at the border arrangements in other states and territories? If so, have any been found to be satisfactory for the state's purposes?

Mr R.H. COOK: Thank you, member, for the question. I will ask Dr Robertson and, if appropriate, Dr Lawrence, to make some comments. However, I will say that all these matters are in front of us all the time. Obviously, we revise, examine and review all the arrangements in relation to our response around COVID-19, and that includes the public health risks that other states represent for us.

In relation to the issues around the travel bubble, we have seen writ large in detail the impact or the failures that can occur when there is a travel bubble. There is supposed to be a travel bubble between New Zealand, New South Wales and the Northern Territory, and as I think we have all seen over the last 48 hours, that travel bubble is not so much around the Northern Territory. However, I think only about half a dozen New Zealanders finally made their way to the Northern Territory. Many more made their way to other states. The member will appreciate that we have a very cautious response to policy proposals such as travel bubbles. The moment arrangements with another state are entered into around these things, is the moment we cede control of the border arrangements or other arrangements to that particular state. As a result of that, we have taken a very cautious approach to travel bubbles.

In answer to the member's question about whether we are aware of arrangements other states are considering, obviously Dr Andy Robertson is a member of the Australian Health Protection Principal Committee, which meets a couple of times a week nowadays, but not every day of the week as it used to. I will ask him to make some comments about that.

Dr A.G. Robertson: Thank you, minister. Arrangements in other jurisdictions are constantly monitored through the AHPPC. A lot of those arrangements are obviously announced publicly as they change. We therefore often do not have much more notice than the general public has, as governments make their decisions on those arrangements. But, obviously, we continue to review them and consider them in my advice to the government about what the next steps should be.

Mr Z.R.F. KIRKUP: Thank you very much, Deputy Premier, and thank you, Dr Robertson. When you say "next steps", what does that mean, sorry?

Mr R.H. COOK: Next steps in this game means the next 24 hours, in some respects. We have to constantly examine what is going on in other jurisdictions and ensure that the processes and policy response we have in place in Western Australia matches what is happening elsewhere, be it overseas with incoming international visitors or in other states. Pleasingly, in Victoria there was one case today, so obviously the situation there is improving, thanks pretty much to the great leadership provided by the Daniel Andrews government under some very trying circumstances of public commentary by the federal Treasurer. Victoria has that situation well and truly under control, so that all feeds into our ongoing data set, for want of a better description, of Western Australia's response to COVID-19.

[10.40 am]

Mr Z.R.F. KIRKUP: When the Chief Health Officer says "next steps", he is providing advice to government on those next steps. What are those next steps?

Mr R.H. COOK: He has not provided formal advice. Obviously, Dr Robertson, like the Commissioner of Police and others, is part of the daily discussions about these things. As the Chief Health Officer advised us, and as was announced on Monday about the easing of restrictions, that process will now take place this Friday, and that is "next steps".

Mr Z.R.F. KIRKUP: When the minister says that the Chief Health Officer does not provide formal advice, does that mean that the government regularly receives informal advice about our border arrangements?

Mr R.H. COOK: No. I just mean that the Chief Health Officer sits around the table with all of us, but obviously when we make decisions they are based upon advice that we provide to everybody.

Mr Z.R.F. KIRKUP: The question to the Chief Health Officer specifically related to the border arrangements that are in place, including the next steps that have been provided to the government. Has the government ever received from the Chief Health Officer or Deputy Chief Health Officer advice about possible arrangements in relation to other states and territories and our borders?

Mr R.H. COOK: No.

Mr Z.R.F. KIRKUP: It is not informal advice?

Mr R.H. COOK: Could the member define "informal advice"? I want to make sure that I provide an accurate answer. I am not saying that to be disrespectful; I just want to understand what the member means by "informal advice".

Mr Z.R.F. KIRKUP: If I can clarify my question, then.

The CHAIR: Please do.

Mr Z.R.F. KIRKUP: Has the government ever received from the Chief Health Officer or the Deputy Chief Health Officer any advice about altering our border arrangements with other states and territories that includes or may include options for us to open up to other states in a safer manner?

Mr R.H. COOK: In general terms, those topics are always being discussed, but, no, we have not received advice as the member has just described it.

Mr Z.R.F. KIRKUP: Sorry, did the minister say, "We have not received advice"?

Mr R.H. COOK: That is correct. We make sure that we provide a copy of the advice, which is the reason that we table it each time it comes through. I can confirm for the member that that is not the case.

Mr Z.R.F. KIRKUP: The Premier has said that as part of the COVID-19 response and recovery, a road map has been put together. I wonder whether that has been initiated yet by the Chief Health Officer or Health?

Mr R.H. COOK: All the next steps and scenarios that we might consider for the future have been contemplated, and the member could understand that they are contemplated on an ongoing basis.

Mr Z.R.F. KIRKUP: I apologise to the minister if this sounds relatively obtuse.

Mr R.H. COOK: No; I fully appreciate why the member wants to dig in and get clarity of understanding.

Mr Z.R.F. KIRKUP: It is probably important to all of us to understand whether the government has been provided with advice about the travel arrangements that exist, which is what we are trying to understand here. I imagine that as part of the road map, some work would be being done to look at travel options for Western Australians. Is that under consideration or has it been under consideration in the past?

Mr R.H. COOK: I assume that work has been done as well, yes.

Mr Z.R.F. KIRKUP: So, the minister assumes that work has been done on travel options for Western Australians into other states and territories?

Mr R.H. COOK: I assume that at some point in time the government will seek advice from the Chief Health Officer on what we should do next.

Mr Z.R.F. KIRKUP: Has that advice been provided to date without the minister seeking it?

The CHAIR: Member for Dawesville, can you please wait until the minister has finished answering the question, and then I will give you the call.

Mr R.H. COOK: I am happy for the member to ask the next question.

Mr Z.R.F. KIRKUP: Has that advice been provided at all without the government seeking it?

Mr R.H. COOK: No.

Mr Z.R.F. KIRKUP: I thank the minister very much. The road map that the government is looking at will obviously include some travel options for Western Australians to go to other states and territories. The minister said a moment ago that that was under consideration going forward. At this point in time, have the Western Australian government, the Minister for Health and the Premier never received advice from anyone, from the CHO all the way through, that there are options available for Western Australians for our travel arrangements other than what exists at the moment?

Mr R.H. COOK: The member is conflating two proposals. One is ranges of options, and all those options are before government and have been canvassed both publicly and privately by the whole community and members of the government's team. In relation to advice from the Chief Health Officer, no.

Mr Z.R.F. KIRKUP: Is that because the travel bubble is still considered to be unconstitutional?

Mr R.H. COOK: Does the member mean the lack of advice or the number of options?

Mr Z.R.F. KIRKUP: Is that why there is no advice? Is it because it is considered to be unconstitutional?

Mr R.H. COOK: I do not have a view about the constitutionality of the travel bubble. My focus as the Minister for Health is on the public health risk. I have always regarded a travel bubble as handing over the management of that risk to another jurisdiction, and I think the experiences of this week have really borne that position out.

Mr Z.R.F. KIRKUP: This is the final question from me.

The CHAIR: You are starting to wonder off topic a little bit as well, member.

Mr Z.R.F. KIRKUP: Just to quote the minister, he said "hand over our border arrangements to other states or territories". During the hearing with the Education and Health Standing Committee it was identified that there were other states that the Chief Health Officer felt satisfied with for our border arrangements. The Chief Health Officer said that under oath in that hearing. Has that advice never been provided to the government?

Mr R.H. COOK: That is correct. We have not considered bubbles. We have obviously had discussions about which states do things better than others. For instance, the Northern Territory has taken advantage of its natural competitive advantage because of its isolation. It has managed its borders very well. We too would be comforted by the fact that we have had very little impact of the disease in the Northern Territory. Queensland becomes a different story. Queensland has had rising and falling experiences with COVID-19, by and large as a result of the presence or otherwise of the disease in New South Wales and Victoria and the movement of people. In addition, there is South Australia, which I think has done a bang-up job of managing COVID-19 within its own jurisdiction, but, as I have said on a number of occasions, it has a highly porous border with both New South Wales and Victoria. Because of those arrangements, it is often put to me that South Australia has a very low incidence of the disease and therefore we should consider opening up to South Australia. The point that the Premier and I have been keen to make is that the moment we open up to South Australia, we are by proxy opening up to all those people who can access South Australia. Of course, we can say that we do not want people to come from New South Wales to South Australia and then go to Western Australia, and that we can stop that, and to a certain extent we can. However, we have learnt that people are incredibly inventive and they will do and say a range of things to circumvent

jurisdictions and the rules they have in place. From that point of view, Western Australians are right to observe the travel bubble proposal with some caution. Notwithstanding a general satisfaction with a range of issues around the country, we are all learning, reconfiguring and repositioning in relation to the disease. Each of the states is meeting with some success, to a greater or lesser degree. The Chief Health Officer was reflecting a general attitude within the community that things are getting better in Australia. From that point of view, I think we are all encouraged by the changing nature of the disease and its profile within the Australian community. We believe that a travel bubble by its very definition is easily popped, and the events of this week bring it into sharp focus.

[10.50 am]

Mr K.M. O'DONNELL: If the respected Chief Health Officer said that the state could open the border today—change the border at Kununurra and Eucla, for example—would the minister and the Premier, based on that advice, do that today?

Mr R.H. COOK: I will not respond to hypotheticals, but let me talk about the generality of what the member said. In general terms the answer would be yes. We have always responded to the global pandemic with a health perspective. That is, we respond to the experts, public health officials and epidemiologists who form part of our public health unit. We listen to the advice they give us and then act in a careful way. As a result of getting the health aspects of the pandemic right, we have got the economic aspects of the global pandemic right. Members would have heard the Treasurer last week in Parliament talk about the commentary from Moody's and Standard and Poor's that Western Australia's economic recovery is outstripping the economic recovery in other jurisdictions, both within Australia and in the rest of the world, because we got the health aspects of it right.

The health perspective in relation to this is also the economic perspective. I have conducted a series of staff forums lately online so that I could speak to the doctors and nurses and other health crew in Kalgoorlie, for example, and also in hospitals. I said to them that they are the engine room of the nation's economy at the moment. Because of the great work our health teams have done right across the state in the provision of good public health advice, we have been able to make sure that our economy keeps moving. That is particularly important from everyone's perspective, which is why we have continued to experience growth in the economy. The state's unemployment rate continues to fall. We continue to see an upward tick in business confidence. Just earlier this week I read that expenditure by Western Australians on hospitality and other mainly small business industries is through the roof—it is up 18 per cent, I think—more so than any other state. That is because we have the health advice right.

In general terms, that is our approach. To the specifics of the hypothetical question, yes, if the health advice says that we should move in a particular direction, obviously we make sure that we follow that and keep Western Australians safe.

Mr D.T. REDMAN: I refer to page 313 of budget paper No 2 under the heading "COVID-19—From Response to Recovery". The one thing in the budget that is bigger than the health budget is the royalties from the resources sector; hence, all those products go in and out of this state via ship, and that is emerging as one of the sharp points of our COVID risk. Could the minister outline the advice he is receiving in response to what would appear to be emerging issues in Port Hedland and also Kwinana port for an increased risk of COVID-positive people coming into Western Australia?

Mr R.H. COOK: The advice is that it represents one of our highest risk vectors, as the Premier is often prone to call it, during the COVID-19 pandemic. The influx of crews on maritime vessels who are COVID-positive is significantly denting our capacity to maintain what the member appropriately described as one of the most vital parts of our economy, which is our ports and their capacity to ship iron ore and other high-value products to market. As the member observed, the regions are driving that economic growth and economic activity. It is an area of significant concern to us. The member would have seen some fairly strident commentary from me in the media about the role we believe the federal government has to play to ensure that our trading routes do not represent a public health risk to Western Australians. We manage those in different ways and in different ports. In Port Hedland, there is zero or next to no interaction between maritime crew and port workers. Obviously, there needs to be a pilot and surveyor on board and a range of protocols in place around the protective personal equipment they must use in that context. As vessels tie up in Port Hedland port, they are still sitting a good 12 metres from the wharf, so there is not much of a risk from that. However, if any vessel puts in a distress call to the shore, we have to respond, both morally and under a maritime law obligation, so we have to provide assistance to that vessel. This is resource intensive. It obviously also represents a public health risk, although a very low one when it is managed as well as it has been. We need to make sure that we can resolve these issues. For the member's information, the reason that we are having this uptick in the number of crew coming in who are COVID-positive is that the Panamanian government, under which many of the worldwide vessels are registered, requires that all ship crews be switched out after 12 months. Many of those crews simply stayed on board during the COVID-19 pandemic. The companies have now been told to get those crews home for their safety and wellbeing and to get new crews. That is why the situation is under stress.

This morning, I spoke with the International Transport Workers' Federation, the organisation that represents maritime crew members. My understanding is that it is doing a lot of work with the International Maritime Employers' Council, and the global shipping agencies or their representative bodies, around making sure that IMEC stands up its own quarantining facilities in Manila to ensure that this situation is brought under control. I understand that about one-third of maritime crews around the world are supplied from the Philippines, so clearly we need to get that under control. It does not explain the situation with the *Al Messilah*, because that ship came from Dubai and has been at sea for many months, but if we can get the situation under control for the crews that are switching out in Manila, I think we will significantly address the issue. This is why the federal government needs to say to the Filipino government, "You have to provide more support to your industry, which provides huge economic benefit to the Filipino economy." It has to provide more support to its industry so that crews can properly quarantine and then effectively switch in and out, to make sure that we provide good, clean passage for these vessels that, as the member says, are so crucial to our economic situation.

[11.00 am]

Mr D.T. REDMAN: It was reported that two people disembarked from the Kwinana ship; one went over east on a plane and one went down to Busselton. What failed in our protocols in receiving those people into Western Australia?

The CHAIR: Member, that question is not particularly related to the item in the budget.

Mr D.T. REDMAN: With respect, Chair, I was talking about ships.

The CHAIR: I appreciate that. It is at the minister's discretion if he wants to respond.

Mr R.H. COOK: Thank you, Chair. I appreciate the member's curiosity. I think it is true to say that nothing failed; all the protocols were observed. The two crew members in question were Australian, and under the nationally accepted protocols that were in place last Wednesday or Thursday when they got off that vessel, they were required to go to home quarantine for the rest of the 14-day period. My understanding is that the ship was at sail from 10 October, and it arrived at around 14 October, so they were required to go to home quarantine or self-isolation for the duration of that 14-day period. Both crew members did that and followed the directions associated with what are known as the maritime directions.

Mr D.T. REDMAN: I have a further question.

Mr R.H. COOK: I am sorry; I have not finished. I am going to go to the nub of the member's question. The member asked why they were allowed to do that. Those were the directions in place at the time, consistent with the public health risk that was identified at the time. Clearly, the situation has now come to pass that that is not appropriate; therefore, the government made the decision on Sunday to change the directions to make sure that, in future, crew members will undertake hotel quarantine for a further 14 days and not complete just their 14 days.

I should say that one of the individuals in question is in the hands of the New South Wales public health officials and is isolating. The other, who is Western Australian, did all the right things up to that point. She made her way from Fremantle in her own vehicle. She drove herself, was isolating at home, and did all the appropriate things. She had not yet completed that 14-day period. We contacted her and interviewed her to make sure that we could identify any close contacts, and my understanding is that there were none, but she then requested to go to a hotel quarantine facility out of what we all now refer to as an abundance of caution. I defend the individuals; they did all the right things. I defend the protocols that were in place because, at the time, they were what they were, but we have now significantly tightened those up to make sure that that situation does not occur again.

Mr D.T. REDMAN: The minister mentioned in his response that the protocols were changed on Sunday. Were they changed in response to a COVID-positive test on that ship?

Mr R.H. COOK: Let me think. Yes. At that stage, we knew that there was a COVID-positive test on the *Al Messilah*. We did not understand the extent to which we were then going to discover further positives. Both those people were tested, and they were negative, which is a good outcome, but I think that presented to us in pretty sharp focus that we needed to tighten the protocols further.

Mr D.T. REDMAN: The minister also mentioned that when ships come into berth, pilots and a number of people have to go on board; whether it be an iron ore carrier or a freight carrier that comes into Kwinana port, people have to go on board and come off. Could the minister remind me of the protocols around PPE and the current advice on that?

Mr R.H. COOK: Yes. If I may, I will hand over to Dr Robyn Lawrence, who is the head of the State Health Incident Control Centre.

Dr R. Lawrence: Thank you. Anybody who boards ships or has contact with seamen on ships, remembering that no seamen are permitted to exit ships in port unless they need urgent medical attention, or to tie off lines or the odd

thing that they are required to do, is required to wear PPE, so gloves and a face mask, and to remain 1.5 metres away from the crew at all times; and, when crew are in proximity, they are also required to wear face masks. The protocols are robust. We know that many of these people obviously do not wear that equipment as part of their usual duties, although we have been in this situation for a long time now, so it is now standard practice. It is really difficult to be diligent with PPE; therefore, even though we know that those people are wearing PPE, we always follow up and have a very close conversation with them when we know they have been in contact with cases to make sure that they were as robust as we would like them to be. Further education is ongoing in those areas.

Mr Z.R.F. KIRKUP: Is the government actively considering issuing directions to refuse vessels from certain countries arriving in Western Australian waters?

Mr R.H. COOK: I know that we are awaiting advice from the State Solicitor's Office and other people on the better management of these vessels. I do not think it is fair to characterise it as seeking means to reject those ships. It does stick in our craw a bit that these vessels come in with crew members who are unwell, from the perspective of not only the welfare of those crew members, but also the public health risk, expect us to bear the cost of assisting them, and then load up millions and millions of dollars' worth of iron ore and ship themselves off. That is a bit galling, to be perfectly frank. But we are not awaiting advice about how we can stop them coming altogether. We are a state government, and we are obviously bound by national laws, which are in turn bound by international protocols and maritime law. I must say that I have learnt more about maritime law in the last week and a half than I care to. Nevertheless, there are limitations to what we can do, but it is annoying that these ships benefit from the trade and the great public health teams that we have in Western Australia, but do not reciprocate those benefits by making sure that they properly quarantine their crew before they get on the vessel.

Mr D.T. REDMAN: Are the people who need to board ships for a range of reasons logged in any sort of report that keeps a record of who has been on board for contact tracing purposes? Should that be something that is needed?

Mr R.H. COOK: I assume so, but I will ask Dr Lawrence to make comment.

Dr R. Lawrence: Yes, those who board the ships are logged, so it is relatively easy to find those. Other interactions along the path are less well documented in a single place. We were able to locate through those different agencies most of the individuals who had contact with those sailors, and we are now working with the port to further refine that so that we can try to create ideally a single repository for that information.

Mr D.T. REDMAN: In response to that, to clarify, Dr Lawrence said that the people who went on board were logged, but that there was contact with sailors that had a less prescriptive strategy of tracing.

Mr R.H. COOK: Dr Lawrence.

Dr R. Lawrence: When sailors come off the ship to go to hospital, for example, groups such as the Flying Angel Club are involved in facilitating that transport, and for providing care and welfare to sailors on board, should they need it. Of course, they know who had contact, but it was not in a single repository so that we could go to the port and say, "Can you tell us everybody who had contact with the ship?", or look at documents that came off the ship, or that sort of thing. Those who board the ship are readily identifiable.

Mr D.T. REDMAN: Does the department keep records of any breaches of the established protocols by either those who are on board ships or those who are interacting with those on board?

[11.10 am]

Mr R.H. COOK: It may be more of a harbour or transport logistics question, but I will ask Dr Lawrence to provide any information that we might have.

Dr R. Lawrence: We do not have oversight of breaches unless we come across them through an investigation, usually related to a COVID-positive ship, so it probably is a question for the ports, I would have thought.

Mr D.T. REDMAN: For clarification, who holds the records of any breaches of established protocols?

Mr R.H. COOK: Member, the ports themselves would have records associated with any pilot activity, surveyors and things of that nature. As Dr Lawrence said, unless the breach itself is of consequence—that is, if it is in the context of an outbreak or investigation by the public health teams—I am not sure it would necessarily come to the attention of authorities. Obviously, there are protocols around what a ship's bridge has to look like, how many people are allowed on the bridge while there is a pilot on the bridge, how they should conduct themselves, and, obviously, there are obligations on the pilots themselves on the wearing of personal protective equipment and maintaining physical distance and things like that. It is a fairly sophisticated operation nowadays. It is really, I guess, incumbent upon the individuals to do the right thing, as is often the case with these sorts of things. But very rigorous protocols are in place that ships are required to observe. They come to our attention only in the event that we have reason to believe that there might be some health consequences as a result of it.

Mr D.T. REDMAN: I take it that the minister does not get ongoing information and data in respect of a breach of established protocols. Health would have had full oversight had it not even put in place what those protocols were from a risk-management perspective. Surely, having feedback on protocol breaches, even if they are not related to an incident of a critical nature, would be fundamental information to feed into Health advice on the practices of our ports.

Mr R.H. COOK: Yes. I take the point the member is making, which is essentially to say that if there are people jumping off the vessel onto the wharf or there are unauthorised visits onto a vessel that is at berth and things of that nature, then that should come to the attention of Health officials. Major breaches like that would probably be drawn to our attention as part of the overall public health oversight of it. There is now a very well understood communication line between our team—that is, the team that is employed by the Department of Health—and the people associated with the ports who have a health surveillance role. They might be agricultural workers, port inspectors, Australian Border Force staff and people like that who might observe and bring major breaches to our attention. Otherwise, I think it is a requirement on each of the port authorities to run a good port and do best practice.

To give the member an indication of how we become involved, often a ship will be coming into port. The ship's master has to keep a log and they have to report whether someone on board is unwell. That information is provided to the Public Health Emergency Operations Centre—PHEOC—and it makes an assessment about whether it is an issue that should give rise to a COVID-like response. For instance, if the ship's captain reports that they have a crew member with a bone fracture or something like that, that does not get elevated to COVID response teams. But if the ship's captain says that they have a crew member on board with a respiratory illness, that gives rise to a whole range of new, elevated actions, which then means that Dr Lawrence's team becomes intimately involved with that ship berthing at that harbour.

In the case of the *Patricia Oldendorff*, it involved a helicopter crew going out onto the vessel to test the crew member on board. In the case of the *Key Integrity*, we did not have helicopter capacity, so we required the ship to pull up alongside so we could get Health teams on board. Those are the incidents in which the public health team that members see in front of them at the moment become involved. Clearly, other authorities such as the Australian Maritime Safety Authority, Department of Agriculture and Food, Australian Border Force, biosecurity personnel and a whole range of others have a role to play as well in the overall vigilance of the vessel, but we become involved only the moment that a distress call or reporting of illness is actually made.

Mr Z.R.F. KIRKUP: Minister, Dr Lawrence made reference to the Flying Angel Club.

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: Some seafarers have been supported by that club. For clarification, has accommodation been provided at the moment for seafarers through that organisation? I do not want to misinterpret what Dr Lawrence said.

Mr R.H. COOK: I will ask Dr Lawrence to elaborate.

Dr R. Lawrence: I am not intimately aware of everything that the Flying Angel Club does, but I think the question was about accommodation specifically and my understanding would be no, because no seafarers are permitted off the ship except if they are exiting the ship to return home or for medical reasons, and they are either returned directly to the ship or, in the case of these seafarers, to a State Health Incident Coordination Centre hotel if they could not return to the ship due to illness or the captain declining them.

Mr R.H. COOK: Members may or may not be aware that we do have international crew members who join vessels in Fremantle. They are required to go on what is called SHICC maritime, which is a low-level health but high-level security hotel arrangement for those seafarers who are coming through. Ordinarily, those seafarers may have stayed somewhere like the Flying Angel Club, but that is not appropriate in the current pandemic.

Mr Z.R.F. KIRKUP: The minister made reference to getting the State Solicitor's advice on further directions that might be undertaken for vessels. Is that in relation to the minister's frustrations relating to the lack of financial support from those companies that might have these sailors land here and then an outbreak occurs or something like that?

Mr R.H. COOK: It is not in terms of financial support. Remember, we passed a bill some time back, with opposition support, so that we could legally invoice companies that benefit from things like deep cleaning and other activities associated with having a COVID-19-positive result on board. The legal advice is that we need to understand where we stand legally in all these things, and so we need to get a better handle on how we manage these vessels in both a Health response and a legal and protective response. But, as I have said, and as I have learnt over the last few weeks, maritime law is incredibly complex.

Mrs J.M.C. STOJKOVSKI: Minister, I will take a slight change in direction, if I can. I refer to budget paper No 2, page 328. The Joondalup Health Campus redevelopment is something that is very important to the people of Kingsley and, in fact, the whole northern suburbs. Can the minister please provide a progress update on this commitment?

[11.20 am]

Mr R.H. COOK: Thank you very much, member. Obviously, this is a key election commitment made at the last election and championed by the member, I might add. We are incredibly excited about the redevelopment of Joondalup Health Campus. It is an important redevelopment to make sure that we continue to grow the Health services that we provide in the northern suburbs, particularly with the expansion of the City of Joondalup, the City of Wanneroo and, of course, in the member's area, the electorate of Kingsley, where growth is off the charts. Therefore, we have to make sure that hospitals have the capacity to meet the demand that will come from those population groups.

I can report that the funding agreement for the Joondalup Health Campus redevelopment stage 2 was executed on 9 July. Fit-out works for the emergency department administration area commenced on 17 July. The works were completed on 11 September. That allows us to move some administration people out of the area where we want to see the expansion of the emergency department. The main construction works are scheduled to commence in early June 2021, and the expansion works are expected to be completed by September 2025.

We are trying, of course, to grow a whole range of services at Joondalup Health Campus. We have to make sure that the emergency department is fit for purpose and can meet the needs of the people of that area. On some days, Joondalup hospital has the busiest hospital ED in the state. The expansion of an extra 12 bays at the emergency department will obviously be welcomed, as well as the expansion of operating theatres plus an increased number of inpatient beds.

The one thing that I am particularly excited about is the expansion of our mental health beds at that facility, which will see an extra 30 mental health beds brought to the campus. That will mean that we can significantly increase the number of young people who are accommodated at that hospital. On many occasions when I have talked to the leadership at Joondalup hospital, they have said that that is their biggest anxiety—their lack of capacity to provide proper mental health accommodation for young people who present at the ED.

The process is galloping forward. The tender documents for the next stage of the early contractor involvement were released on 14 September, the process closed on 2 October, and the review and acceptance of the contractor's firm price for construction is scheduled for late March 2021. Obviously, it is incumbent on every government to make sure that it has hospital services to meet the needs of the community. The member's electorate is a rapidly growing community and obviously people in her electorate will greatly appreciate the growth in the number of beds. We will continue to consolidate the great work that Ramsay Health Care is doing at that hospital. Does the director general have anything to add to that? No.

Mr Z.R.F. KIRKUP: Going back to the initial question about advice from the Chief Health Officer about the freedom of movement between Western Australia and other states and territories, has advice ever been given to the state that this could be considered, particularly in the context of our current restrictions?

Mr R.H. COOK: Which line item is that, member?

Mr Z.R.F. KIRKUP: This is in relation to page 313 and the COVID-19 response and recovery, and will continue to be.

Mr R.H. COOK: Have we received advice? I think we have tabled all the advice that we have received. I think the only advice we have not tabled to date is that which led to the announcement on Monday about the changes we have made to the easing of the phase 4 restrictions. I am happy to provide that to the member, but we have not received advice in the way that he characterises it, no.

Mr Z.R.F. KIRKUP: Effectively, the advice in September that was tabled suggested that there could be options that the government could consider for freedom of movement and travel between Western Australia and other states and territories. Does the minister recall that?

Mr R.H. COOK: Sorry; could the member say that again?

Mr Z.R.F. KIRKUP: The advice that was tabled in September suggested that there could be freedom of movement and travel between Western Australia and other select states and territories if they met certain criteria. In the Education and Health Standing Committee, it was nominated that it would be the Northern Territory, South Australia, Queensland, Tasmania and the Australian Capital Territory. Given that advice like that was tabled in September and the states have since met the criteria that was confirmed to the Education and Health Standing Committee, is that now a consideration of government?

Mr R.H. COOK: I guess that everything is open for consideration by government. The member is right; those particular jurisdictions are all performing really well. I think all states are now going great guns, and we have previously talked about being clear of community spread of the disease for 28 days, which I think would be fast approaching given the low numbers in Victoria. The most recent discussions on this stuff have been focused on the extent to which we open up the Western Australian economy—that is, whether we move from phase 4 to phase 5.

Mr Z.R.F. KIRKUP: On the idea of the 28-day rule that we keep referring to, the minister said in a previous contribution that the situation in Victoria is now under control and he credited the Andrews government. Does that mean that he considers that Victoria will start to meet the criteria as well for further consideration of travel between Western Australia and that state?

Mr R.H. COOK: I guess the way that I would properly describe the situation in Victoria is that it is coming under control. All these things give rise, as the member says, to the opportunities to consider our options going forward.

Mr Z.R.F. KIRKUP: Obviously, the state has been provided with criteria, on the advice of the Chief Health Officer, that says that if a state or territory meets those criteria, options could be considered to allow freedom of movement between Western Australia and that select state or territory. The Education and Health Standing Committee nominated that the states were the ones that I have previously outlined and the minister has indicated that perhaps Victoria is getting close to that point.

Mr R.H. COOK: And New South Wales, to be fair, member.

Mr Z.R.F. KIRKUP: Sure, and New South Wales. The entirety of the country is at that point or getting very close to it. If the minister has the advice of the Chief Health Officer, and the criteria are being met in most states and territories and are starting to be met in New South Wales and Victoria, at what point does he consider that that freedom of movement will be available to Western Australians?

Mr R.H. COOK: As the member observes, there is a range of criteria that we are looking at that guide our thinking on that and it is ultimately informed by advice from the Chief Health Officer and also by our concerns that any movement between other states has to be cognisant of the movements both within and outside that state. All these things are in front of the government and we need to give due consideration to them as the situation unfolds.

Mr Z.R.F. KIRKUP: I am conscious of the criteria. I am trying to understand the process for the minister, the Premier and cabinet. The advice that has predicated our border arrangements comes from the Chief Health Officer for consideration by the minister and others who make the decisions about our restrictions. If the advice says that people can now travel safely to, for example, the Northern Territory because that state has met the criteria and has not had an outbreak for more than 200 days, why has the decision not been made by the government to open up to the Northern Territory?

Mr R.H. COOK: We have not received that advice. The Chief Health Officer's advice, as I have said on a number of occasions, is the bedrock upon which our decisions are based. Obviously, there is a range of considerations that feed into that, including how we can manage the exposure to other jurisdictions. When we receive that advice, we will obviously make decisions.

Mr Z.R.F. KIRKUP: Are the restrictions based solely on the health advice?

Mr R.H. COOK: Yes. As I said, member, that is the bedrock of our decisions. That is correct.

Mr Z.R.F. KIRKUP: So they are based solely on health advice.

Mr R.H. COOK: The member says "based solely" on that advice and that is clearly what provides us with guidance. We obviously have to be cognisant of the legal frameworks, as well as the logistical and operational frameworks, within which we work. Fundamentally, at the end of the day, we move in a direction that is informed by the health advice.

Mr Z.R.F. KIRKUP: Is there no consideration for the economic impact?

Mr R.H. COOK: As I have said to the member for Kalgoorlie, the economic impact is in the strength of the health decisions that are made.

Mr Z.R.F. KIRKUP: There are states and territories that were identified in the advice tabled in September as meeting the criteria under which we can open up our travel.

Mr R.H. COOK: Is that the member's assertion or his question?

Mr Z.R.F. KIRKUP: I am questioning it, because I think it was confirmed in the Education and Health Standing Committee, so that is the question.

Mr R.H. COOK: So, it was confirmed in the Education and Health Standing Committee.

Mr Z.R.F. KIRKUP: I will repeat the question. Can the minister confirm that currently there are states and territories that meet the health advice given to government that would allow Western Australians to move between those states and territories in a safe manner?

Mr R.H. COOK: I cannot recall off the top of my head whether they meet the criteria. Obviously, that was advice that we provided to the member and the committee of which he is a member. We will consider that advice when we consider the next steps in what we do with our borders. But, as I said, all these things are taken in the context of our legal frameworks and our operational and logistical frameworks.

[11.30 am]

Mr Z.R.F. KIRKUP: How long does the minister think it will take to consider those further steps? Every day people continue to be separated from their families, particularly in states that the government has been told meet the criteria of a safe travel option. That is obviously having an impact on families in Western Australia. Every day that passes in which people are not able to travel safely to the Northern Territory, for example—even though the health advice says that they can do so in a safe manner were the government to take that advice on board—is having a significant impact on the Western Australian community. When does the minister imagine those next steps will be taken? What threshold has to be met for the government to consider those arrangements?

Mr R.H. COOK: There is nothing stopping people from travelling to other states to be with their family members, but, obviously, there are restrictions on how people enter the state. We continue to monitor those restrictions to make sure that they reflect upon and are a proportionate response to the public health risk. We will continue to do that. At the appropriate point, we will make a decision based on the health advice.

Mr Z.R.F. KIRKUP: What is the appropriate point, minister?

Mr R.H. COOK: The appropriate point is when the Chief Health Officer and other people who inform the decision-making process basically provide a context in which we should make those decisions.

Mr Z.R.F. KIRKUP: Who are the other people, minister?

Mr R.H. COOK: That is a good question, member. Obviously, a range of people feed into the advice that the Chief Health Officer makes public—all his public health team, the State Health Incident Coordination Centre and the COVID-19 Public Health Emergency Operations Centre, and other people involved in those discussions. Perhaps I can characterise it in the following way. On most days, we have a meeting in the morning, which I chair. The Premier is at that meeting. Dr Robertson, as well as the State Emergency Operations Controller, otherwise known as the Commissioner of Police, Chris Dawson, are at that meeting. Dr Russell–Weisz attends those meetings as a representative of the Hazard Management Agency. The State Recovery Controller, the Public Sector Commissioner, Sharyn O'Neill, is at those meetings. The director general of the Department of the Premier and Cabinet and a range of other staff also attend to provide advice, technical or otherwise, on decisions, all of which impact the state's response around COVID-19.

Mr D.T. REDMAN: The member is pursuing a line of discussion in and around border constraints and closures, and future prospects for that. An underlying premise identified by Treasury in the budget assumes that the borders will open in April next year. Did Treasury consult the Department of Health for its input into the scenario that provides information on the basis of driving this theme through a budget that there will be an opening in April?

Mr R.H. COOK: Not that I am aware of, but I will invite the director general to comment and answer on behalf of the department. The Treasurer described that issue by saying that every budget is predicated on assumptions, whether they are assumptions around the price of iron ore, the unemployment rate or other issues that impact on the economy. Treasury has to build in those assumptions just so that it can land at a point. Clearly, Treasury had to work to a date in its modelling and the impact around its decisions. I understand that the discussion was not about which date to pick; it was simply about economists picking a date so that they could land somewhere. The Treasurer also explained to me that that date does not significantly impact the flow of numbers either way; Treasury simply had to, for the purposes of the built-in assumptions in the budget, land on a date, so it took that one. I invite the director general to provide an answer on what advice it sought from us.

Dr D. Russell-Weisz: We have obviously been working closely with Treasury on the whole COVID-19 response and recovery. It is very iterative. We work closely with Treasury anyway on our health operations. All I really can say is what the minister said—the Health department or the Chief Health Officer gave no formal advice to Treasury to make those assumptions. Those assumptions have been made by Treasury. Yes, there have been general discussions about the COVID-19 response and readiness, but that goes much more to the cost of, for example, PPE; the cost of our public health and state incident control centres and how long they will last; and looking to the future about how long these significantly resourced control centres will stand up to make sure that we are prepared for any outbreak that might happen not only now, but also in the future.

Mr Z.R.F. KIRKUP: Can I ask a follow-up question?

The CHAIR: You can ask a further question.

Mr Z.R.F. KIRKUP: You are very kind, Chair. The confusion that appears to have reigned is that clearly options have been provided to government that could be considered to expand travel from Western Australia to other states and back again so that Western Australians can have freedom of movement between certain states and territories. That advice has clearly been provided and confirmed. It was confirmed in the advice that has been tabled and in the hearing of the Education and Health Standing Committee. At what point in time will the government act on that advice?

Mr R.H. COOK: I cannot provide a time line to the member on when decisions of this nature will be made but, obviously, we will do so in a timely fashion to make sure that the response is proportionate to the public health risk.

Mr Z.R.F. KIRKUP: Is there much risk in the Northern Territory at the moment, where there has been no community transfer or spread of COVID-19 for 200-plus days?

Mr R.H. COOK: The member is asking a politician and not an epidemiologist that question. I would say that the situation in the Northern Territory is riskier now than it has been for a few weeks now that Howard Springs is being utilised as a quarantine station. From what I have seen on the telly—again, applying my amateur epidemiology and understanding of infection control—it does not look like a particularly well-run facility. There has been a lot of interaction between the guests staying at Howard Springs. I think someone reported seeing on Twitter the other day that there had been a dance party there. That does not look like gold-standard hotel quarantining to me. My response is that I think the risk in the Northern Territory is probably low, but it is probably increasing. That is why we have to monitor these things on an ongoing basis rather than wedding ourselves to particular time lines.

Mr Z.R.F. KIRKUP: Obviously, the advice to government, I imagine, is exclusive to having no community spread, which is what has happened in the Northern Territory. There has not been community spread in the Northern Territory. If the government has the advice that says people can travel freely between Western Australia and X state where there has been no community spread—the Chief Health Officer confirmed that it was in those states that I outlined previously—why has the government not acted on that advice?

Mr R.H. COOK: Because we have not received that advice. The Chief Health Officer and others have made observations about the relative public health risk in different jurisdictions, but at this point in time we have not been advised that we should open up travel to particular states or territories, or all states and all territories. Obviously, these matters are under ongoing consideration.

Mr Z.R.F. KIRKUP: Further to that then.

The CHAIR: Member, you have asked that question just about every which way possible and it has been answered every single time.

Mr Z.R.F. KIRKUP: I appreciate that.

Mr R.H. COOK: This is like one of the Premier's press conferences. I just answer the same question in different directions.

Mr Z.R.F. KIRKUP: Further to that, how does that square with the fact that Dr Robertson in the Education and Health Standing Committee said, and I quote —

> As I said in September, I did say that they were options the government could consider.

The minister just said that the government has not received that advice and Dr Robertson said in the Education and Health Standing Committee that he has provided those options to government.

Mr R.H. COOK: No. What I have said is that we are considering a range of options and a range of approaches.

Mr Z.R.F. KIRKUP: The minister just said a moment ago that he had not received that advice.

Mr R.H. COOK: With respect, this is estimates; not a pub discussion. We could bounce backwards and forwards all day if we wanted to, but I am not sure that we would do justice to the budget. In answer to the member's question: obviously, the government is considering a range of options subject to public health advice. We will make a decision in due course consistent with the public health risk.

Mr D.T. REDMAN: Minister, I refer to page 226 of budget paper No 3, the summary of state government social concessions. I appreciate the minister may not have that volume with him.

Mr R.H. COOK: I do have it.

Mr D.T. REDMAN: Under the item "Health" it refers to the patient assisted travel scheme under the WA Country Health Service. There was one for Peel. The minister does not need to look at the page. I am looking for an entry point into the question.

Mr R.H. COOK: Fire away, member.

Mr D.T. REDMAN: Minister, I want to confirm whether the patient assisted travel scheme is still solely funded from royalties for regions; and, if not, what is the current funding arrangement for the patient assisted travel scheme?

[11.40 am]

Mr R.H. COOK: I do not have details of the funding source for PATS; that work is undertaken by Treasury and by the Department of Primary Industries and Regional Development. At the moment, we are continuing to look at the 2015 report and how we can improve the scheme. I cannot give the member any indication about the scheme's future funding sources, but, with the Chair's indulgence, I might ask the director general or one of his team to respond to that question.

Dr D. Russell-Weisz: I will ask Mr Jeff Moffet, chief executive of the WA Country Health Service, to answer that.

Mr J. Moffet: PATS is funded through the royalties for regions program through the country health initiative and a subprogram called "Digital innovation, Transport and Access to Care". It is a subset program but it is funded by royalties for regions.

Mr D.T. REDMAN: In the minister's earlier response, he referred to the 2015 report. Can he give me a more comprehensive response about where that is at? It contained a number of recommendations with regard to PATS.

Mr R.H. COOK: As the shadow Minister for Health, I was surprised that the previous government did not pick up many of the recommendations in that report. I do not know whether the member was involved in the committee or whether it was a joint committee or a Legislative Council committee, but it was a pretty comprehensive examination of the issues. These things date, to a certain extent. Telehealth now plays a much bigger role in providing health care to people living in remote communities. However, the government's formal response to the report, which I think was in 2016, supported eight out of the 21 recommendations. Recommendations 13, 14 and 16 were not supported by the previous government. Many of the review recommendations have subsequently progressed, including recommendations 6, 7, 9, 11, 12, 17, 19, 20 and 21, which have already been addressed. Recommendation 18 is currently being implemented. Some of the recommendations that have progressed include exceptional circumstances reforms for patients with long-term conditions, clearer information about the PATS policy and appeals process, investigation into other suitable accommodation options for patients such as medihotels, and reforms to streamline PATS payments, including electronic funds transfer reimbursements.

In addition, in July 2019 the south west PATS office moved from being run by Medibank Private in Mosman Park to being run in-house in the south west. A backlog of claims was inherited by the department that blew out processing times. Extra resources were put in to clear this. The member will be very pleased to hear that that backlog has now been cleared and people are now getting their PATS payments in a speedier fashion.

As I said at the outset, clearly health care is changing. We now have emergency telehealth, telehealth and telechemotherapy, which is being rolled out right across regional Western Australia. That will change the role that PATS plays into the future, but I hope that as that change happens, we have an opportunity for reform to continue to make sure that PATS better reflects an appropriate compensation for the expenses that people incur.

Mr D.T. REDMAN: Thank you, minister, for your response. Mr Moffet mentioned the royalties for regions program and the line item "Digital Innovation, Transport and Access to Care", from which PATS is funded. It receives funding in the out years of $58.1 million, $58.3 million and $58.3 million. It would appear that in the out years, which is consistent with previous years, there is no increase in funding; in fact, there is a decrease in funding. If that includes PATS, which according to the other part of the budget is funded to the tune of $31.5 million, it appears that the government is not intending to invest any more resources into PATS. Some of the recommendations in the report that we referred to enhanced some of the investments to support those people in isolated areas in regional Western Australia to get the medical services that they deserve. Can the minister confirm what the budget papers appear to be telling me: there is a reduction in PATS funding going into the out years, which implies a negative response to the 2015 report?

Mr R.H. COOK: I acknowledge that the actuals for 2019–20 were $35 779 000. The budget estimate for —

Mr D.T. REDMAN: Sorry, minister, but that refers to recipients.

Mr R.H. COOK: Sorry, my apologies. It is just over $31 million. The budget estimate for 2020–21 is $31 400 000. It is anticipated that there will be a slight increase. This is the opportunity that I was talking about, member. As technology changes the way that we deliver health care, it provides us with an opportunity to look at PATS and the way it works to ensure that we continue to provide the services that people need. As the member can see, the 2018–19 actual is $33.7 million with 37 500 people receiving care. The provision of $31.4 million will still see an estimated 36 200 people receiving assistance. In that respect, fewer people need to access PATS because more people are getting health care in their regions or via a digital means; that will forever be thus. As we continue to drive

reform in the healthcare system, making sure that we have devolved good health services in the regions, we will rely less upon schemes such as PATS. I understand the point that the member has made: the overall expenditure on PATS is decreasing because fewer people need to move around the state to receive their health care.

Mr D.T. REDMAN: The minister may need to provide an answer to this next question through supplementary information. Page 173 of budget paper No 3, as Mr Moffet highlighted, contains the line item that contains a PATS component of funding. As I said in my first question, it receives funding in the out years of $58.1 million, $58.3 million and $58.3 million. In other words, there is no significant change in funding. Can the minister provide me with a breakdown of the PATS component of that funding so that I can get an appreciation for the PATS numbers going into the out years? The only visibility I have on PATS funding is the 2020–21 budget of $31.413 million.

Mr R.H. COOK: What was the page number, member?

Mr D.T. REDMAN: I am referring to page 173 in budget paper No 3. Down the bottom under the heading "Putting Patients First", it is pretty much the first line item —

Mr R.H. COOK: Yes. Does the member want the breakdown of the digital —

Mr D.T. REDMAN: — "Digital Innovation, Transport and Access to Care". It is a global figure that would include telehealth, I assume.

Mr R.H. COOK: The member is asking for a breakdown of expenditure, for both 2020–21 and the out years, for the line item "Digital Innovation, Transport and Access to Care" on page 173 of budget paper 3.

[*Supplementary Information No A7.*]

[11.50 am]

Mr D.T. REDMAN: When I first asked the question, I was referring to page 226 of the *Economic and Fiscal Outlook*, under the "Summary of State Government Social Concessions". It referred to the patient assisted travel scheme, which shows only one year. Just under that is the line item "Peel Health Service", so it is in the context of the PAT scheme, and it is a fairly significant change, albeit in the thousands—$40 000 to $80 000. Can the minister give us some understanding of that shift?

Mr R.H. COOK: That what?

Mr D.T. REDMAN: That shift.

Mr R.H. COOK: I was going to say, "You can't say that". With such a potty mouth of the member for Warren–Blackwood, I might invite the director general or one of his advisers to comment.

Dr D. Russell-Weisz: I think we will probably have to take that on notice to look at the specific Peel change and come back to the member.

Mr D.T. REDMAN: Come to think of it, it is only a fairly small number.

Dr D. Russell-Weisz: It is.

Mr D.T. REDMAN: It is all right.

Mr R.H. COOK: In the notes to that it states that this concession has been significantly affected by the COVID-19 pandemic.

Mr D.T. REDMAN: I am happy with that.

Dr A.D. BUTI: I refer the minister to "Other COVID-19" on page 312 of budget paper No. 2, and specifically the cost of hotel quarantining for COVID-19 people and what extra funding will be needed to keep Western Australians safe. What is the cost so far and what future funding is required?

Mr R.H. COOK: Obviously, we will need to provide a range of services to make sure we continue to be in a safe space in relation to COVID-19. COVID-19 expenditure across our system relates to COVID-19 hospital services of about $131 million; public health activities of $96.9 million; quarantine and repatriation costs of $43.9 million; and private hospital provider payments of $47.8 million, which relates to the subsidy provided to private hospitals when we closed down their services as part of the earlier response to COVID-19. I note that that has been fully funded by the commonwealth. For capital and other equipment, we have spent $29.6 million on medical equipment, and $1.5 million on minor emergency capital works, which has been predominantly around retrofitting emergency departments to ensure that we have enough negative pressure rooms to keep both patients and other people safe in those places.

We have spent $43 million on personal protective equipment and critical medical supply stockpiles. As many people will be aware, our global supply chains were significantly impacted by the COVID-19 pandemic. We were

really challenged by the amount of personal protective equipment we had available for our teams. Teams were literally working around the clock, taking advantage of each of the global time zones to ensure that we could purchase the PPE we needed. Significant work has now gone into that. The amount of $3.6 million has been allocated to key pharmaceutical product reserves. Many of the pharmaceutical products that we take for granted in our pharmacies, our hospitals and so on were significantly challenged during the COVID period. There were also pathology testing kits, reagents and information communications and technology equipment. In total, we have spent in excess of $400 million to make sure that we have the necessary hospital equipment and hospital services to meet our needs.

Obviously, a range of expenses are associated with the quarantining services that we provide. Quarantining expenditure to 30 September is $43.9 million. I think everyone understands just how important it is to make sure that our hotels are offering a standard of quarantining that can protect the Western Australian community. With the exception of the cases in the last few months associated with the vessels coming to Western Australia, all our reported cases have been in quarantine in our hotels. That is an indication of two things: firstly, where our risk factors are—that is, external people coming into Western Australia—and, secondly, that we have a system that works and can protect the rest of the Western Australian community. The hotel quarantining system is exceptional and has served us very well.

Mr K.M. O'DONNELL: I refer to outcomes and key effectiveness indicators on page 319. About three-quarters of the way down the page is the percentage of fully immunised children. I see we are doing really well with fully immunising five-year-old Aboriginal children, the rate of which is outscoring that for non-Aboriginal children, which is great. However, I notice that the rates for Aboriginal kids who are 12 months old and two years old are well and truly behind those of non-Aboriginal kids. Is more funding being directed towards improving those figures? What is being done to improve the figures for two-year-old kids and those who are 12 months, when the government has got it right for five-year-old kids?

Mr R.H. COOK: Thank you for the question. I will refer the member's question to Dr Andy Robertson, the head of public health, unless the director general has some comments.

Dr D. Russell-Weisz: I would like to refer to Dr Robertson, but I think, generally, there is a significant focus on prevention, which was the first recommendation in the sustainable health review, so efforts are being made in relation to immunisation, but, overall, prevention remains. One of the recommendations was that between now and 2029 we spend up to five per cent of the health budget on prevention activities. Obviously, that would take into account a significant focus on improving our immunisation right across the board. I will hand over to Dr Robertson.

Dr A.G. Robertson: We continue to work on improving our immunisation services, particularly for that cohort. Within some of the subsets of that, particularly around meningococcal vaccination, for example, a number of programs have been established. A lot of this is funded nationally through the national immunisation program, and we obviously work very closely with the commonwealth to improve those figures. We also have supplemented, where required, issues with emerging diseases. For example, we have introduced our own program for meningococcal disease. There continues to be a lot of focus in this area and programs are ongoing to enhance the rates, particularly among very young Aboriginal children.

Mr K.M. O'DONNELL: I want to acknowledge the Chief Health Officer. From my perception, no other person in this state is under more pressure than he is. We hear repeatedly the phrase, "I refer to our medical advice." I want to say thank you and ask: are you okay?

[12.00 noon]

Mr Z.R.F. KIRKUP: I refer to public hospital admitted services on page 320 of the *Budget Statements*. I am going to move away from COVID for a moment. I have seen media coverage that something like over 20 specialists have been banned, suspended or investigated at Royal Perth Hospital over recent years.

Mr R.H. COOK: Sorry, could you say that again?

Mr Z.R.F. KIRKUP: There was a media article earlier in the year about 20 specialist doctors that were banned, suspended or investigated at Royal Perth Hospital. Is the minister aware of the issue?

[Ms J.M. Freeman took the chair.]

Mr R.H. COOK: I did not see the article, my apologies. What is brought to my attention in an operational sense is limited to some extent. I am obviously aware of discussions among senior staff at Royal Perth Hospital.

Mr Z.R.F. KIRKUP: The article quoted the number of 20, which seems like a very large number of specialists who have been investigated, banned or suspended from practice. Is there an insight about why that would be occurring at RPH? Obviously, the loss of expertise at RPH would be quite a concern for all of us.

Mr R.H. COOK: I might refer to the director general or East Metropolitan Health Service.

Dr D. Russell-Weisz: I recall seeing some articles some months ago about that. There is a very robust process for any medical practitioner, be they junior or senior—or any clinician, not just medical practitioners—who may be suspended from practice or may have their credentials changed. We do not take this lightly, but there is a proper process. Obviously, the most important thing is the safety of our patients and staff. I refer the specific question about Royal Perth Hospital to Ms Liz MacLeod, who is the chief executive of East Metropolitan Health Service.

Mrs E. MacLeod: We are aware of the media report and at the time we did an investigation, but were unable to identify the number of staff who had been reported as being investigated as the media reported. We have a number of staff investigated on an ongoing basis, and that is the normal practice we would imagine in any large health organisation. We were unable to make the numbers correlate to what was in the media.

Mr Z.R.F. KIRKUP: I appreciate that there are ongoing investigations into relevant complaints that are received. What is the number of specialists suspended or restricted from practising in general at RPH and/or across the system more broadly—not by name, but just the numbers?

Dr D. Russell-Weisz: Across the system the number would not be large. I cannot give the number off the top my head of junior and senior medical practitioners. I would have to say that it is a rarity. There would be some numbers across the sector, and that would be ongoing in relation to when practitioners need to be investigated for issues that had occurred, but it is certainly not the norm. I should say that this is not just focused on medical practitioners. There are systems in place for when incidents occur. We look for the systemic issues, and that is why we have a very robust system of root cause analyses done throughout our sector. I certainly would not want to give the impression that there is a huge cohort of senior medical practitioners out there who are suspended.

Mr Z.R.F. KIRKUP: I am obviously continuing with RPH under the heading "Public Hospital Admitted Services" in budget paper No 2. I am referring to the budget, because undoubtedly the Chair was about to pull me to that in a moment or so.

The CHAIR: I did ask the clerk where the budget line item was!

Mr Z.R.F. KIRKUP: I suspect so, Chair!

The CHAIR: Yes, you should!

Mr Z.R.F. KIRKUP: Given that RPH is obviously one of the state's, if not the country's, top tertiary hospitals, certainly from a teaching perspective, if a large number of specialists are no longer there because they have either resigned, been suspended or otherwise been prevented from practising there, does that present some issues in attracting juniors or students to get their practical experience at the hospital at this time—that is, the ability to attract those young doctors? I am only going on the media report, and I appreciate that Ms MacLeod said that the numbers did not stack up, but if there is a large exodus of doctors from a particular hospital, it is obviously cause for concern for all of us, with the ongoing impact it might have on the provision of clinical services and attracting students and young junior doctors to that facility. Have health services seen any impact that that might have had?

Mrs E. MacLeod: No, we have not. To clarify, we do not have a large number of doctors off at the moment who have been suspended. There are annual surveys run for junior doctors by the Australian Medical Association about their wellbeing. In fact, Royal Perth Hospital is usually at the higher end for junior doctors' wellbeing and morale. I have just had some advice about the new survey, and, again, we performed well in the survey and have done for some years. We continue to be oversubscribed with applications for interns, so there is absolutely no concern at all about attracting junior doctors to Royal Perth Hospital.

Mr Z.R.F. KIRKUP: Is there a large number of specialists or practitioners who have resigned their tenure at RPH or who refuse to practise there—that is, people who say they will work across the system more broadly, but no longer want to work at Royal Perth Hospital? Has that been an issue; and, if so, have a number of those people taken that decision? Can a number be put to that at all?

Mrs E. MacLeod: We have had no advice that there are people who are refusing to work at Royal Perth Hospital for the reasons the member has described. There are some specialties to which we have difficulty recruiting to the full contingent, but they tend to be specialties that my colleagues in other health services in the public sector would equally struggle to fill to a full contingent. We have had no advice that people refuse to work at Royal Perth Hospital for the reasons the member has described. There are obviously specialty services that do not align with what they might like to practise, but nothing for the reasons the member has described and that have been portrayed in the media.

Mr D.T. REDMAN: I refer to page 313 of budget paper No 2 and specifically the significant issues impacting the agency under the heading "COVID-19 — From Response to Recovery"—that is, issue 5.4 and issue 10. They refer to pharmaceutical and medical supplies. In asking the question, I highlight that a number of venues in regional

Western Australia ran out of key pharmaceutical and medical supplies. What is being done to ensure that this does not happen again, given it was quite clear that the supply chain broke down entirely and arguably put lives at risk?

Mr R.H. COOK: I will ask the director general to make some comments shortly about some of the specific measures that were taken to resolve the situation at the time. One of the things that has become utmost in people's minds is what would be described as a sovereign manufacturing capacity—that is, our ability to provide ourselves with the basic personal protective equipment and medical equipment necessary for us to be resilient in case we are completely cut off from our supply chains. A lot of work was done during early experience of the pandemic on sanitisers, face shields and other basic equipment we were struggling to get hold of. Some great Western Australian manufacturers stepped up to the plate at that time and made sure that we could get through that crisis point. I struggle to use the term "come out", because we not have come out of anything, but we are in a good place at the moment in relation to the pandemic.

We have bought ourselves some time, so what do we do now to learn those lessons? A range of discussions were undertaken at the national level with my colleagues, the other health ministers, about a national approach to sovereign manufacturing capacity of PPE and basic medical supplies. That did not go so well once the initial panic had passed. There were some initial good discussions. There was some investment in Victoria by the commonwealth around a mask manufacturing facility there, but by and large we did not make much headway in a national response. However, at a state level we are ensuring that we at least do some work. Recently the Treasurer put out an expression of interest under the market-led proposals program for local manufacturers in the supply and manufacture of PPE and other basic medical supplies. A range of companies have come forward to participate in that program to see whether we can fill that gap, for want of a better description. That process is being undertaken by the Treasurer and is ongoing. I will ask the director general to comment on what we did at the time and how we filled that space.

[12.10 pm]

Dr D. Russell-Weisz: It certainly was a challenging time. If we think back to February and March, there was a certain Thursday when things just dried up. We thought that the pathology reagents for tests would be coming through. Basically, we were told that our order would be here the next week, but then the supply from the United States dried up that afternoon. We had a team working around the clock to make sure that Western Australia was safe, because we wanted our staff to know that there were no issues with PPE, reagents or ventilators. A huge amount of work was done by a team within the Department of Health, and also by Liz MacLeod, who is sitting behind me, and her team, in getting some of the equipment ready, and also scoping up the number of beds from about 121 critical care beds to over 630 potential critical care beds when we saw the devastation this virus was causing in Europe.

My focus was on PPE and to make sure we opened up new supply chains that we could rely upon so that we would get enough. Our health support team went from having about two warehouses to four or five now. We just wanted to get enough PPE. To give members a sense of security on PPE—I will not go through every line item—for face shields, we were really struggling, and we now have 132 weeks of supply based on current usage; and, for N95 masks, we now have 227 weeks of supply. We make no excuse for that, because we know that if we do get a COVID-19 outbreak, the usage will increase significantly, and we need to be prepared if in the future our supply chains potentially dry up. We wanted to secure enough PPE. We have also secured enough ventilators. The ventilators came in through a period. We saw around the world what was happening with people requiring respiratory support in intensive care units. We went through a methodical process of buying more ventilators, in conjunction with our clinicians.

We set up a clinical group on the use of PPE, led by an infectious diseases clinician. We wanted the PPE to be used properly and appropriately, and we wanted it to adapt as we learnt about the virus. Our whole focus was on making sure we had enough PPE for every hospital in the state, irrespective of whether staff were at Tom Price or Fiona Stanley Hospital. We also worked with private hospitals, the Australian Medical Association and the WA Primary Health Alliance to make sure that they were comfortable securing their own supplies.

There were some shortages of pharmaceuticals in the early stages. At times there has been a potential shortage of pharmaceuticals coming in. That is still occurring in the private sector. However, we are working very much with the Pharmacy Guild of Australia to make sure we have enough supply of pharmaceuticals going forward. A huge amount of effort continues to be made in this area. We are not working 24 hours a day, but we are making sure we have enough supplies well into the future, whether there is a vaccine or not.

Mr D.T. REDMAN: The director general referred to the Pharmacy Guild and those in general practice, who are key, frontline people representing the pharmacies in regional Western Australia. Why are they not represented on the high-level discussions that occur with government about the COVID-19 response, particularly given the frontline nature of their work and the need to have sufficient key medical supplies for those in many cases isolated areas that need to have the drugs that have been prescribed?

Mr R.H. COOK: It is a great question. The forum I described before was an internal decision-making process of government. One of the pleasing aspects of the pandemic experience has been the way all elements of our local health system have come together, particularly with the primary care sector. I have been working also with the Pharmacy Guild on how we respond from a medication supply point of view. Everyone has done a great job. As recently as last week, I held a forum with the primary care sectors, the Australian Medical Association, the WA Primary Health Alliance, the Royal Australian College of General Practitioners, the Aboriginal medical services and several of my team, to discuss different aspects of how this is unfolding, and to reflect on how things went as well. For instance, PPE was a huge problem for GPs in the early days and, quite frankly, the commonwealth did not step up to the plate. We would expect it to do so because it is the one responsible for primary care. The state government had to provide reassurance to our GPs that we would be able to protect them if we needed to.

In addition, we are working closely with the Pharmacy Guild around the continuation of medication supplies. I distinctly remember walking into a chemist one night to buy some products—I cannot remember what I was buying—but a chap leapt out of a car, keeping the engine running. That was about the seventh pharmacy he had been to. He had a handful of coins and he was trying to find some Ventolin for his daughter but could not find a chemist that still had supplies of Ventolin. The Pharmacy Guild has described to me that Australia is at the end of the global supply chains and Western Australia is at the end of the national supply chains. That is a scary situation. It is a scary situation for the system manager, the director general, and it is a scary situation for me, but imagine that parent being unable to provide Ventolin to his daughter. We have to find a better way to make sure that Western Australia becomes more resilient.

Recently the Pharmacy Guild put a proposal to us that we have a reserve in Western Australia, so that as new orders come in and stock comes out, basic medical supplies are preserved that pharmacies can depend upon in case of this potentiality. I am pleased to say that the department is conducting a feasibility study to see whether that is a way to move forward. I am picturing that in the member for Warren–Blackwood's mind is pharmacies working in small communities that had run out of PPE, hand sanitiser and basic medical supplies and were wondering how they would be able to serve the community. In many cases, they were the only medical-like facilities because the older GP might have had to close shop because he or she did not want to be put at risk. Those are all elements of how we have to learn from the experience and do it better. That personal experience I had really drove home to me that we have to make sure that does not happen again.

Mr D.T. REDMAN: The sharp point of my question goes to the seriousness of the issue, given that pharmacies and the like are critical to people's medication, in rural and isolated areas in particular. I seek the minister's response as to why the Pharmacy Guild and/or the AMA and/or representatives of general practice are not included in the government's response committees to have input on things that both my question and the minister's response have identified as critical issues.

Mr R.H. COOK: I guess the short answer is that they are. I meet with them, but I know Russ's team meets with those groups constantly as part of their advice to us. I might ask him to provide some further detail. Apologies, member.

[12.20 pm]

Dr D. Russell-Weisz: I think, again, going back to February and March, we recognised that there were some key groups and key workstreams we had to have a focus on: aged care, mental health, primary health care and prisons. We went through and looked at what was coming and how we should address each one of those, and we set up individual workstreams. When we needed personal protective equipment, people from the private and public hospitals and the public health system represented by me and representatives of the Australian Medical Association all sat around and said, "How are you going to get PPE?" We offered to get PPE for the whole state. At that stage, we did not, but we actually have enough. If any aged-care provider ran into real strife, we would have the ability to provide PPE to them. Indeed, we have provided that. One of the things that was brought up by the WA Primary Health Alliance at the recent primary healthcare forum was that some of the after-hours doctors or locum private general practitioners are having difficulty getting PPE. Next week, we will be setting up a meeting with Dr Robyn Lawrence, the state health incident controller, and WAPHA to make sure that if anybody is falling through the gaps, we know where they are. For example, if a group of pharmacists were to come to us and say, "We cannot get PPE anymore and we want the Department of Health to provide it to us", no doubt they would pay for it, but we would provide it. We would just need to increase our orders. We have really good visibility over where we are ordering PPE from.

We have done some specific work on pharmaceuticals. I refer to the minister's point and the ventolin example. We have done really specific work on that, and we are working with Andy's team in the Department of Health and our Chief Pharmacist to see if there is an opportunity to bring medications in and store them here. That is not just for the public sector but for pharmacists in the private sector as well. What I am saying is that we are open to all options. We did offer at the time—not to the pharmacists but to a lot of others—to purchase PPE for the sector. That was not taken up, and that is fine. But we have recently found some gaps, and we are very open to providing for them.

Mr S.A. MILLMAN: I refer to budget paper No 2, page 338, and the commonwealth contribution to the state pool special purpose account and the National Partnership Agreement on COVID-19 Response. Has the commonwealth met its obligations to provide 50 per cent of the funding to WA?

Mr R.H. COOK: Member, thank you very much. The commonwealth has met its obligations. I think that one of the successes has been that the partnership with the commonwealth has worked on these larger level discussions. The commonwealth has been a good partner in the national partnership for shared payment for quarantine or things of that nature, and also for the private hospital subsidy or support arrangements. The commonwealth has done a good job in making sure that our private hospital sector did not basically disappear and go out of business as a result of the pandemic. However, just on the issue of the commonwealth–state relationship, I think that the COVID-19 pandemic has really demonstrated just how unintegrated and disjointed our whole health system is. The commonwealth runs primary and aged care and we run hospital care and public health, and the gaps were absolutely yawning. Australia really has been done a disservice as a result of that lack of integration—that lack of "joined-upness" in our health systems, particularly around aged care. I think, if we do nothing else coming out of this global pandemic, we need to learn and respond in a transformational way and change our health system in Australia to ensure that it meets the needs of the community into the future.

The separation of responsibility in health care invites a protectionist approach whereby we look at each different part of the puzzle, make critique and essentially say, "That has nothing to do with us." Before COVID-19, our system was already out of balance and heading to the rocks anyway—let us face it. Our aged-care sector in particular was marginal at best. This has demonstrated that once we deliver a shot to that system, it is fundamentally flawed and fragile and is reeling as a result of the pandemic. If we look at other health systems around the world, particularly in the United States, where we see a fragmented system without the appropriate levels of investment in different areas, we see how badly they perform in relation to COVID-19. There have been almost a quarter of a million deaths in the United States. One of the things we have to do is actually decide as a country how we are going to do things differently. I think we have to have an honest conversation about whether states are better deliverers of service than the commonwealth and whether we should be taking over responsibility for aged care.

We have to remember that the aged-care sector is the fundamental weak point in our health system. The Royal Commission into Aged Care Quality and Safety made an observation on 19 September—so these numbers are a bit old—that 844 people had died in Australia as a result of the virus. Of these people, 629 were living in aged-care homes at the time of their death, although many of them died in hospital. As of yesterday, 20 October, there have been 683 deaths. We listen to the critique from the commonwealth government about what is going on in the states, and we say, "My God, look at yourselves!" Josh Frydenberg said that the Victorian government demonstrated a fundamental failure of public policy because of the way it managed the pandemic.

The commonwealth is responsible for, funds and regulates the sector in which there have been 683 deaths. If the failure is anywhere, it rests solely with the federal government. I think it is time that we say enough is enough. Clearly the system is broken, clearly the commonwealth is incapable of running the aged-care sector, and clearly we need to find a new way to regulate, finance and support that sector. It staggers me that we have a situation in which someone like Mathias Cormann can provide an ongoing critique of different governments. He is like the worst of sporting spectators. When their team wins, they claim the victory, but when they see their team not performing at their best in particular functions, they become Monday experts. These federal politicians have absolutely no operational role to play and refuse to accept responsibility for the deaths that occurred on their watch in the sector that they regulate and fund, yet seem to regard the critique of state governments and their management of COVID-19 as a national sport or national pastime. The other day, Mathias Cormann said that in Western Australia —

> "We haven't really set up the systems and processes to minimise the risk and respond to it as swiftly as we can on the basis that we believe that our border is going to keep us secure. Well, it might, it might not."

This is just plain wrong.

Mr S.A. MILLMAN: It is gratuitous.

Mr R.H. COOK: It is gratuitous, it is ignorant, and it lacks a fundamental understanding of all the work that has gone on in public health to ensure that we learn from the lessons of this and make sure that we have outbreak plans that can respond, whether in an aged-care, school, community or religious setting. A large amount of work is going on in this state to make sure that we are ready for any outbreaks, which is really what Dr Robertson was referring to when he talked about his satisfaction with other states. The outbreak planning and preparation across the country have been outstanding. The one player that has fundamentally failed the people of Australia is the federal government. It regulates and funds residential aged care, which is the area that has most let down the people of Australia and where we have seen the most deaths. It is time we had a conversation about how we improve the system and it is

time that the commonwealth contemplates how well it can transition residential aged care to the responsibility of the states, because we deliver services, we do it better than the commonwealth, and we can make sure that sector performs better for the people in those facilities.

[12.30 pm]

Mr K.M. O'DONNELL: I refer to page 318, the heading "Service Summary", and the fifth line item, "Aged and Continuing Care Services". In the budget for this year, every one of the 11 items under that heading has increased in value from the 2018–19 budget, except for the fifth item, "Aged and Continuing Care Services", and the tenth item, "Health System Management—Policy and Corporate Services". The fifth item has decreased by 10 per cent, or nearly $36 million, from 2018–19 to this year. In the forward estimates to 2023–24, every one of those items has gone up in value, except for the fifth and tenth items. Aged and continuing care services has gone backwards by $5.5 million from this year's budget. How do we expect to offer a first-class service to the frail elderly and to young people with disabilities when other services are getting more money allocated to them and are therefore able to provide what they can now and improve what they will have, whereas funding for the fifth item is just going backwards?

Mr R.H. COOK: I thank the member very much for that question. It really goes down to the point of an important transition process, which is ongoing at the moment, as a result of the introduction of the National Disability Insurance Scheme. Previously, many people received a home and community care package—it used to be called HACC—which was a jointly funded program between the commonwealth and the states. Under the national disability support services, those who receive a home and community care package under HACC and are under the age of 65 will be transitioned to the NDIS, and those who are over the age of 65 will continue to receive a community care package. Therefore, I am assuming that the reduction the member sees over that period of time is to do with that transition and the split with that particular funding. I will invite the director general or one of his advisers to provide more granularity on that.

Dr D. Russell-Weisz: I think the minister has answered that very well. I have nothing else to add. I will ask Mr Anderson whether he has anything to add.

Mr R. Anderson: No. The minister has answered that correctly.

Mr D.T. REDMAN: I have a minor question on the transition from what were essentially state-controlled arrangements to federal arrangements, which the minister's government signed off on.

Mr R.H. COOK: Is the member talking about the NDIS now?

Mr D.T. REDMAN: Yes, and home care packages and the like. There have been a number of transitional challenges in the rollout of that, into regional locations in particular. It has been at the front line of a lot of questions and a lot of issues that I have raised directly with Health when I have been trying to get assistance. Gaps have emerged in fulfilling the service level that was previously delivered under the WA Country Health Service. I am wondering whether there was scope to have an audit or something like that at this point in time that would give a very clear readout of the service gaps that are emerging and the challenges that people face in what is now supposedly a bedded-down transition. I think we all understand that transitions are always challenging, and I respect that, but now that that is, in many cases, actually bedded down, is it not time to have an audit of that just to do a check step that there is in fact the level of service that was provided previously? I do not think there is the same level of service; there are some gaps that have not been identified.

Mr R.H. COOK: I think that is a really good question and I acknowledge the member's advocacy, particularly in the Mt Barker area, and particularly for services for aged people who are living in their own home. In terms of regional home care and aged support, I will invite the chief executive of WACHS to make some general comments and hopefully that will clarify the member's question. In relation to the audit, again I might rely on Jeff Moffet to make some comments.

Mr J. Moffet: Thank you, minister. As the member indicated, there is a program of transition from the old HACC to the Commonwealth Home Support Programme. WA Country Health Service has taken a position—in fact, I guess it is a government position—to ensure that the choice and control elements of the commonwealth reforms are respected and that when we can make way for private providers in regional settings, we do not unfairly compete with them. Within WA Country Health Service, we have ensured that that is underpinned by a program that we will not leave clients with no services when we are the current service provider, so we are continuing to provide a safety net on both the NDIS and the CHSP reforms.

CHSP has transitioned in the upper and lower south west, as the member may be aware. At this stage, that is the only part of the state in which we have had a full transition of service, and that appears to have gone very smoothly. We have done some surveys from clients as well, who appear to be, in general, very satisfied with the process of transition and the new service arrangements. I think it is correct to say that the level of service in the new CHSP is not always

as good as it was under the old program. Part of the reason for that is that the pricing from the commonwealth and the CHSP does not account for regional price differences or economies of scale or cost differences, whereas in the past the HACC program allowed a macro approach—it was not an individual-plan approach—to management of demand and the sorts of services that were required; for example, we could facilitate increased meals or increased transport, subject to the circumstances of clients at points in time. That is no longer. The flexibility appears to have reduced on that front because of individual plans and the fact that the pricing does not allow for regional cost factors.

Therefore, our observation is that I suspect, in time, the CHSP—the old aged-care HACC program—will penetrate further and further into the great southern and midwest regions and, potentially, further north. The whole of the Pilbara has transitioned to CHSP—in the past, HACC was transitioned as well—so the Pilbara has been operating in a private non-government organisation capacity for quite some time quite successfully. It is a part of the state in which one might have thought that providing supply was a significant issue. I suspect that WA Country Health Service will need to maintain its presence in some areas over time. It is inevitable that perhaps the outer wheatbelt and parts of the Kimberley and the goldfields may not see enough provider interest emerge for full transition to the markets. Time will tell on that front.

The NDIS is a very similar program picture, if you like, but much more transition is going on across the state. As the member knows, our role in the NDIS is more around the provision of therapy services, so it is a narrower clinical role. Again, our position is very much to ensure that everyone who is enrolled in our program and is getting disability support continues to get support. WA Country Health Service is not involved as a provider in the program. We are seeing some good engagement from the Aboriginal medical services sector, which is really pleasing. Some good work has been done by the department and our teams around getting the Aboriginal medical services sector involved in disability care. Again, as we get more remote from Perth, markets do prevail, and I suspect there would need to be some adjustments to the commonwealth program to get providers to service the areas that are currently unviable to service under the current model.

In terms of the question whether it would be worth doing an audit, we have done some reviews ourselves. We work closely with the department on this issue. At the moment, we have a sense of where the gaps are, but I would definitely support the work, if the minister is happy to do that, to try to quantify and formalise at this point in time or approximately two years down the track how we have seen the market respond and at what stage the transition has got to.

Mr D.T. REDMAN: I am interested in a response from the minister on that. I take it from Mr Moffet's comments that WACHS will offer to be a service provider of last resort, when thin markets mean that we are not able to get sufficient supply of service in the market-led options that are there; and, by extension, an audit would be really appropriate just to see how far that extends. Although we can intuitively recognise that it is in the outreaches of the wheatbelt and the outreaches of the Kimberley and Pilbara, I suspect it is actually much closer to home.

[12.40 pm]

Mr R.H. COOK: I think it is a good suggestion, member. I was going to make the observation that the WA Country Health Service is always the provider of last resort, whether it be primary care, aged care or whatever it may be. I think Jeff's team does an amazing job providing health care in the bigger —

Mr D.T. REDMAN: But that is not an acknowledgement that the minister has made, because I have asked him this question before.

Mr R.H. COOK: Sorry?

Mr D.T. REDMAN: In respect of the "provider of last resort" comment, we had a conversation in this house during debate on a motion and that was not the response the minister gave, so acknowledging that WACHS is a provider of last resort is a shift from that commentary.

Mr R.H. COOK: I am sorry, member, if it appeared that I was being evasive last time.

Mr D.T. REDMAN: Never, minister.

The CHAIR: Through the Chair, members.

Mr R.H. COOK: I am just trying to nail down the answer to the member's question to his satisfaction. I acknowledge that WACHS is the provider of last resort in pretty much every aspect of health care, whether it is aged care, primary care, mental health care or whatever. We will not let regional Western Australians down if the provider is not there.

On the member's other question about an audit of this stuff, I think that is a pretty sensible suggestion. At the director general's urging, I defer to him.

Dr D. Russell-Weisz: We do hear about, and we certainly see, in not only WA country areas, but also the metropolitan area some of the challenges with the National Disability Insurance Scheme and some of that transition. We have

in the department—Jeff was referring to this—a chief allied health officer who oversees the link with the NDIS. Certainly, if the minister wishes, Dr Williamson can make some comment on that, but we will take that on board. Whether we look at a formal audit or at specific areas in WACHS, we are happy to look at it.

Mr Z.R.F. KIRKUP: I refer to the works in progress outlined on page 329 of the budget papers and the line item for the expansion of Peel Health Campus. Has any work been undertaken by the Department of Health, the minister's office or the South Metropolitan Health Service on taking over the management of Peel Health Campus from Ramsay Health Care and putting it back under South Metro?

Mr R.H. COOK: Obviously, the health services at Peel Health Campus have been provided through a public–private partnership model since 1998. The contract to provide hospital services was novated to Ramsay Health Care in 2013. The initial 20-year term of the contract came to an end in 2018 and the state executed a five-year extension to the current contract in 2016, effective in August 2018, which means that the contract will now end in August 2023. There is no provision for further extensions under the current contract. There are three years remaining before the expiry of the contract term, and the state government will need to undertake due diligence in reviewing the terms of the contract with Ramsay, as well as the needs of the entire Peel region, with a continued focus obviously on making sure that we provide safe and quality health care to the people of the Peel area, an area that the member has observed on a number of occasions is rapidly growing and will therefore need a greater volume and a high level of healthcare services.

All these matters need to be considered in due course. Obviously, because the contract is coming to an end, a range of decisions have to be taken, including whether we go to market, whether those services come back in-house or whether we do some other form of policy initiative. All those things are being considered in the appropriate time lines and we will have to make a decision in due course.

Mr Z.R.F. KIRKUP: As part of the decision-making process in looking at options available to government when the contract comes to an end, when would the state start anticipating the options available to it? It will obviously come to a head in August 2023, but when will the state start looking at its options for the management and operation of that hospital?

Mr R.H. COOK: I understand that work is being undertaken in the department and with Treasury as we speak. That will take some months. As the member will appreciate, it is a big contract and a big piece of work, so it will go on for a little while yet. I do not have a time line for the member.

Mr Z.R.F. KIRKUP: Obviously, I am agnostic about who operates hospitals, as I have said in this place a number of times. The time line for transition is of interest. It would be the first time in some time that the operations of a publicly owned but privately run hospital were taken in-house, if that option were to be exercised. Is there usually quite a long lead-up time to that transition process? For what it is worth, there is a level of uncertainty within the community about what that will look like post-2023. I imagine that the government and South Metro will move to try to allay those concerns sooner rather than later.

Mr R.H. COOK: Yes, and I assume that in the context of a big contract like this, there will be a big lead-up time anyway. I recall when it was run by the previous crowd, so there has to be a period of transition. In the event that it goes to another operator, the current operator will have to leave the asset in good condition, and that includes some of the medical equipment, which involves contributing to a sinking fund as part of the renewal process. It is a big body of work and I assure the member that a range of government ministers will impact on that decision-making process. That is in the future; it is not before us at the moment.

Mr Z.R.F. KIRKUP: I appreciate that it will involve a large body of work by government in the lead-up to the decision-making process for the renegotiation or non-renewal of the private operator's contract. How long did it take for the government to make a decision about the management contracts with Serco Australia at Fiona Stanley Hospital?

Mr R.H. COOK: That is a really good question. I defer to the director general, if I may, Chair.

Dr D. Russell-Weisz: I can get the exact dates for that, but that was a movement or a transition of some of the services in the Serco contract at Fiona Stanley Hospital back to the state. I think, from recollection, it was not that long ago. There were 650-odd staff who were moved back. Predominantly, the work that they were doing there was the work that they would be doing in the future. It certainly needed a lead-in time, but it was at least two years. That is when we started it. I think Paul might have the exact dates when he started the transition process, which is well started now. The contract was obviously signed in 2011 and this review was done after the first 10 years, so we had to be ready for 2021. From recollection, it is 4 August 2021.

Mr P. Forden: The transition program was around 20 months for transfer. We had 20 months. If we had to do it quicker, we would have done it quicker. If we had more time, we would take more time, but 20 months is what we are running with at the moment.

Mr Z.R.F. KIRKUP: Just in case I missed it, obviously a body of work was done before the government made that decision. That is what I am trying to get to in understanding that time line. How long did it take from when

the work was initiated until the minister and the cabinet made a decision? Obviously, there is a transition post, and I appreciate that, but what was the lead prior to cabinet coming to that decision?

Mr R.H. COOK: The director general.

Dr D. Russell-Weisz: Again, I can give the member the exact time on notice, but I think we did work at that time on looking at all the options to present to government. It took up to about six months. It was quite complex because the existing provider was staying, but, from recollection, there were 25 services, some of which were then moved over.

Mr D.T. REDMAN: I refer to paragraph 37 on page 317 of budget paper No 2, which states —

> To support the implementation of the *Voluntary Assisted Dying Act 2019*, the Government has heavily invested in ensuring appropriate palliative care services are available for Western Australians. The table below outlines budgeted expenditure on palliative care for 2020-21 and across the forward estimates period:

Can the minister please provide a breakdown—it might be by way of further information—of the regional component of that? I understand that those numbers are the investment in the service. They are not a capital spend; they are a service delivery spend. Can the minister break that down into a spend in the WA Country Health Service subregions?

[12.50 pm]

Mr R.H. COOK: I will let the chief executive of WA Country Health Service answer that question in the first instance and then talk about the supplementary information the member is seeking.

Mr J. Moffet: The current uplift in investment for palliative care is $34.7 million over time and $5 million in capital for the creation of palliative care capacity at Carnarvon Multi Purpose Service. The program has been rolled out over a number of years, but last year was the first year the program was expanded. There has been an increase of approximately 28 full-time equivalents across every region. The program is at district level now, so the focus of the service expansion is on 20 districts across country health; whereas, previously they were largely regional teams. The multidisciplinary teams increased in size and capability last year, and will continue to do so this year. That will include bringing on board part-time palliative care specialists to service each region.

There is GP generalist participation as well from GPs resident within each region. We are establishing some digital elements to the program, so that as palliation in the home increases, we can support families with palliative care issues as they arise 24 hours a day, seven days a week through the use of iPad technology and existing systems and relationships. That program is currently in development; it has not been established yet.

An important part of the program is the home support package for people palliating at home. If they require home support options, we are able to provide short-term grants to assist them with daily living activities, personal care needs or transport. There are a lot of aspects to this program, which really started with strengthening in the districts. Over the next few years, as part of that $37 million, significantly more palliative care will be provided in the home.

We have made very good progress in what has been a difficult year because of COVID, but we have had success in every region to the point that there are appointments in every region now. That has driven the development of 20 district programs over the past 12 months. We really have only another 12 to 18 months in which to implement the digital and virtual care side.

Mr D.T. REDMAN: To help the minister, I seek over the forward estimates a breakdown of budgeted figures for both hospital-based and community-based palliative care for regional Western Australia, broken down by the WACHS subregions, including the dollars and the FTE.

Mr R.H. COOK: Yes.

The CHAIR: Minister, is that okay?

Mr R.H. COOK: It was beautifully described by the member.

The CHAIR: I will allocate it supplementary A8, but the minister has to describe it. Please tell Hansard what information you understand you will be giving.

Mr R.H. COOK: Chair, we will provide a breakdown of expenditure on palliative care services in the WA Country Health Service delivery subregions by dollars and FTE.

Mr D.T. REDMAN: Across the forward estimates.

Mr R.H. COOK: Across the forward estimates.

If I may, the outer forward estimate might not be drilled down to the same clarity as 2020–21 or 2021–22.

[*Supplementary Information No A8.*]

Mr K.M. O'DONNELL: I refer to page 321, paragraph 4, "Mental Health Services" and mental health presentations. I understand that mental health presentations to emergency departments have been increasing, which is contributing to ambulance ramping. Can the minister confirm that that is the case, and by how much it has increased?

Mr R.H. COOK: Thank you, member. The member is quite right. The number of people with mental health issues presenting to our emergency departments has increased significantly. In addition, there has also been an increase in the complexity of conditions in people who are presenting to emergency departments, which is putting significant pressure on emergency departments. The member will recall that over the early period of the COVID-19 pandemic, there had been a significant drop in the number of people presenting to emergency departments, particularly people with mental health issues. That situation has now completely reversed. It is true to say that there is now a significant increase in the number of people presenting to EDs compared with the levels before the COVID-19 pandemic.

That said, the transfer of care rate results in terms of ambulance presentations continues to be good. The transfer of care performance in the metropolitan area has improved and is 70.9 per cent in this calendar year, which is up from 69.2 per cent in the last calendar year. In this calendar year to date, the median ambulance transfer of care time remains at 22 minutes, which is well within the target time frame of 30 minutes.

We have found that we are significantly constrained by the number of beds and the capacity to admit people who are presenting with mental health conditions for further care. That means people have to stay in emergency departments for between 24 to 72 hours, and that sometimes they are chemically constrained. The government is fundamentally concerned about this and has been doing a lot of work in this area. I meet with the director general of Health and the Mental Health Commissioner on a weekly basis to talk about the challenges facing emergency departments. We continue to do a range of things in our EDs to ensure that they are better equipped to deal with those people presenting to emergency departments.

I will go through that. For instance, a mental health observation area has opened at Joondalup Health Campus. As I said earlier, that ED has been expanded by 12 bays. There is a $19 million expansion for the ED at Sir Charles Gairdner Hospital, including the addition of a behaviour assessment urgent care clinic, which will be available for people suffering a drug-induced condition. It will be a different place in which people can be cared for. A mental health observation area, as well as a behaviour assessment unit, have been installed at the Royal Perth Hospital. In particular, a safe haven cafe will be set up at Royal Perth Hospital Perth. It will be a low-key, or de-escalated area, where people suffering from mental health conditions can go to get care in a more relaxed and comforting environment than in the ED.

There is funding for a mental health observation area at Midland Public Hospital as well. Again, that will be four beds and one chair bay, and it will enable the hospital to better deal with mental health patients. I am most excited in particular about a pilot program that is to be undertaken between health service providers and some community mental health providers, called assertive response teams. Assertive response teams will make sure that people who continue to suffer from an ongoing mental health condition are moved out of an ED environment are cared for in the community and connected up with community services to make sure that they do not go back into crisis and tip back into our EDs. That unit will play an incredibly important role in making sure that people with mental health conditions get the care that they need in our emergency departments without being rather unfortunately referred to as "frequent flyers". This is all part of continuing to expand the bandwidth of what is done in EDs and is also changing way in which we provide services so that people can move away from the hospital care environment.

The CHAIR: We are dealing with division 23, Department of Health. The question is that the appropriation be recommended.

The appropriation was recommended.

Meeting suspended from 1.00 to 2.00 pm