Division 21: WA Health, $5 313 300 000 —

Ms J.M Freeman, Chair.

Mr R.H. Cook, Minister for Health.

Dr D. Russell-Weisz, Director General.

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

Ms A. Kelly, Assistant Director General, Purchasing and System Performance Division.

Dr A.G. Robertson, Assistant Director General, Public and Aboriginal Health Division.

Mr L. McIvor, Assistant Director General, Strategy and Governance.

Mr P. May, Executive Director, System Finance; Chief Finance Officer.

Mr R. Anderson, Executive Director, Information and System Performance.

Mr J. Boyle, Chief Executive, PathWest.

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

Dr R. Lawrence, Chief Executive, North Metropolitan Health Service.

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

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

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

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

Mr N. Fergus, Chief of Staff, Minister for Health.

[Witnesses introduced.]

The CHAIR: This estimates committee will be reported by Hansard. The daily proof *Hansard* will be available the following day. It is the intention of the Chair to ensure that as many questions as possible are asked and answered and that both questions and answers are short and to the point. The 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 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, 31 May 2019. 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.

Minister for Health, you may win the prize for the number of advisers this year! Member for Dawesville.

Mr Z.R.F. KIRKUP: Minister, I refer to the works in progress on page 282 of budget paper No 2. As the minister would expect, I am going to talk about Peel Health Campus. I am keen to understand why there is no money in the forward estimates, from 2020 onwards, for the emergency department for Peel Health Campus.

Mr R.H. COOK: I am just trying to find it, member. Please bear with me. Under "Metropolitan Plan Implementation Peel Health Campus Development Stage 1" the member will see that there is $5 million in relation to the works which are currently ongoing. After that, there is a further $5 million in emergency department reconfiguration, with $3.9 million in 2019–20 and $1 million in the estimated expenditure for the 2018–19 year. In addition to that, the member will be aware that both the federal government and the federal Labor opposition made commitments in the period preceding the federal election. I think the federal government announced a $25 million commitment, which includes funding for community mental health and eating disorders, but the lion's share of that will be going to further works at the Peel Health Campus. I think imaging was an aspect of that as well. We have to fully understand the nature of that. I do not think that we have been formally informed about the Peel Health Campus commitment from the federal government, but we are looking forward to having those conversations in the very near future to get a better understanding of how the commonwealth wants to spend that money.

As the member will be aware, there was no major redevelopment of the Peel Health Campus under the previous government; in fact, the assets were essentially run-down over that period of time. We are committed to making sure that the hospital meets the needs of the community, particularly through the expansion of the emergency

department. During my visits there, it struck me that the waiting area in the emergency department is particularly deficient, so we are looking to do some major works there to make sure that people are more comfortable in that space. I think there is also going to be further work in relation to short-term beds. I will invite the director general to make any other comments, if he thinks it useful.

[10.30 am]

Dr D. Russell-Weisz: I think the minister has covered everything. We are obviously awaiting further information in relation to the commitment from the federal government. Obviously, the priority at the moment is to expand and refurbish the ED, the imaging department and community mental health.

Mr Z.R.F. KIRKUP: For some clarification, minister: I know that we are talking about the federal opposition and commonwealth government commitments. I refer to page 108 of the federal Liberal Party's budget paper No. 2 for 2019–20. There is $25 million sitting there now. It is not a commitment; it is budgeted. It is cash in the bank. That is done. I am keen to understand where that $25 million sits in the transaction between the commonwealth and the state. Does this government have it, and what is it doing with it? Secondly, can the minister confirm—as per my previous question—whether there is any money going towards the emergency department in 2020 onwards?

Mr R.H. COOK: Yes. It is in the budget, so we are confident that we will get that money. The money has not been transferred to us. The member will recall that the federal budget was delivered after our budget cut-off. We cannot represent that money in our budget given that the federal budget was delivered after our budget cut-off period. I think that money will come. I know it will come. Greg Hunt rang me and told me it would come. Clearly, that money will be utilised in the very near future, but, obviously, that is subject to the formal processes of the passage of the budget in the federal Parliament and the transfer of that money to our account. From that point of view, we can understand that will be the lion's share of the work in 2019–20. We need to understand what that flow of dollars is and then make sure that we program that work as quickly as possible.

Mr Z.R.F. KIRKUP: I appreciate the minister's response. The emergency department reconfiguration stated under works in progress on page 282 does not show a dollar going beyond 2020. Is there any money in the budget in front of us for the Peel Health Campus emergency department in 2020 onwards; and, if so, how much is it and what does it do?

Mr R.H. COOK: As the member would be aware, our total commitment for asset investment in Peel Health Campus is $10 million. That $10 million is in front of the member. It includes the works that were associated with the development of stage 1. I think that was a bunch of CCTVs, the car park expansion —

Mr Z.R.F. KIRKUP: There is nothing for the ED.

Mr R.H. COOK: No, that is right. The lion's share of the emergency department reconfiguration will take place in 2019–20. The budget shows us that $1 million of that expenditure is in 2018–19. I am interested to hear from the officials about that work, but the lion's share, $3.9 million, will be spent in 2019–20 to bring about a long-awaited upgrade of the emergency department. Thank goodness we have a McGowan Labor government —

Mr Z.R.F. KIRKUP: The minister does not have to tell me it is long awaited; we know it is.

Mr R.H. COOK: That is right. We had to wait a full eight and a half years to make sure that —

Mr Z.R.F. KIRKUP: I am keen to understand now, in the budget in front of us, whether there is any money for the ED —

The CHAIR: Member! I will talk over the top of you quite easily.

Mr Z.R.F. KIRKUP: You do it very well.

The CHAIR: Yes. So, let the minister finish.

Mr R.H. COOK: She talks over me all the time! When the Liberal–National government was in power, it did not spend a jot on this hospital.

Mr Z.R.F. KIRKUP: I am talking about this budget, minister.

Mr R.H. COOK: That is right. There is $3.9 million for the expansion of the ED in the form that we discussed, which is growing the number of bays, improving the waiting area and making sure we have better patient flow. Only one government is doing that. Only one government is spending on Peel Health Campus and that is our government. The former government failed to do it over eight and a half years. I remind the member that the previous expenditure on asset investment at that hospital was under the previous Labor government. Then we had eight and a half years of drought and the former government essentially running down the asset.

Mr S.K. L'ESTRANGE: Let us move on to the hospital, minister.

Mr Z.R.F. KIRKUP: Not me.

Mr R.H. COOK: We are the first government in eight and a half years to invest in that hospital. That is to the Liberal Party's eternal shame and, I am sorry, member, but that is part of the Liberal Party's legacy in office. The fact of the matter is we are investing in this hospital, and the member should be providing credit where credit is due.

Mr S.K. L'ESTRANGE: One of the issues with the emergency department is the waiting area and the separation of children from people who may come in affected by alcohol and other drugs. It is a pressing issue. The member for Dawesville is concerned about it and no doubt the member for Mandurah is concerned about it. Bringing it back to the government's budget, the government has one more budget to go before the next state election. Let us focus on the now, not the past. Is there a commitment to make sure that we can fix up that ED as quickly as possible, and how much is the government allocating to it?

Mr R.H. COOK: We have allocated $3.9 million this year alone, so we would anticipate those works starting straightaway. I invite the chief executive of south metro to make some comments about the plans. There is a kids waiting area in the current one. It is about the size of a phone box.

Mr S.K. L'ESTRANGE: We have to move through the main waiting area to get to it —

Mr R.H. COOK: It is completely inadequate.

The CHAIR: Members! There is no general discussion.

Mr R.H. COOK: Chair, I invite Mr Forden to make comment.

Mr P. Forden: Planning is already underway. Construction commences in January next year and is aimed to be completed by around July next year.

Mr Z.R.F. KIRKUP: I appreciate the response. That was announced in May last year and it will be completed in July next year; is that correct?

Mr P. Forden: Yes.

Mr Z.R.F. KIRKUP: I want to clarify: there is no money from 2020 onwards for the ED?

Mr R.H. COOK: As the member is aware, the federal government has made a $25 million commitment.

Mr Z.R.F. KIRKUP: From this budget in front of us now, minister.

Mr R.H. COOK: We are completing the work by July next year, so why would there be money in the budget after that?

Mr Z.R.F. KIRKUP: We are done. From the government's perspective, Peel Health Campus is done. Can I just clarify?

Mr R.H. COOK: That is a ridiculous question to ask. The budget is in front of the member. He has the opportunity to ask questions about this budget. We have made a commitment around expanding the ED. If the member wants to commit to expanding it even more, that is the member's political prerogative.

Mr Z.R.F. KIRKUP: The minister does not think that the government has —

The CHAIR: Member, through the Chair.

Mr Z.R.F. KIRKUP: Does the government have a commitment to expand Peel Health Campus —

Mr R.H. COOK: Member —

Mr Z.R.F. KIRKUP: Can I finish my question, please, Chair? The government has no intent to expand the Peel Health Campus emergency department any more, given that it is not in the budget.

Mr R.H. COOK: We will work with our colleagues in the commonwealth government to expand the emergency department, the imaging department and the community mental health services. The member has now chewed up 20 minutes making a fool of himself. Let the member for Churchlands ask some questions and we can get to the proper point of estimates.

Mr V.A. CATANIA: I refer to the works in progress under the asset investment program on page 282, and specifically to the item "Small Hospital and Nursing Post Refurbishment Program". I want to talk about Laverton Hospital. The previous Liberal–National government committed $19.5 million in 2015 to build a new Laverton Hospital, which this government took out in 2017. Laverton has been left without an adequate hospital to deal with the community there. The federal opposition committed $13.5 million if it were to be elected, which the state government supported. Minister, will there be any money in the budget, or a reinstatement of the money that was taken out by the government, for the Laverton Hospital?

Mr R.H. COOK: Both the commonwealth government and the Labor opposition committed to completing the Laverton Hospital. I can confirm for the member that the full build of the hospital will take place.

[10.40 am]

Mr V.A. CATANIA: When will that be taking place; and how much has been allocated by the state and how much by the federal government?

Mr R.H. COOK: The funding of $16.8 million was approved in the 2019–20 budget, with $4 million going towards capital contribution and $12.2 million held in global provision and not recognised in the state budget papers. We are now looking forward to working with our friends in the commonwealth to complete the build and getting on with the building process. We will have those conversations in the very near future, as soon as the new federal Minister for Health is confirmed and the budget is confirmed. As the member knows, planning for that hospital has been going on for some years. I will invite Mr Jeff Moffet, the chief executive of WA Country Health Service, to provide an idea of the time horizon for that expenditure.

Mr J. Moffet: There are two stages to the delivery of the project. Once funding is confirmed, it will be approximately 18 months for planning, design and procurement—the tendering process—and approximately 18 months for the construction period. Those are the current estimates.

Mr V.A. CATANIA: I have a further question on the small hospital and nursing posts refurbishment program. The nursing post in Mt Magnet was allocated $5.4 million or $5.6 million—I cannot remember—which was then taken out of the state budget when the present government came to office in 2017. Is there any money in this line item to build a new nursing post in Mt Magnet?

Mr R.H. COOK: I thank the member for the question. I will ask Jeff Moffet to again provide more detail on the nursing post redevelopment.

Mr J. Moffet: There are currently no funds in this budget for Mt Magnet. Mt Magnet previously had some funds notionally allocated to it through the royalties for regions program, but they were de-committed in the previous budget. We are currently going through a strategic asset planning process and Mt Magnet has emerged as one of the priorities amongst other priorities, but currently there is no funding in this budget for Mt Magnet.

Mr V.A. CATANIA: I have a further question on that line item on small hospitals. Meekatharra Hospital, which had been allocated $10 million for the first stage of building a new hospital, is a 1955 building that is cracked and falling apart. Is there any money in that line item to build a new Meekatharra Hospital, which is desperately needed by the community?

Mr R.H. COOK: We have spoken about this before in the broader Parliament, and I think the member and I both agree that Meekatharra Hospital is due for refurbishment. The member is correct in saying that some money was initially set aside under royalties for regions, but that was for a primary care centre, not for the redevelopment of the hospital. I am agnostic about whether the primary care centre is more urgent than the broader redevelopment of the hospital. We need to develop a multipurpose health campus there. This hospital is a bit like Laverton Hospital; we need to get on with the task of refreshing that asset, and making sure we do some work in that space. The primary care centre was de-committed in our review of royalties for regions in the 2017–18 budget. I keep asking the department what the needs of that community are, to make sure that we have a refresh of that asset. Clearly, we are not going to have a new Meekatharra Hospital in its current configuration. It is a big, beautiful old building, but a modern facility would look very different from that, and I think we need to consolidate the services around primary care to make sure that we have something that meets the needs of the contemporary community.

Mr V.A. CATANIA: Under that same line item for the hospital and nursing post refurbishment program, my understanding was that, under royalties for regions, $5 million was allocated to the Paraburdoo nursing post. That seemed to disappear when the present government came to office. Are there any funds for the Paraburdoo nursing post in that budget line item?

Mr R.H. COOK: I do not have any contemporary information on Paraburdoo, but I do not think so. I will ask Jeff Moffet to make some following remarks.

Mr J. Moffet: Previously, a small amount of money was notionally committed to Paraburdoo, but through the de-commitment process, it was removed. We currently do not have any funds for Paraburdoo, so there is no funding currently on the horizon for Paraburdoo. It was primarily around refurbishment; it was not for any substantial work.

Mr S.K. L'ESTRANGE: I refer to the second line of the service summary table on page 273 of volume 1 of the *Budget Statements*, for public hospital emergency services. Compared with the 2018–19 state budget estimates for 2019–20, 2020–21 and 2021–22, this year's budget shows a $38.457 million cut for this service for those years. Can the minister provide an explanation of why funding for this service is less in this budget, at a time when ambulance ramping is going through the roof and major hospital emergency departments are failing to meet the four-hour rule for patients?

Mr R.H. COOK: Ultimately, the allocation for in-hospital services, such as emergency admitted and, to a lesser extent, not admitted, is based upon the activity-based framework. I will ask Angela Kelly to make some comments on that specific allocation, and then I might provide some other commentary.

Ms A. Kelly: There is a big difference between the 2018–19 budget papers and the 2019–20 papers. We have a new service line item in the outcome-based management framework, which is the service lines. In 2018–19, we had 10 service line items, and in 2019–20 there are 11. Following discussions with the Department of Treasury, we created a new line item for pathology services. It is $300 million that in previous years was split across the hospital services. Service line item 2 that the member has mentioned would have had pathology services included in it. Those services are now covered by service line item 7. The total budget has actually increased, it is just that there has been a redistribution across the service line items.

Mr C.J. TALLENTIRE: My question relates to the delivery of services, on page 267. It is about Western Australian elective surgery wait times. I would like to know what key performance indicators are available for elective surgery targets, and what strategies are being used to ensure patients receive treatment when and where it is needed.

[10.50 am]

Mr R.H. COOK: As everyone would be aware, we continue to be under a great deal of pressure on elective surgery. I am very pleased to say that, at the end of April 2019, the percentage of over-boundary cases—that is, the percentage of people who did not receive their operation within the clinically recommended time for reportable procedures—had reduced to 5.7 per cent, which is a decrease of one per cent from the end of April 2018. To put it another way, that means that over 94 per cent of all patients received their operations within the clinically recommended period. That is an amazing outcome, and I think we should all be very proud of what the department and the health service providers have done to deliver that outcome. In the year to date April 2018 to April 2019, we have seen a 1.7 per cent increase in the number of cases, which is 70 859 cases of elective surgery. Despite that increase in the number of elective surgery cases, the median waiting time for reportable procedures has remained the same. For category 1, it is 14 days; for category 2, 49 days; and for category 3, 85 days, which is an extraordinary outcome. For non-reportable procedures—that is, those not captured under the national framework for activity-based funding—we have seen a reduction in the median waiting time. That is an amazing outcome. As members would all be aware, our hospitals are running flat chat when it comes to elective surgery. As I said, there have been 72 072 reportable elective surgery cases for the year to date at April 2019.

People might think that there is lots of hospital activity everywhere, but there is not. The fact of the matter is that surgery activity in our private hospitals is plateauing. That is a significant concern because that tells me that a range of patients are entering the public health system who could be accommodated in the private health system. I think this is a wake-up call for Australia. We need to take a close look at the way our private health system is functioning. Private health insurance premiums are always said to be the reason that people are dropping out of the private insurance market, but it is not. We have a vibrant market for private health insurance, with a lot of players all competing. Private health insurance premium rises are being suppressed because people are switching between insurers much more readily, and cross-examining their level of cover to make sure that it is at the bare minimum. We cannot simply kick the private health insurers and say that they are the problem with our private health system. They are not. The reason we have a problem with private hospitals is out-of-pocket expenses. People go to a private hospital and get pinged by the hospital, the anaesthetist, the surgeon, and all the associated outpatient costs. A significant body of work needs to be done by the federal government to make sure we get the situation under control. Essentially, out-of-pocket expenses represent greed by doctors. It is simply a way that they can make patients pay more. Patients do not know the difference between one doctor and another. They just assume that doctors are all competent. If a doctor charges them more, they probably think that that doctor is better, but that is not the case. We need greater transparency around the out-of-pocket expenses that doctors charge. We have to call their bluff.

Minister Hunt convened a ministerial advisory committee on out-of-pocket costs in January 2018, and in March 2019 it provided advice on improving transparency about out-of-pocket expenses for medical specialists. It proposed a website and education about those expenses. There have been no initiatives from the federal government about reducing out-of-pocket expenses. It is quite simple. The government should make doctors publish their fees and have some transparency. I think the government is having a lend of us. When it came out with those measures in April this year, I think it was playing an April Fool's Day joke on us. The federal government has to get dinkum about out-of-pocket expenses. It has to create greater transparency in the system and make sure that doctors publish their out-of-pocket expenses so that patients can make a decision about who to go to. As I said, this is simply an exercise in greed by doctors. It is why our public hospitals are struggling to meet the elective surgery needs of our community. People do not think it is worthwhile going to a private hospital because they will be slogged with out-of-pocket expenses by the anaesthetist, the surgeon, the hospital, and outpatient clinics. It is time we called BS on this behaviour. It is time for the federal government to clamp down and create greater transparency so the people who go to our public hospitals are those who need to, not those who could afford to enter a private

hospital system if it were running properly. Our friends at Ramsay Health Care, Healthscope and St John of God all report low activity in their private hospitals. Our public hospital system relies on a vibrant and thriving private hospital system in order to cope. That is my message.

Mr V.A. CATANIA: I refer to public and community health services on page 278. I want to talk about Murchison nursing posts. I think this part of the budget covers that area. The need to provide nursing coverage for the Murchison towns of Yalgoo, Cue and Mt Magnet is dire, because there are often gaps when a nurse is not based at those nursing posts. This year alone, Yalgoo went up to three weeks without a nurse present. We have had issues in Cue when there was no nurse for a week or two. The community does not know whether or not a nurse is there. Recently a person presented with heart issues—they were having a heart attack—and the receptionist said that she would not call for an ambulance because the nursing post would be charged. Clearly there are some budget constraints on being able to phone an ambulance from a nursing post in Cue. We can forget about whether the nursing post is adequate and needs a bit of upkeep such as new carpet or paint. I know the constant issue is that they are hard to staff, but agency nurses can surely be put there to cover those gaps. Is it a budget issue?

In this day and age it is not appropriate to have one nurse based in a town such as Cue, Yalgoo or Mt Magnet. We have gone away from the model of police officers being based in a station by themselves. For the wellbeing and mental health of nurses and community safety, when will the government consider putting two nurses into these single-nurse posts, of which there are only eight in Western Australia?

Mr R.H. COOK: I appreciate the question. The member will not be surprised that I will ask Jeff Moffet to make some comments on that shortly. As I have confirmed for the member in the past, currently there are eight single-nurse nursing posts. Two of those are currently in transition to become multi-nurse nursing posts. I think they are at Coral Bay and Burringurrah. That is off the top my head, but I will confirm that in a second.

I can only apologise to the patient in Cue. I assume that is what happened—that she was told they would not call an ambulance.

Mr V.A. CATANIA: I have a detailed email.

Mr R.H. COOK: I do not question that testimony and apologise to the patient involved. That is not good enough. On that specific incident, there was no nurse at that time because a nurse was coming in from an emergency call who was due to arrive at, I think, 11.30 am, which was after the patient arrived. Another nurse was flying to Cue that day to relieve the previous nurse. The idea was that they would be together for the handover, but the flight was delayed. It was an unfortunate set of circumstances.

Mr V.A. CATANIA: That was another incident, not the heart-attack incident. It was a week before.

Mr R.H. COOK: I am very pleased to say that the woman who had chest pains could be delivered to Fiona Stanley Hospital in Perth by about three o'clock that afternoon. It is good that we were ultimately able to engage the services to get her down to Fiona Stanley. I will invite Jeff Moffet, the chief executive officer of WA Country Health Service, to comment on the transition away from single-nurse nursing posts.

[11.00 am]

Mr J. Moffet: This issue of single-nurse posts has been examined over the past few years since the incident in South Australia that resulted in the death of a remote area nurse. We have had a very close policy look not only at single-nurse posts, but also for all staff working in isolation because many staff in small hospitals work in isolation in higher risk circumstances from time to time around the state, and the vast majority of the security and aggression incidents that we see are not in our remote posts but in some of our larger district hospitals and some of our smaller hospitals. The issue of risk to staff pervades all our facilities, particularly when nurses are working alone, or radiographers or other staff for that matter.

We had eight remote area nursing posts with single-nurse stations. We have moved to approve and fill two-nurse stations in Marble Bar, Nullagine, Coral Bay and Burringurrah. We are yet to recruit staff in Coral Bay and Burringurrah, although a staff member is going to Coral Bay in the next month or so. There are four other remote area posts. They are in Menzies, Cue, Yalgoo and Yandeyarra, which is a drive in, drive out service in the Pilbara that we are attempting to find solutions to. Mt Magnet has more than two nursing staff—2.6 FTEs of nursing. Notwithstanding that, even with two staff, there are times when, due to fatigue leave or personal leave, we are down to one staff member. In Yalgoo, we have a 1.2 FTE of nursing, which is a single nurse who gets relief, and similarly in Cue.

We want a plan for the Murchison area around trying to attract and retain staff. We have engaged with local government recently. I have had discussions with Michelle Fyfe from St John Ambulance to see whether we can partner with it. One of the challenges is that in places such as Cue and Yalgoo, there is often only one patient attendance per day, so it is a very low workload and that workload is not uniform and smooth. On some days there

is very little workload. Attracting and retaining staff in an environment in which there is little professional work is a constant challenge, no matter how many FTEs or how much budget we have allocated. We want to partner potentially with St John Ambulance, for example, to see whether we can have some joint appointments or a shared model with a paramedic, for example, which will assist with transport services as well as services inside the health centre and the community. Notwithstanding that, we accept that it is very difficult to have a single staff member in a place such as Yalgoo, given the fact that the volume would require 0.2 of a nurse. I think we are at the point now, as we concluded in Coral Bay, Burringurrah, Marble Bar and Nullagine, that if we are going to deploy staff into areas that are quite remote, there needs to be a minimum of two. That may not always be two nurses; it could be a nurse and a health worker or a nurse and an all-purpose orderly or a nurse and a paramedic, for example. We are working on a Murchison service plan to attempt to increase services there. We regularly use locums and fly staff in from both Meekatharra and Geraldton to fill unplanned gaps. They are obviously unanticipated, sometimes day to day and shift to shift. In fact, we had a call last night that we had to respond to this morning to get someone to fill a shift in either Cue or Mt Magnet.

I am aware of one of the incidents that the member raised but not the one he just referred to. We will investigate those to see exactly what occurred. Ambulances should be called if ambulances are required. I do not know the circumstances of that incident. It does not sound like an appropriate policy response but we need to look at that.

Mr V.A. CATANIA: I thank the adviser for that. The issue we have is that we have signs on the road that say "nursing post". In the incident I mentioned, when someone presented with a heart attack, the nursing post was not staffed yet the door was open. This incident occurred a week and a half ago. It has been well documented in the news. I sent a letter to the minister and the local government of Cue also made a complaint, so I am surprised that the department is not aware of that issue. Someone is going to die in that region. I urge the minister to come up with an immediate solution to provide coverage there until he works out a longer term solution. At the moment there are too many gaps and people's lives are being put at risk. Please fix the issue now and find a longer term solution down the track.

Mr R.H. COOK: I am not quite sure what the question was, Chair.

Mr V.A. CATANIA: Make sure that the nursing posts are staffed adequately now.

The CHAIR: What is the question?

Mr V.A. CATANIA: Staff the nursing posts before someone dies, not until the minister works out something down the track.

Mr R.H. COOK: What is the question?

Mr V.A. CATANIA: Will the minister staff the nursing posts 24/7 now to prevent a death from occurring?

Mr R.H. COOK: We will staff the nursing posts according to the needs of the community. I invite Jeff Moffet to make a further comment.

Mr J. Moffet: As stated, we have moved on four of the eight nursing posts. It has been difficult to attract staff to very quiet sites. Notwithstanding that, we continue to recruit for Burringurrah. I suspect that we will do similar, although it may be in partnership with St John Ambulance—with a paramedic, for example—in either Yalgoo or Cue.

Mr V.A. CATANIA: With all due respect, they are volunteers.

The CHAIR: You cannot interrupt an adviser.

Mr J. Moffet: I understand that having continuous service coverage in small towns and communities is a continuing 24-hour-a-day challenge for us. Even when we have two or three nursing staff members, there are times when our resources are tested based on what presents and what circumstances are affecting staff. We cannot fully mitigate the risk in some of those towns. I think we need to attempt to get a second person into Yalgoo and Cue. The question is how we achieve that in a way that will see us able to attract and retain staff. My personal view is that having a mixed model with a paramedic and a nurse would make a lot of sense. It would also improve the transport service. I fully agree that having service gaps is a risk and an issue. These problems are not unique to Yalgoo and Cue. There are times when we are overwhelmed with demand in many of our small sites around the state. I agree that there is a specific issue for us to address in Cue and Yalgoo in particular. Equally, we have health directors, as the member would be aware, as our first point of call after hours. It is likely that we will use our emergency telehealth service to provide a first point of contact for community members needing immediate assistance or advice when presenting to those health centres. We are fully committed to improving and finding a solution, including technology. However, I cannot say that having two or three nursing staff will remove that risk because, for example, in Mt Magnet, we have increased numbers of nursing staff and there are still challenges with service continuity.

Mr R.H. COOK: To answer the member's question, we agree with the member that single-nurse nursing posts are not optimal and that is why we have a program to change that. Essentially, we will continue to support those

nurses to ensure that they can continue to provide great services to the community, which essentially is more than the member's party did when it was in government.

Mr Z.R.F. KIRKUP: I have no more questions on Peel Health Campus, because we do not get any answers from the minister.

The CHAIR: Member for Dawesville, just ask the question.

Mr Z.R.F. KIRKUP: I refer to page 286 and voluntary redundancies. This page highlights that there is a gap of approximately $8 million in voluntary redundancies that have been paid out, yet it also notes that the FTE numbers have grown from 36 496 to 37 449 up to 2019–20. I am keen to understand why the government has paid out approximately $8 million in voluntary redundancies yet the FTE count continues to grow despite a voluntary redundancy package being in place.

Mr R.H. COOK: I thank the member for the question. Obviously, the member will be familiar with our voluntary redundancy program, which we introduced as part of our budget efficiency measures. Another body of work is also going on, which is about the transitioning of casual and contract staff who have for years been on casual arrangements and contracts, allowing them to transition to permanency. This is a really important piece of work, because one of the things the Liberal Party did in government was to decide that budget efficiencies would be achieved simply by chopping the number of FTEs. That led to an explosion in contract and casual staff, because they are off the books as FTEs. There might be a small uptick, I guess, in relation to FTEs, in addition to the program of voluntary redundancies. I will ask the director general to go through the specifics of the member's question.

[11.10 am]

Dr D. Russell-Weisz: Yes, we have had a voluntary redundancy program in place. The health system has undergone significant reform over the last three years to devolved governance. The health service providers are now accountable for their safety, quality, clinical and financial performance, and there has been a lot of scrutiny on financial performance and also FTEs. We have certainly moved to reviewing the performance of health service providers and also the department, taking the whole budget into account. FTEs are one component, but they are a very large component. The voluntary redundancy program was also about making sure that the health system was fit for purpose in the newer, much more complex environment that we are in. We have had a track record, I think, over the last few years of getting the budget under control. That is about making sure we have the right staff in the right place with the right skills. That will require health service providers to adapt to recruit staff to specific areas, while losing staff in others. But I can say we have had very tight controls over FTEs. As the member knows, there is activity and population growth year on year and health service providers have to react to that. We really concentrate on their activity performance, their safety and quality performance, and their financial performance. The health system's financial performance has expenditure growth under control. We really do not micromanage those FTEs anymore, unless, obviously, a health service is under considerable financial constraint. We would then want to know what they are doing about their FTEs. But it is a balance of right-sizing the system without micromanaging it too much.

Mr Z.R.F. KIRKUP: As part of the voluntary redundancy process I am keen to understand, perhaps via supplementary information, the amounts that have been paid out and the age staff were when they left. I am keen to understand the profile.

Mr R.H. COOK: Let me take some advice. Yes, that is not a problem. We will provide details of voluntary redundancy programs and payouts, and the age profile of those employees who received voluntary redundancy payouts.

[*Supplementary Information No A13.*]

Mr M. HUGHES: I am interested in what the government is doing with aged care and palliative care.

Mr Z.R.F. KIRKUP: It is most important.

Mr M. HUGHES: It is absolutely, member for Dawesville. I note the member's longstanding interest in my interest in this particular subject! Are there no more guffaws from the member for Dawesville? I refer the minister to spending changes. Could the minister tell me what investments and extra support in enhanced community-based palliative care services are provided for in this budget? Perhaps when the minister considers the answer, he could also tell me what we are allocating to aged-care services in Carnarvon.

Mr R.H. COOK: I appreciate the member's question. Perhaps the member for Dawesville does not understand the needs of an ageing population, although he should, given that he is the member for a region with a population looking towards its needs in the future as it ages, and we want to make sure we provide the best services for it. One of the frustrations we have is that although aged-care services are the responsibility of the federal government, it continues to short-change Western Australia around aged-care provision. That is a point of incredible frustration. The member may be familiar with the statistics, but I will remind him nevertheless. In Western Australia, we have

just over six aged-care beds per 1 000 people, whereas the national average is just over eight. That means that a range of health consumers are sitting at a state-run hospital awaiting a commonwealth-funded aged-care place. This is felt particularly acutely in the member for Kalamunda's electorate, where there is an ageing population. As a result of that, there is a great deal of distress in the community as loved ones try to find a place for their relatives to move to, particularly when they are no longer able to go home after an episode in hospital. One thing we have been particularly keen to make sure of is that we work with members, such as the member for Kalamunda, to identify state-owned land in their electorates that we can make available to aged-care providers, so that we can grow the number of beds available for people in the community. I want to particularly acknowledge and thank the member for the work he has put into that.

We are really keen to make sure that we better understand the end-of-life experience for patients and that we provide them with the care they need so they can enjoy their final years of life. The member might be aware that we have committed an extra $41 million for end-of-life choices and palliative care in Western Australia. This is a 74 per cent increase in funding, particular for regional palliative care, member for North West Central. I particularly want to acknowledge the work that the member for North West Central has undertaken for aged and palliative care facilities in his electorate, particularly in the town of Carnarvon, where we have now committed to fully funding a 38-bed facility.

Mr V.A. CATANIA: Reinstated!

Mr R.H. COOK: We have committed to fully funding the 38-bed aged-care facility in the town of Carnarvon. This is an important step, because one thing the member for North West Central and other colleagues in the Parliament have said is that we need to have improved facilities in that town to meet the needs of the ageing population there. We want people to be able to age in their communities. We invited the commonwealth to fund those places, but, unfortunately, it neglected to do so. The local member neglected to even support the application, which was particularly disappointing.

Mr V.A. CATANIA: The federal member!

Mr R.H. COOK: Yes, sorry, the federal member neglected to support the application, which I thought was an extraordinary repudiation of her obligations to that community. We are now very pleased to have that funding in place and to see the development go ahead.

Mr V.A. CATANIA: The minister mentioned funding of $41 million for end-of-life choices and palliative care services. Can the minister provide a breakdown of where that $41 million is going to be spent across regional WA?

Mr R.H. COOK: Yes, I am very happy to provide that information to the member. Through the 2019–20 budget, a total package of $40 million is provided over five years to support end-of-life choices and palliative care. This includes $5.8 million in project funding to progress the joint select committee's recommendations. This covers both the voluntary assisted dying and end-of-life and palliative care recommendations, and will include an allocation of funding for patient-led and external reviews of palliative care across both 2018–19 and 2019–20. As I said, there is $5 million for the Carnarvon aged and palliative care facility. This additional funding supplements the existing $11.6 million to support the new build, at a total of $16.6 million for those 38 beds. There is also $30.2 million to expand palliative care services in the regions. We have basically said we want to design those regional palliative care services in conjunction with the palliative care sector, and we have committed to holding a summit with the palliative care sector, I think next month, to really sit down with it and understand the specific needs in the regions. One of the things we are looking at is a 24/7 palliative care telehealth service, so that we can better support nurses and other staff working in hospitals in a regional setting on the palliative care needs of their patients. In particular, we are going to make sure that we put greater commitment into the training of general nursing staff and other care workers, so that they are better equipped to deal with the palliative care needs of patients.

I spent some time yesterday in West Perth at a Hall and Prior facility with the National Policy Advisory Committee palliative care training team. Through sitting down with its carers, it was really driven home to me that they need to have the backup of good palliative care support to ensure they have the skills to provide the right level of care for their patients. We want people to have their end-of-life experience in the place that they call home, whether that is literally their home, working with Silver Chain and other organisations, and to make sure that we improve those services, or in their aged-care facility, which has become their home, rather than having them be transported to a hospital during those final stages. A hospital is a clinical, very interventionist environment that quite frankly is likely to increase a person's anxiety, rather than provide them with a more relaxed end-of-life experience.

[11.20 am]

Mr V.A. CATANIA: I thank the minister for reinstating that $5 million for the aged-care facility in Carnarvon; I appreciate that. The minister talked about the Carnarvon aged-care facility being palliative care. Has that $5 million come from the palliative care budget under that $41 million? What is the difference? Does the minister see aged care as palliative care?

Mr R.H. COOK: I can confirm that that $5 million comes out of that $41 million package. Palliative care is different from aged care. Although one may be palliating someone in an aged-care facility, it does not necessarily equate to a palliative care service. Because I am familiar with it I can say that some of the facilities at the Carnarvon facility are engaged in advanced palliative care services. But, by and large, an aged-care facility is where people age in place. From that perspective, an aged-care service is not necessarily a palliative care service, although there may be palliative care aspects to that activity. People need to understand that palliative care is not just those final hours or days of a person's life, although obviously that engages intensive palliative care services. Palliative care is about understanding how people who are entering the final stages of their lives want to live their life in those final stages and ensuring that we can support them properly, so that they are comfortable, surrounded by loved ones and cared for. From that perspective, there are obviously some synergies between an aged-care facility and palliative care services.

Mr S.K. L'ESTRANGE: Does the $41 million funding in the minister's end-of-life choices budget include spending for his voluntary assisted dying policy?

Mr R.H. COOK: We do not have a voluntary assisted dying policy, other than to say that we have committed ourselves to presenting voluntary assisted dying legislation to Parliament. Voluntary assisted dying is a very specific and small part of the palliative care continuum or spectrum of services. Ultimately into the future, we could see a situation in which someone accesses voluntary assisted dying services, if it is legalised in Western Australia, as part of their palliative care package. We do not anticipate this $41 million being committed to anything associated specifically with the activity of voluntary assisted dying because it is not a part of a service model in Western Australia. If the Parliament decides that it wants to legalise voluntary assisted dying, obviously that will then begin an important and long period of work that will need to be undertaken to understand the clinical framework for that process. This money is not specifically allocated to any activity associated with that.

Mr S.K. L'ESTRANGE: Has any of the $41 million been directed towards providing more full-time equivalent psycho-oncology consultation-liaison psychiatry positions to care for people suffering from exponential distress while living with a terminal or chronic illness?

Mr R.H. COOK: I am not qualified to answer that question. I might ask Dr Williamson to make some comments.

Dr J. Williamson: I do not think I can answer that specifically, but the funding that is provided to country health services would include clinical services. I know that they are looking for specialists, palliative care physicians and associated staff, and whether that might also include additional FTE for psycho-oncology, that would really be up to the service delivery arm.

Mr S.K. L'ESTRANGE: Staying on this theme, what is the government strategy to increase the number of specialist palliative care doctors in our regions?

Mr R.H. COOK: I will seek the support of Jeff Moffet, the chief executive.

Mr J. Moffet: The $30.2 million for palliative care service expansion in country areas relies on a number of things, including, obviously, increasing specialist capability where we have volume, for example in the south west, lower south west, great southern areas and potentially the midwest of the state. But we also plan to have digitally enabled access to palliative care specialists for all services across the state. The service model is premised on around 20 district sites having multi-disciplinary teams, albeit they will be fractionalised or part time rather than just the small regional teams we have at the moment, to make care much more accessible both in local hospitals, but importantly as close to home or in-home, preferably. The whole intent of that strategy is to get more palliation for people in-home, in particular, and to make those sorts of choices available. We will see an increase in palliation specialists, either virtually through digital means or physically in those higher-volume regions. Equally, just to go back to the original question around psychology and other support, we will inevitably, probably through digital means, initially provide support for those who require psychological or mental health assistance during periods of palliation as well. That may mean referral through to our existing mental health teams or other services, for example, that are locally available. All those issues will be addressed. Obviously, it is a very large state with very many communities. We are moving this down to a district level, which will vastly improve the accessibility of the service. But the intent is to, as much as possible, provide a contemporary, close-to-home and patient-focused service in those weeks, months and sometimes even years of palliation as necessary.

Mr S.K. L'ESTRANGE: What is the total amount of operational funding allocated for state government spending on palliative care services for this year, 2019–20, and then the 2020–21, 2021–22 and 2022–23 years? What proportion of this funding will be spent for each year on metropolitan and regional services? If that is too much, maybe that could be provided in a table form.

Mr R.H. COOK: I think I can assist the member. These numbers will come in relation to community-based palliative care services. I will look momentarily to Angela Kelly and hope that she nods when I say that the provision of palliative care in a hospital environment does not get calculated under its specific activity.

Ms A. Kelly: Yes.

Mr R.H. COOK: This is in addition to those patients who are palliated in a hospital environment, because that is not caught under activity-based funding as a specific activity. In addition to all that activity that takes place in a hospital setting, in 2019–20 we have a total statewide budget expenditure of $47.4 million and existing expenditure is $6.9 million. The new expenditure will be $5.1 million, with total expenditure on regional services at $12 million. In 2020–21, it is $49.9 million. The expenditure in regional services is $7.1 million and new expenditure is $6.5 million. That is a total expenditure in regional areas of $13.6 million. I go back to the 2019–20 figure: total expenditure statewide is $47.4 million. For regional services, the existing expenditure is $6.9 million and new expenditure is $5.1 million, so the total regional spend is $12 million.

[11.30 am]

Mr S.K. L'ESTRANGE: Is that in this budget?

Mr R.H. COOK: That was for 2019–20. In 2020–21, it is $49.9 million across the state. The existing regional spend is $7.1 million. The new regional expenditure is $6.5 million, which brings total regional expenditure to $13.6 million. In 2021–22, total statewide expenditure is $52.6 million and the existing regional projected expenditure is $7.3 million. Under this new package, total expenditure will go to $8 million. That will take total regional expenditure to $15 million. In 2022–23, the total statewide budgeted expenditure is $56.4 million. The total projected regional expenditure prior to the package was $7.5 million, so new expenditure will be $10.6 million, which brings the total regional expenditure to $18.1 million in 2022–23. Across the forward estimates, the total statewide expenditure is $206.2 million. The total for the regions under the existing expenditure projections is $28.7 million. New money is $30.2 million. That produces total expenditure of $58.9 million in regional services across the forward estimates.

Mr V.A. CATANIA: Does that include Carnarvon aged care?

Mr R.H. COOK: It does not include capital.

Mr S.K. L'ESTRANGE: Is that all state money or does it include a component of federal money?

Mr R.H. COOK: That is state money. That is our package.

Can I clarify one other point. I gave an answer before about whether any of the money was going to be spent on voluntary assisted dying services. I can confirm that VAD services were not part of the package, but there were some recommendations from the Joint Select Committee on End of Life Choices to cover both voluntary assisted dying and palliative care. There is an allocation against funding for patient-led external reviews of palliative care across both 2018–19 and 2019–20, so it is not for the delivery of voluntary assisted dying. Obviously, the joint select committee recommendations require some policy work to be done.

Mr V.A. CATANIA: When it comes to the ratio of palliative care specialists, how do we compare with the rest of the country? What is the gap? I understand that as of last year, Western Australia had about 13.5 palliative care specialists, which severely lags behind the rest of the country. I think we have about 0.52 FTE per 100 000 people, compared with Victoria with 0.7 FTE, Queensland with 0.9 FTE, New South Wales with one FTE, South Australia with 1.1 FTE, and Tasmania with 1.8 FTE. How much money needs to be allocated in Western Australia so it can keep pace with what is happening in the rest of the country?

Mr R.H. COOK: Thank you, member. I might take that on notice and provide that state-by-state analysis by way of supplementary information. However, in addition, I make the observation that Western Australia has a very unique health setting in which to deliver services. We are the largest and most isolated single health authority jurisdiction in the world. The way we deliver health care is a unique proposition, so often those comparisons are inadequate to provide an understanding of resource allocation. However, I am very happy to provide the information as requested.

Mr V.A. CATANIA: It would be nice to know the true amount that is needed to keep pace with other states over east.

Mr R.H. COOK: It is a really good question. We will get that information for the member.

The CHAIR: Can the minister repeat what he is providing?

Mr R.H. COOK: The member has asked for a comparison of the breakdown of palliative care specialists in other states per 100 000 people. In addition, we will provide information about other palliative resourcing when compared with other states.

[*Supplementary Information No A14.*]

Mrs A.K. HAYDEN: The minister said that $5.8 million of the $41 million for the end-of-life choices and palliative care package will go towards following up the standing committee's recommendations. Can the minister

break down that $5.8 million, considering that he just said that some money will go towards the voluntary assisted dying policy? Can he outline how that $5.8 million will be allocated and spent?

Mr R.H. COOK: I would be delighted to provide that by way of supplementary information. I will provide an additional breakdown of the $5.8 million allocated for progressing the joint select committee's recommendations on voluntary assisted dying and end-of-life and palliative care services.

[*Supplementary Information No A15*.]

Mrs A.K. HAYDEN: On page 270 of budget paper No 2, under the heading "End-of-Life Choices and Palliative Care Services", paragraph 14 states in part —

> … advance care planning; end-of-life and palliative care; and voluntary-assisted dying.

Can the minister explain the difference between end-of-life care and voluntary assisted dying?

Mr R.H. COOK: I am happy to provide my understanding of it. If the member wants a clinical definition —

Mrs A.K. HAYDEN: I want an understanding of it with regard to the budget and how money will be allocated. The minister has talked about end-of-life care and about voluntary assisted dying. When we talk about that, I think we need to understand what funding is being allocated and for what purpose.

Mr R.H. COOK: Obviously, a lot of policy work is being done on voluntary assisted dying to support the Ministerial Expert Panel on Voluntary Assisted Dying. Extensive work is being undertaken at the moment to support the ministerial expert panel. In relation to end-of-life and palliative care, that is as it suggests—it is work that is being undertaken to better understand the needs of our community around end-of-life and palliative care, and to provide extra resources for the provision of those services. We have introduced a $41 million package to improve palliative care. Many colleagues have said that while we are contemplating voluntary assisted dying legislation, we must ensure that enough resources are available for palliative care services. We have brought the total statewide funding for community-based palliative care services between 2019 and 2023 up to a record $206.2 million. Never before in this state has such a significant amount of money been allocated to improve palliative care services.

The member for North West Central could tell the member for Darling Range about the dire need to support those people who are ageing in our regional communities. So the lion's share of that $40.1 million package, which we have announced, will go towards making sure that we improve palliative care services in regional and rural communities. Most of that will be spent on supporting frontline workers to make sure they have the support they need to provide quality palliative care and give them confidence around their understanding. That will involve a certain level of training. In specific instances, it will provide better support, such as through palliative telehealth. That will significantly contribute to improving palliative care in rural and regional communities. I very much look forward to seeing the whole package brought to life and being informed by the palliative care summit. A lot of palliative care specialists around the state share our anxiety about palliative care services in rural and regional communities. I want to make sure that we work closely with them to make sure that people in our regional communities, particularly those in small hospitals, have the resources they need.

My mother-in-law worked as a nurse at the Nannup Hospital, which in some respects is an aged-care facility. A lot of aged patients there are too sick to return home, so many of the nurses there, although they are generally trained nurses, provide high-level or advanced palliative care services. It is important that we take the opportunity to make sure that we provide them with better training and better backup, and to continue to make sure that they have the confidence to provide those clinical services.

[11.40 am]

Mrs A.K. HAYDEN: I hope I will get a shorter answer to this question.

Mr R.H. COOK: That can never be guaranteed in estimates, member!

Mrs A.K. HAYDEN: I gather that. I want to clarify that when that breakdown of the $5.8 million is received, the minister will differentiate between the end-of-life and voluntary assisted dying funding allocations. The minister commented on the palliative care summit earlier. Can he advise on what date that will be, and will the results of the summit be made public?

Mr R.H. COOK: We are still working on the actual date for that. I assume it will be in June or July.

Dr J. Williamson: It will probably be towards the end of July.

Mr R.H. COOK: Yes. Member, I think it will operate similar to the preventive health summit that we held. I do not think there will be any secrecy around it. It may not be the all-singing, all-dancing show that the preventive health summit was, because we had people there with specific skills. I do not think it will be that large, but the idea is that it will be an open forum. It may not be open to the extent that we invite all members of the community

to come along, but we will certainly make all outcomes and discussion papers public. This is something that I am committed to in the context of making sure that we have a better community conversation around end-of-life choices. We always talk about people leading great lives; seldom do we talk about people leading great deaths. This is something that people care about very much. From that perspective, I think it is an important community conversation to have.

Mr S.K. L'ESTRANGE: Minister, I refer to page 269 of budget paper No 2, volume 1 and specifically to paragraph 6.5. Does the appropriation of $1.6 million for a culturally appropriate housing facility for Aboriginal people cover the establishment of an Aboriginal medihotel; and, if not, where is this election commitment at?

Mr R.H. COOK: I thank the member; I appreciate the question. This goes to the heart of our election commitment to create a medihotel specifically for Aboriginal patients. It is all about our agenda to put patients first. We want to make sure that when people are coming to Perth, particularly from remote communities where English is a second or third language, we have an appropriate way to support those patients on their journey. Funding of $1.6 million over three years was secured in the 2019–20 budget to enable the delivery of this election commitment, including $1.2 million of capital funding and $0.4 million of recurrent funding. I am wondering what information will be useful.

Mr S.K. L'ESTRANGE: Where will it be built? How many beds?

Mr R.H. COOK: The WA Country Health Service consulted with the following stakeholders on the Aboriginal health strategy: the East Metropolitan Health Service, the Department of Health's Aboriginal health policy directorate, and the Aboriginal Health Council of Western Australia. It established a working group to deliver on the election commitment. The business case submission outlines the areas of focus, which are to investigate the access of patients to their accommodation service, improve the cultural appropriateness and facade of the existing facilities, and develop a wraparound service model with a focus on delivering an improved patient journey. I will invite Mr Jeff Moffet to make some comments on this shortly. This will combine with our meet-and-greet service, which was another election commitment, which is about providing a service to patients who are arriving at what, for many, is a very foreign airport. It is about ensuring that they are met and provided with, as I said, wraparound services to make their patient journey much smoother and less stressful. I invite Mr Jeff Moffet to make some further comments.

Mr J. Moffet: Thank you. The culturally appropriate housing election commitment is intended to optimise the use of existing accommodation. For example, at Derbarl Yerrigan, we do not have full utilisation of existing capability, so it is very likely that we will invest in ensuring that all those beds are utilised on an ongoing basis. Equally, we will be working with other providers over the next six months to see what other improvements we can make to the amenity and use of the facility to increase capability in the system. As the minister indicated, we want to improve the experience for Aboriginal patients and families residing in these facilities. In all likelihood, we will be providing some technology investment to continue to link people back to their families while they are residing in Perth, because it is a very lonely and isolating experience for some. We want to make sure that we use the best technology available to continue to connect people with their families. Finally, we also want to ensure that we integrate our existing services. As the minister indicated, we have a Country Health Connection meet-and-greet service, which is very much around supporting people who need to access care, ensuring that their transport options are optimal, and getting people to and from appointments as well as to and from airports in an efficient way. We believe those services could be much better integrated with the existing accommodation provider. This election commitment will allow us to explore that opportunity to build a much more comprehensive service that seeks to optimise the existing capability of Derbarl Yerrigan and other facilities.

Mr S.K. L'ESTRANGE: I want to try to separate those two outcomes. We have the Elizabeth Hansen Autumn Centre in Bayswater, which is run by the Derbarl Yerrigan Health Service. That contract is up at 1 July this year; I understand it will then be taken over by the WA Country Health Service. Given the service provided by the Elizabeth Hansen Autumn Centre costs $85 per person per night, what is the government's rationale for moving it away from that health service and across to country health? I do not think that country health will be able to achieve that low cost of service provision. What will be the cost to the WA Country Health Service per patient per night? Then I will come back to the build that the government is going to do, but only because part of that answer was around Derbarl Yerrigan Health Service and its running of the Elizabeth Hansen Autumn Centre. I would like to get some clarification of what is happening there.

Mr R.H. COOK: Yes. Again, I will invite Jeff Moffet to make some further comments, because those conversations have been going on primarily with WA Country Health Service. I have not been involved with them, although I understand that they were difficult conversations. One of the problems is that the current facility is underutilised. To the extent that it is utilised, I think it is 100 per cent utilised by Kimberley patients. We have Derbarl Yerrigan, which is fundamentally a Noongar-based organisation, providing accommodation services for the Kimberley.

Mr S.K. L'ESTRANGE: That makes sense, I guess.

Mr R.H. COOK: Well, they are country. That is right.

Mr S.K. L'ESTRANGE: We are hardly going to have the Kimberley mob running it down here.

Mr R.H. COOK: No, that is right, but the point I am making is that there is some discussion about whether that is the best vehicle. Having said that, I do not think that Derbarl Yerrigan is really interested in continuing to run that facility, although I am not privy to those negotiations. My preferred outcome is that ultimately it is transitioned to the Aboriginal Health Council of Western Australia, so that AHCWA can run it as part of its statewide provision of services for Aboriginal people generally. I think a combination of both the meet-and-greet service and the Aboriginal medihotel service run by a community health service with a statewide mandate makes much more sense in terms of the overall framework of that policy. Having said that, WA Country Health Service is responsible for negotiating with Derbarl, so I invite Jeff Moffet to make further comments.

Mr S.K. L'ESTRANGE: Just before that, I heard the minister say that he was not sure that Derbarl Yerrigan Health Service wanted to run the Elizabeth Hansen Autumn Centre in Bayswater. I would like to have that clarified, because I am picking up different information from the minister on that.

Mr R.H. COOK: Well, they were unable to come to an agreement about the contract, despite the hard work that was done by both parties.

Mr S.K. L'ESTRANGE: What I am hearing is that if an organisation—it may be small compared with the WA Country Health Service—is passionate and keen to do a really good job, and what it is doing is well received by the clients who are attending that centre, for want of a better term, would the government not rather have part of the Department of Health mentor and support this group, particularly if it is achieving costs of only $85 per person per night? I do not think anywhere else would be able to achieve that.

From the perspective of organisations that are passionate and want to do well and want to be supported, plus have budget savings due to the efficiencies of the organisation if they know what they are doing, would we not rather support them and recontract them going forward with increased support, and, possibly, as the minister said earlier in his answer, with increased capital spend to build their capacity. Why would we not take that approach as opposed to just taking a service off an organisation and giving it to a government department?

[11.50 am]

Mr R.H. COOK: We certainly do not want to take it off them. It is a question of whether Derbarl Yerrigan Health Service can come to an agreement with the WA Country Health Service. I understand what the member is trying to suggest, but I think the way he characterises the negotiation—big heavy Department of Health and small Aboriginal community-controlled health organisation—is probably not very accurate in the way the conversations have gone. It is a tricky discussion. Again, I have not been party to those discussions. I get the occasional update via the media, I notice, but I invite Jeff Moffet to make some comments.

Mr J. Moffet: The first point to make is that the WA Country Health Service does not seek to run hostels anywhere in the state. However, we find ourselves in that position from time to time as a result of market failure or the inability of local service providers to deliver the service. Wherever we can, as a principle, particularly for hostels that are providing services primarily to Aboriginal clients, we seek to find community-controlled organisations or non-government organisations—including, for example, Aboriginal hostels or local organisations—to run those services. That remains the case with the Elizabeth Hansen Autumn Centre. We anticipate that we will take over this service on 1 July, making some changes and improvements, as I suggested in my earlier response. We will work with the Aboriginal Health Council of Western Australia and potentially other interested parties to get that back into a non-government organisation's hands as soon as possible. That is the intent and the spirit with which we have received the service back.

The background to this is complex. Derbarl Yerrigan Health Service has been in administration for several years. ACHWA is the contract holder for the services. We procure around $6 million of services, including the Elizabeth Hansen Autumn Centre, ordinarily from Derbarl, but since it has been in administration, we have novated our contracts across to AHCWA. That has been an intense process of program management improvement and supporting Derbarl in the background to increase its capability over time to take back contracts from both the commonwealth and the state directly, rather than through AHCWA. I think this is one of the issues that has been caught up in the financial improvement and the financial straightening up of its balancing sheet and operating statement. It became clear to Derbarl late last year–early this year that it felt this was a loss-making service and it requested some funds. We attempted, I think with good faith, to understand the nature of the cost structure and the challenges it was facing with a fairly open-book approach, as we have provided grants and we provide patient assisted travel scheme subsidies on a daily basis for each client there. However, we were unable, together with the board and the management team, to understand its cost structure and find a suitable grant arrangement.

The grant arrangements that were being requested changed significantly over a period of a couple of months, moving from a couple of hundred thousand dollars to well over a million dollars for the subsidy that was being pursued. In the end, Derbarl chose not to continue with this service, as there was financial exposure for it. We support that decision. We will run this service as effectively and efficiently as we can, initially. We will incorporate technology improvements and ensure that utilisation is not at 50 or 60 per cent but closer to 90 or 100 per cent. We will work with the community-controlled NGO sector to get it back into its hands as soon as possible. It has been a very complex process. We would rather have seen a different outcome and continuity of the service, but the reality for a new Derbarl board CEO and chair is that it has a significant amount of other responsibilities to receive back from AHCWA, including $6 million in service funding from us, as well as the Elizabeth Hansen Autumn Centre. I think Derbarl felt it was a bridge too far to navigate that issue at this point. We will continue to approach the issue in good faith and it may well be that Derbarl at some stage is the provider in the future. We have not closed our mind to anything. Our key and only focus through this is to make sure the Aboriginal clients in that facility have a service on 1 July. That has been the key issue in the last few months.

Mr S.K. L'ESTRANGE: Thanks for that answer. Bringing it right back to the original question, is the appropriation of $1.6 million for a culturally appropriate housing facility for Aboriginal people going into the Elizabeth Hansen Autumn Centre in Bayswater or is the department looking to build a distinctively separate facility?

Mr R.H. COOK: I thought it was one and the same project, but I will double-check.

Mr J. Moffet: We are engaging with the sector, not only Elizabeth Hansen and Derbarl but also other providers such as Derbal Bidjar Hostel, for example, and other Aboriginal hostels around the best use of the capital allocation. It is unlikely that any build will occur. There is not sufficient capital to undertake a new build. Our position and our understanding is that at this stage a new build is not required. We have sufficient capability if we invest in better utilisation of the assets we have. The Autumn Centre is a good example of that, but it is not the sole intended recipient of any grant funds to improve capability. There may be other hostels.

Mr S.K. L'ESTRANGE: I think we have now separated out the Autumn Centre as possibly needing some capital upgrades to be able to deliver a better service. I got that answer. Bringing it back to the Aboriginal medihotel, I am hearing that that is a separate facility the government is looking to build. Where and when is it looking to build that?

Mr R.H. COOK: No, we have committed to culturally-appropriate accommodation for patients coming from Aboriginal communities when they are transitioning to a Perth-based hospital. We are agnostic on the question of whether it is an existing facility with the capacity to meet the needs or it is a fresh build. We are essentially allowing the health service provider—in this case, WA Country Health Service—to inform us about the most appropriate strategy; and, from that perspective, I am fairly pleased with the engagement that WACHS has had with the Aboriginal community-controlled health organisations.

Ms E. HAMILTON: My question relates to page 282 of the budget papers and Joondalup Health Campus under "Asset Investment Program". We know that we have had a significant population growth in Joondalup and the surrounding areas. Can the minister let us know what health services are being provided in the northern corridor to help meet the needs of local residents?

[12.00 noon]

Mr R.H. COOK: I thank the member. I appreciate the question. I appreciate in particular the member's ongoing advocacy for the issues around the need to grow health services in the Joondalup area. I am just trying to locate my specific notes so that I can provide the member with a more fulsome answer. As the member would be aware, we are looking at the next stage of the redevelopment of that hospital. At this stage, the project represents investment of $161 million to the expansion of the hospital. The expansion is focused on areas of most urgent need and provides a new 77-bed mental health building, an additional 12 emergency department bays and 30 additional in-patient beds to support the expanded ED. We are still working on the project definition plan. That has been prepared to further evaluate the potential requirements, specifically for additional operating theatres and to nail down the specific needs for in-patient beds at that hospital.

Since we have begun this journey, the federal government committed to the growth of health services at Yanchep. We need to sit down with the commonwealth government and get a better idea about what it is contemplating to develop in that Yanchep area. That will obviously inform us on the demand in Joondalup. It might take away from the demand, or it might contribute to the demand. From that perspective, we are looking at what else we need to do at that hospital to make sure it meets the needs of the growing population. As the member will be aware, we are also committed to a 12-bed stroke unit at that hospital, and we have been able to deliver on that. That has been a really important addition to the services there. The member and I had the honour of opening that unit a short time ago, as well as having a look at the therapy rooms attached to the unit. It has been widely welcomed, and it is pleasing to see the way it has been embraced by the community.

We also have to look at the service agreement between the WA government and Ramsay Health Care, under the public–private partnership arrangement, and the scope, as we outlined in our election commitment. In particular, under the memorandum of understanding we signed with Ramsay, we want to make sure that the contract we are operating under at that hospital is a modern contract that meets the needs of the community. Ramsay has been there now since 1998. Since then, our understanding of the way public–private partnerships work has evolved considerably. Members will be aware that, since then, we also have the public–private partnership at the St John of God Midland campus, which is a much more modern iteration of that contract. The member might be interested to hear that Royal North Shore Hospital, which was planning a similar arrangement, looked at the Midland St John of God contract and declared that it was now the industry standard. We also now need to look at what is developed at North Shore to determine the new contemporary vision.

We are looking at construction starting early next year. We have got to get on with this. As the member knows more than anyone in this room, it is a growing community with growing needs for hospital services. We must make sure that we redevelop that hospital to meet the needs of the growing community. One of the reasons we are gripped by a sense of urgency about that is the member's advocacy, so thank you very much.

Mr V.A. CATANIA: I refer to page 274 of the *Budget Statements*, under "Outcomes and Key Effectiveness Indicators". As we look down the table we see survival rates from stroke. The department is coming up with some amazing statistics, and the interventional neurologists are doing a fantastic job. I would just mention Tim Phillips, a fantastic doctor there. As I go down the page I come to the item "Percentage of responses from WA Health Service Providers and the Department of Health who are satisfied or highly satisfied with the overall service provided by Health Support Services." It is right at the bottom of the table. It shows 47.7 per cent in 2017–18, 50 per cent in 2018–19, and an estimated actual of 66.7 per cent. Does this 66.7 per cent estimated actual include how safe employees are, or how they feel in the department?

Mr R.H. COOK: One of the things we have been really keen to do is to understand the health and wellbeing of our staff. As part of our health reform process, this year we have implemented a statewide staff morale survey—a health and wellbeing survey—making sure that we are informed by how we are tracking in staff morale and satisfaction with working in the service. That was rolled out at the beginning of this year, and we have just received the raw data. I have sent that off to the health service providers to give us their feedback, and consolidate the information in a form that can be understood. We believe that understanding the morale of our staff is an important part of what we do. This is the first survey that we have done, and the idea is to do it annually from here, so that we can track our progress in improving the wellbeing of our staff. Health is a people industry, so unless our staff feel engaged, valued and listened to and willing to come to work, we will continue to fail the people that they are there to care for—the patients. The member is right to identify this as an important piece of work. I will invite the director general to make some comments about how we are tracking on some of these issues.

Mr V.A. CATANIA: Especially safety.

Mr R.H. COOK: We will come back and talk a bit more about safety once we have a bit of background.

Dr D. Russell-Weisz: Taking up the member's point about the satisfaction with Health Support Services, Health Support Services has undergone significant reform over the past two to three years. It is a very important health service provider; it is a health service provider in its own right. It deals with things that are very critical to staff working in our system. It has been reformed significantly. If the minister is happy, I will ask Mr Rob Toms to make some comments. It is recognised that its client service focus in the past may not have been optimal, and it needs to be reformed significantly. This is not tweaking around the edges; this is a whole of Health Support Services organisational reform. It wanted to measure whether staff are happy or not happy with the services it provided. It provides the majority of services to other health service providers over a number of areas, such as pay and information and communication technology services. I want to recognise the work that Health Support Services has done under the leadership of Mr Toms. He has gone in there and reformed the service, but also recognises that we want to see improvements year on year. We want to ask the staff and the health service providers how satisfied or dissatisfied they are, and therefore the specific areas in which we need to improve. If the minister is happy, I would like to ask Mr Toms.

Mr R.H. COOK: I invite Mr Toms to make some comments.

Mr R. Toms: We run this survey every quarter, and we survey all the people across the WA health system to understand what percentage are satisfied or highly satisfied with the services that HSS provides. It gives us a really good indication of the areas where we are doing well, and areas where we need to improve. That is all part of the overall transformation of our organisation that we are going through now. It does not measure the degree to which staff feel safe, or staff engagement or culture. That is picked up separately through our engagement surveys and culture surveys and the plans that are established to deal with those issues. This survey measures customer satisfaction with the services that we provide.

Mr V.A. CATANIA: Does the minister accept that it is quite concerning that only 50 per cent are satisfied with the services that are being provided? What is the minister doing to try to increase that satisfaction rate? What is the target? Is it 75 per cent or 95 per cent?

Mr R.H. COOK: The member is quite correct. In the past there has been a great deal of disillusionment with some of the other elements by which the staff are serviced. The health corporate network had a reputation of continually getting pay packets wrong. It was overpaying on a lot of occasions, and then trying to get that money back from the staff member, which was a source of great dissatisfaction. Under the new governance model we now have Health Support Services, and that has been an important transition to make sure that part of the health system is focused on providing better services to our staff, particularly the information technology they get to work with, the support they get and, from a corporate perspective, the accuracy of their pay, how their grievances are responded to and so on. Since we have established the health service providers, the director general has established PathWest and Health Support Services as standalone operations under a chief executive—Joe Boyle in the case of PathWest, and Rob Toms in the case of Health Support Services—to make sure that we have better customer-focused services in those parts of the system. I think they are responding significantly to the needs. As the member highlighted with some of those stats, it needed to be responded to. I think the member wanted to talk about how safe staff feel within the hospital environment; is that correct?

[12.10 pm]

Mr V.A. CATANIA: I was wondering whether that was part of the survey.

Mr R.H. COOK: The survey was specifically about how staff members are serviced as employees by the Department of Health and health service providers. Some very concerning staff safety incidents have taken place recently, particularly at Royal Perth Hospital, and we need to increase our efforts to ensure that staff feel safe in their workplace. We cannot eliminate all aspects of risk—I think we are all realistic about that—but we want to make sure that the systems in place can anticipate when situations are escalating to the point where there may be an outbreak of antisocial behaviour or can respond to those circumstances as best they can so we get on top of the issue before it becomes too dangerous. I think we have done pretty well at the latter—our security staff respond really well to emergencies, particularly in emergency departments. We have more work to do to make sure that systems better support situations as they start to escalate.

Mr V.A. CATANIA: Does the minister think that the pay freeze, for want of a better word, of $1 000 a year is having an effect on the morale of staff in the health sector?

Mr R.H. COOK: No. The member would be aware that this government has a wages policy. Members of Parliament and judges are subject to a pay freeze, but staff are subject to a wages policy of $1 000. For some hospital workers, a $1 000 increase will represent a good increase that is well and truly above the 1.5 per cent average that we have witnessed. It will not represent a big gain for other workers, but I think people understand that we are in a process of getting the state's finances back on track. I think people respond more in the workplace to whether they feel valued, whether leadership listens to their concerns when they raise them, whether they have the resources they need to provide the care they are trained to provide, and whether they feel leadership is taking them in a direction that continues to improve healthcare services. That is what nurses and doctors talk to me about when they talk about morale in the workplace.

Mr V.A. CATANIA: Given that we are looking at a 50 per cent satisfaction rate, there is clearly a lot to do to increase the morale of the Department of Health. I think the issue of pay influences how people feel and is having a significant impact on the 50 per cent satisfaction rate, but the minister is hoping to get it in the range of 66.7 per cent. I suppose that is more of a statement.

Mr R.H. COOK: I appreciate that, member. One of the reasons we are able to provide record investment in health, mental health and palliative care is that we are doing the hard work to bring the state's finances back under control and repair them after the previous government's crippling impact. I think people understand the importance of that work. They want to see the state get back on its feet, so we are making some difficult decisions. We do not step away from the fact that repairing the state's finances after the crippling impact of the Liberal–National government will take some hard work and some hard decisions. I think people understand that we are getting back on track.

Mr V.A. CATANIA: The minister's answer was good up until that point.

Mr R.H. COOK: I thought I would spice things up a bit.

Mr V.A. CATANIA: I cannot be bothered responding to it.

Mr R.H. COOK: The member cannot. That is the beauty of estimates.

Mrs A.K. HAYDEN: I refer to paragraph 21 on page 270 of budget paper No 2, which states —

> The Government is also enhancing its investment in existing core non-hospital services, with an additional $99.7 million to be spent on these services over five years.

How much funding has been allocated to prevention services, as a dollar amount and as a percentage of the total health budget for 2019–20 and the forward estimates?

Mr R.H. COOK: I thank the member for her question. Non-hospital services include a range of things, such as community health, public health and things of that nature. In the 2019–20 budget, an additional $99.7 million has been secured for existing core non-hospital services, including $43.4 million, resulting in a model output relative to previous non-hospital service budget settings. That sounds interesting! This includes parameter updates to obligations such as the Royal Flying Doctor Service and St John ambulances and so on. A sum of $5.6 million is allocated over two years to recognise demand pressures on services provided by the non-government human services sector. A sum of $29.3 million is allocated over two years to recognise contractual cost indexation across all contracts. A sum of $8.6 million is allocated over two years to continue to meet the costs of supporting the Karlarra House residential aged-care facility in Port Hedland. A sum of $12.8 million is allocated over two years to mitigate risks associated with the transition of home and community care services. The member talked about preventive health services.

Mrs A.K. HAYDEN: I am asking for the total preventive health budget and the percentage that is of the health budget.

Mr R.H. COOK: I will happily provide, by way of supplementary information, a breakdown of preventive health services. I also make the observation that under the sustainable health review —

The CHAIR: Minister, can you clarify what that supplementary information will be so I can allocate a number?

Mr R.H. COOK: The supplementary information will provide a breakdown of preventive health services under the state health budget.

Mrs A.K. HAYDEN: And the total dollar value and the percentage those services are of the total health budget.

Mr R.H. COOK: It will be the preventive health budget in a dollar amount and the percentage that is of the overall health budget.

[*Supplementary Information No A16*.]

Mr R.H. COOK: My understanding is that the sustainable health review came up with a number of 1.7 per cent of the total budget being dedicated to preventive health. The review made a recommendation that it should transition to five per cent by 2030, and we have accepted that recommendation. What first has to be done is to capture what we consider to be preventive health under that calculation. Let us say that it is 1.3 per cent. We need to be confident that it captures all the preventive health measures. I have often said that one person's preventive health measure is another person's chronic disease management, so it has to be clear in our minds what that number represents. That is the first piece of work we have to do on that recommendation of the sustainable health review. It will then be the responsibility of the system manager—that is, the director general of the Department of Health—to ramp up the budget and the activity associated with preventive health over time until it represents five per cent of the total health budget. I can assure the member that it is highly unlikely that I will be the minister in 2030, so it will be the responsibility of all —

Mrs A.K. HAYDEN: The minister will be looking for that palliative care, will he not?

Mr R.H. COOK: I hope it is not that soon!

It will be the important task of all members who are committed to preventive health being a greater part of our service delivery to make sure that we get to that five per cent over that time, and avoid scope creep, so that future directors general, or this one if he has enough legs in him, do not decide that things are preventive health just because they add to the five per cent budget. It will be a pretty important piece of work going forward. I hope ultimately that nationally we get a greater understanding of what preventive health is and does so we do not get that slippage. I share the member's passion for ensuring that we grow it as part of our overall budget.

[12.20 pm]

Mrs A.K. HAYDEN: I thank the minister for the answer. I wanted to clarify something. Is he saying that it is roughly 1.7 per cent now?

Mr R.H. COOK: Yes.

Mrs A.K. HAYDEN: The minister will provide me with the details by way of supplementary information. He said it will grow to five per cent by 2030.

Mr R.H. COOK: That is one of the recommendations of the sustainable health review, which we have accepted.

Mrs A.K. HAYDEN: I think it is 2029.

Mr R.H. COOK: I will be happy if we crack it by 2030; that will be good.

Mrs A.K. HAYDEN: What is a year! Considering that preventive health and assistance is the key to bringing down a health budget, does the minister think that is enough over a 10-year period? That is a long time to go from 1.7 per cent to five per cent. What does the minister think the increment will be? Will it be closer to this part of the decade or the latter part of the decade before we get to that five per cent?

Mr R.H. COOK: It is a great question. That is obviously part of the important work that we do under the sustainable health review, which is about precisely what the member just mentioned. We need to get ahead of the game so we can start preventing chronic disease, those risk factors that are associated with people requiring hospital care, and ensure that we are investing in the future of people's health rather than simply fixing people who present at a hospital. That is a complex and long-term piece of work and one that we have now put a number on. I am hoping that we will now be in a position to test ourselves, and see how we can shift the dial. The member is suggesting that if we have already got to three per cent by 2025, perhaps we should be looking at eight per cent by 2029–30 rather than the five per cent that we are currently committed to. That would be the task of future governments, but we are on the road.

While we are talking about those issues relating to the sustainable health review, I hope that the opposition sees it in a similar fashion to the Reid review; that is, it is an important piece of work that has to take place over successive governments. It is not a political document; it is a document on which governments of all persuasions should be able to anchor their work when reforming our health system, not just growing our hospitals and our hospital services to treat an ageing population with a higher incidence of chronic disease but challenging the elements that drive our health costs.

At some point I would love to hear some public commentary from the member for Churchlands on his attitude to the sustainable health review and the recommendations.

Mrs A.K. HAYDEN: As a personal indulgence, I have had quite a few people come through my electorate office. As the minister knows, it is in Byford. People are struggling. Spare cash is extremely hard to come by.

Mr V.A. CATANIA: That is why you got elected.

Mrs A.K. HAYDEN: That is right; exactly. One of the biggest issues that has been highlighted to me, which was a surprise, was obesity. People are struggling to combat that with no assistance. Unless they are on full health care cover, there seems to be no assistance. Is there anywhere here that the government will address that or try to help? Obviously, obesity leads to diabetes and other medical conditions that go along with that. These people are also suffering from mental health problems and depression because they cannot see a way out. They cannot afford to go to a gym and they cannot afford diet food. It is cheaper to buy McDonalds for the family than to make a healthy meal. Under the preventive strategy, is the state government looking at a way of implementing some sort of program to help people in this area?

Mr R.H. COOK: That is certainly one of the things that I have asked our population health section to challenge us on, looking at a range of these policies. The member would be familiar with a couple of our election commitments. One is the "health in all policies" framework, which is about trying to say that it is not just hospital services that impact on health. The member and I both have electorates in outer suburbs. I drive through the member's electorate quite a lot.

Mrs A.K. HAYDEN: The minister should stop and say hello.

Mr R.H. COOK: Indeed, member. One of the things that struck me is that as these new suburbs develop, we see an extraordinary proliferation of fast-food outlets. I am often challenged and wonder how I am going to eat healthily some nights. I do not always have time to go home to prepare a meal. Where do I go to get that healthy meal? I usually find myself going to a service station and looking at the protein bar section and a packet of nuts because I am in damage control at that point rather than thinking that I will ultimately get a healthy meal. These are huge challenges for us as a community. Our "health in all policies" framework and also the future health research and innovation fund will provide a significant change in the resources we have to put into the research of the questions around obesity in our community, and therefore the incidence of diabetes. To illustrate the member's point, Diabetes WA informs us that one-third of all hospital beds are taken up with someone with an issue either directly or indirectly related to type 2 diabetes. That disease is not always but often driven by lifestyle issues and essentially is one of the things that is crippling our health system. That is the reason we are now investing a record $9.1 billion in our health system.

As a member of this chamber, the member would know that the Education and Health Standing Committee is undertaking an inquiry into type 2 diabetes. I am really interested in seeing the outcomes of that committee's report because they might inform us about some other strategies that we can take up.

Mr V.A. CATANIA: I have noticed that a lot of the members on that committee have lost weight.

Mr S.K. L'ESTRANGE: I refer to page 277 of budget paper No 2, volume 1, and note 3 at the bottom of that page. It relates to the planned closure of the Quadriplegic Centre in 2020. I want a bit of information from the minister today. How many patients are still residing at the centre? Where is planning at, both with new infrastructure and the personal planning processes, for the residents? Can the minister provide an update on the work undertaken to identify alternative respite and accommodation options for those patients?

Mr R.H. COOK: I appreciate the member's concern about this. This is an important piece of work that we have to do to provide a better model of care for these consumers. I can confirm that there are 21 residents, which I think is down from 68 or 86 when this decision was first made. Clearly, a lot of residents at the quad centre have already transitioned out of the quad centre. We are continuing to support the needs of the residents who are still there and are working with individual service organisations around the needs of those specific patients. This is fairly complex and ongoing work but it is receiving a lot of attention from the North Metropolitan Health Service. One of the changes that we have made is that we have incorporated the quad centre from being a standalone board-driven entity to one that is now part of the North Metropolitan Health Service under an executive director, who is responsible for the quad centre and the transition to the new service model. I will ask Robyn Lawrence to provide us with some more detail about the work that has been undertaken.

[12.30 pm]

Dr R. Lawrence: Five workstreams are progressing and they are all progressing quite well. Planning for the existing residents is now at a phase that we have had some external providers working with the residents. That piece of work has now been overlaid by a clinical review provided by the existing clinical team that looks after those residents to determine the final level of care that each of those individual residents both desires but also requires, and therefore where it may be most appropriate for them to transition. The other work streams, of course, include a spinal cord injury service being established, and that has progressed well. There is a work stream that involves the construction of housing by the Department of Communities essentially aimed at individuals who have a newly acquired spinal cord injury, so they are not tending to go to the quadriplegic centre. There is also the construction of housing for existing residents who cannot transition to community living, and there is transitioning of the workforce. All of the work streams are on track. I think we are still finalising the work with the residents to determine the ultimate best model for those requiring ongoing supported residential care in the residential area.

Mr S.K. L'ESTRANGE: When there is a reference to "local area", we need to be clear what "local" is here. The reason I say that is that although a number of the 21 patients have families living in other local areas, they consider where the centre is at the moment to be their local area. What are we doing to support them?

Mr R.H. COOK: As the member would be aware, there is the development directly opposite the car park, which is the Montario Quarter. I understand we have an option on a range of lots there as part of the solution or a package for those residents for whom moving from that area is suboptimal. That is part of what we are contemplating for those who do not want to move from that site. I emphasise to the member that this is something we will do in conjunction with the residents. We are not going to force people out or away or into circumstances that do not meet their needs. We want to make sure that we are doing this sensitively and against a time line that is about meeting their needs and not about meeting our desired construction time lines. We want to make sure we do this very carefully. If the member would like a further briefing, we will detail work that is going on. I am very happy to make that available to the member, because this is an important piece of work and we want to do it as sensitively and methodically as possible.

Mr S.K. L'ESTRANGE: I thank the minister for that offer. We will take him up on it. One of the things my research officer and I have been trying to do is to get back in front of those 21 people, who are keen to talk to us. I am not looking at this as some divisive political issue.

Mr R.H. COOK: No, I appreciate that.

Mr S.K. L'ESTRANGE: I am generally trying to represent these people, and we have not been able to get access to them. I would appreciate it if, following the briefing, I could then get access to these people, sit down with them and have a cup of tea and a conversation, like I did last year. That would be much appreciated. In the minister's answer he mentioned that the government was looking at options of lots of land directly adjacent to the current facility. Does the minister have an update about where the planning of the facility is at, how many beds it is thought it will have, what it will cost, what it will look like, how many full-time staff there will be and that sort of thing?

Mr R.H. COOK: I will invite Robyn Lawrence to make further comment.

Dr R. Lawrence: It is very early in the process, to be honest. We have some preliminary designs and we have scoped what it could look like. Until we know the exact number of residents and the level of care they are all going to need, it is pretty hard to finalise that. There are also options about where it is located in conjunction with other services that will also be in the area and how we may be able to work together for the best outcome for the residents.

We are trying to keep that scope open until we are 100 per cent clear what the residents require and where they desire to have that.

Mr R.H. COOK: Anecdotally, some said they wanted to live with other residents and others want to live alone or in a single room. We just need to understand it better. Again, this is about working with the residents to get the best possible outcome for them.

Mr C.J. TALLENTIRE: My question relates to the future health research and innovation fund referred to on page 267 of budget paper No 2, volume 1. There are some significant figures relating to changes and new initiatives there. Can the minister tell us how the McGowan government is progressing his commitment to the establishment of that future health research and innovation fund?

Mr R.H. COOK: I thank the member. This is obviously one of the key features of this budget. It is one of our key election commitments as well. The future health research and innovation fund is a policy about setting the health system up for the future and making sure it is doing a range of things. It is about creating jobs in a diversified economy by making sure that we significantly improve the amount of money available for medical research and innovation in this state. I mentioned the other day that we made the budget announcement about this at the Harry Perkins Institute of Medical Research. We stood at the Harry Perkins institute to make this announcement and across the road is the Telethon Kids Institute. The member might be interested to hear that that represents the workplace of over 1 000 different medical researchers and staff, so this piece of work relates to jobs. It is an important part of contributing to the diversification of the Western Australian economy. In addition to that, it is about making sure that we have the best clinical services available to the Western Australian population. We made that announcement with a chap called David, who unfortunately fainted during the press conference. He testified that it was because he was able to get early exposure to clinical trials that he was cured of the cancer that had riddled his body to that point in time. It is also about getting the very best and brightest to practise in Western Australia. It is about making sure that Western Australia attracts those young researchers and people who are really hitting their clinical straps and that they come here not as part of a decision often typified as one made towards the end of a career, but because we have the best researchers and they want to be in this space. That has a huge dividend for patients. Of course, it is about making sure that our patients get the best possible care. Ahead of our legislation, which is about repurposing the future fund into a sovereign wealth fund for medical research and innovation, we are indicating in this budget a $52 million investment that will take our overall medical research and innovation investment over the forward estimates to more than $126 million. At the moment we spent somewhere between—I could never get a straight answer out of the former government when I was in opposition and I still cannot!—$12 million and $18 million for medical research, depending on what cycle we are in around what I think was then called the future health initiative.

Dr J. Williamson: It was up to $8 million in addition to the base funding—now $20 million—that we had at the same time.

Mr R.H. COOK: We are looking for a significant uplift around medical research in this state, because we want WA to be global leader in research and medical services and we want to have a real expertise in them. We have great expertise in lung, heart and some cancers, particularly with the delivery of remote health care. That is one of the reasons that it is important that we look beyond simply what we are doing now and really invest in a way that we can envisage how our health service will change in the future. Now, more than ever, the digital economy and health technology are changing the way we deliver health services in a way that we have never done before. The current generation of medical practitioners and clinicians have a bigger opportunity than any generation of medical staff in the history of the world. Now is the time for us to really get in and do some significant investment in medical research and innovation. I am excited about where we can go on this.

Mr V.A. CATANIA: I refer to "Sustainable Health Review" on page 269 of budget paper No 2, volume 2, and note 10, which refers to King Edward Memorial Hospital. Firstly, is it the minister's understanding that 65 per cent of the proceeds of sale of the TAB that this government is proposing—before coming to government the Labor Party said it would not sell any assets, but I will put that aside—will go towards the build of a new King Edward Memorial Hospital at the Queen Elizabeth II Medical Centre site? Is that predicated on the sale of the TAB?

[12.40 pm]

Mr R.H. COOK: Under the sustainable health review we identified a new women's and babies' hospital being a high priority for Western Australia. We all understand that that hospital, which was built in 1916, is an ageing piece of infrastructure that really needs to be improved to meet the needs of the community going forward. The member will recall that the Reid review of healthcare services recommended a new women's and babies' hospital be developed at the Queen Elizabeth II Medical Centre site, and that work is now in the planning stages as part of a $3.3 million allocation for pilot projects under the sustainable health review. That work will now start to take place. We are looking forward to starting the early planning of that and getting an idea what that build will look

like, where it will be located and what are the other needs around QEII at the same time—we envisage that it will need a new car park and so on. In addition, the government has committed 65 per cent of the sale of the TAB to go towards a new women's and babies' hospital. Prior to the election, we said that we would listen to the racing community on what it thought would be the future for the TAB, to clarify the member's characterisation of our election commitment. That is because we wanted to be informed by the racing fraternity—doggies, thoroughbreds and trotters—about the needs of their industry and whether the sale of the TAB would be part of that equation. Those negotiations and discussions, as the member knows, have been informed by the racing community, and we have agreed that we will sell the TAB as part of the reform of that industry.

Mr V.A. CATANIA: They have agreed to sell the TAB and will put 65 per cent into the hospital?

The CHAIR: Member for North West Central, let the minister finish his answer, then you can ask him another question.

Mr R.H. COOK: We are now starting to stray off the issue of the new women's and babies' hospital, but will the Chair indulge us for two more minutes? They agreed that 35 per cent of the sale of the TAB would go to an industry fund, out of which many country racing clubs and grounds would continue to receive support, particularly around infrastructure and things of that nature.

Mr V.A. CATANIA: What is the anticipated amount if the government sells it? Has the minister spoken about that?

The CHAIR: Member for North West Central, hold your horses and let the minister finish his response.

Mr R.H. COOK: Yes. I appreciate the question. Apologies, Chair. The answer to that is that I do not know, because that is the nature of the sale. I am not privy to that information and if I were to provide an answer, I would be guessing. The government has committed to making sure that 65 per cent of the sale goes to the new women's and babies' hospital because we recognise that that is an investment into the future for the people of Western Australia. Each year around 3 000 babies are born at King Edward Memorial Hospital for Women. A large proportion of those are people who come from regional communities and who are suffering from complex needs during their pregnancy, and therefore have to be in a tertiary setting to ensure their safety and that of their baby. This is a statewide facility. It has provided care for literally generations of mothers and babies right across Western Australia. It is an important part of what we do in health care. From that perspective it is a great way to make these resources an investment into the future for everyone in Western Australia, in particular mums and bubs. We know that King Edward Memorial Hospital for Women continues to do great tertiary work around premature babies and understanding their health needs, but it also continues to provide important health care for people of Aboriginal background, people from rural and regional communities, and people right across the metropolitan area who have complex needs and need to be in that tertiary environment.

Mr V.A. CATANIA: I totally agree with the need to have a new King Edward Memorial Hospital for Women. My son was a premature child and born at King Edward Memorial Hospital for Women and spent several weeks there before he was able to go home. I do not disagree with the government's intent and will, because it is an ageing piece of infrastructure that is well and truly past its use-by date, but the government is banking on, as the minister said, 65 per cent of the proceeds of the sale of the TAB going towards a new hospital. What is that 65 per cent? The minister has said that he does not know what the sale of the TAB could be worth. If the sale of the TAB is worth $300 million and that is all the government can get, 65 per cent is not a huge amount of money to pay for a new hospital, nor is it a huge amount of money to put into racing or to protect regional racing. Can the minister see how I think that predicating a new hospital based on the sale of the TAB can be fraught with danger because there is no guarantee of a price? The minister is saying that a contribution will be made to build three quarters of a hospital.

Mr R.H. COOK: I understand the question now. I appreciate that member. We are not pretending for a moment that that will pay for a new hospital. I do not know what the TAB is worth, but the bloke on my right says I am not going to get much change out of $1 billion for a new tertiary hospital, particularly on a site as constrained and active as QEII is.

Mr V.A. CATANIA: And given what the Perth Children's Hospital cost.

Mr R.H. COOK: Too soon! The wounds are still open! The idea is that that money will go into a special purpose account, which will be a down payment on the hospital. Clearly, it will not pay for a whole hospital; we understand that, but we think it is an important down payment and contribution to building the women's and babies' hospital.

Mr V.A. CATANIA: What if the bill for the sale of the TAB does not pass through Parliament? What options will the government have? Will it contribute the $300 million owed to the state by BHP to the new King Edward Memorial Hospital, as happened with the Perth Children's Hospital when the resource companies made a contribution?

The CHAIR: You are starting to push the boundaries, member, in regard to relevance.

Mr V.A. CATANIA: No, the question I am asking is: has the minister sought alternative ways of funding a new hospital, given the fact it is going to cost around $1 billion? Who knows? Has the minister looked at any other ways of funding that hospital if the bill for the sale of the TAB is not passed through the houses of Parliament and is not supported by industry? If the sale returns only $300 million, there will not be much left to protect the industry into the future.

Mr R.H. COOK: It is an interesting question. Obviously, that is outside the purview of the Minister for Health. I will take any contribution to the hospital and part of that $3.3 million will be used to look at the funding options that are available to us. As the member knows, in a sophisticated financial market there is a whole way of financing these things. I am not anticipating which way we would go with that; that is the detailed planning that now needs to take place. I am looking forward to that work starting, because it is time that it did start. As I mentioned, King Eddy's is an old hospital. Staff tell me that the roof leaks. I do not doubt that and I certainly know it leaks at Harvey House, which is the original building that housed the hospital. In this year alone, we will spend $15.2 million just on works to maintain the current hospital site and to make sure that it can continue to maintain world-class health care. It is a tertiary hospital; it needs to be functional right up to the point when we transition those patients out. It is early days, member, and from that point of view, $3.3 million is there for planning over the current 12 months. That will get the ball rolling. We will have the proceeds, whatever they may be, as a down payment, and that will sit in a special purpose account. Treasury will determine the basis on which we draw upon those funds, but, ultimately, it will all come together as part of the business case for the hospital.

[12.50 pm]

Mr V.A. CATANIA: Is the minister saying that if the sale of the TAB does not go ahead, that will not prevent a new hospital being built? In the minister's words, the hospital was built in 1916 and we need a new one, so it has to happen no matter what.

Mr R.H. COOK: Yes.

Mr V.A. CATANIA: If the sale of the TAB does not go through because the industry thinks that there will be no benefit from its sale, the government will put aside that funding model. Does it have other funding options up its sleeve to build a new hospital?

Mr R.H. COOK: Ultimately, we have to build that hospital. We will continue to examine those opportunities. I should say also that the current hospital site and the car park is smack in the middle of Subiaco. We are talking about good real estate here. We should be able to do a range of things that will assist the procurement of that build, but it is for people above my pay grade to crunch the numbers and to look at the opportunities.

Mr S.K. L'ESTRANGE: I refer to the outcomes and key effectiveness indicators table on page 274 of budget paper No 2, volume 1, and the data relating to immunisation. The table shows that a smaller proportion of Aboriginal children aged 12 months and two years old were immunised in 2018–19 than were non-Aboriginal children. Given the government's recently introduced Public Health Amendment (Immunisation Requirements for Enrolment) Bill 2019 will exempt Aboriginal and Torres Strait Islander children from those immunisation requirements for enrolment, how does the government intend to achieve the 95 per cent target for this cohort of children in 2019–20?

Mr R.H. COOK: I appreciate the question. I will ask the Chief Health Officer to comment after I make my initial observations. The no jab, no play legislation will implement a policy announcement of Prime Minister Turnbull to improve the level of immunisation rates for children right across our community. In the first instance, the legislation will require preschool education entities—that is, kindergartens and preprimary schools—to record and maintain a register of immunisation rates of the children in their care. When we find out where these kids are, we will be able to work with their families and those institutions to make sure that we bring those children's immunisations up to speed. We will not exclude a child simply because they are not fully immunised. It is an opportunity to intervene and provide health care to a particular child. The way that it will operate is that when any child—Aboriginal or non-Aboriginal—comes to preprimary or kindergarten and their purple book reveals that they are not up to date with their immunisation, we will have an opportunity to identify that child and make sure that we update their immunisation. The exclusion of a child will be the final resort only when parents refuse to participate and will not get that child immunised.

Mr S.K. L'ESTRANGE: I understand the policy, but my question related more to the fact that the percentage of Aboriginal children who are immunised is significantly lower than that of non-Aboriginal children at the moment and that the government has introduced a bill to try to fix that situation but that it will exempt Aboriginal and Torres Strait Islander children from complying with the bill's provisions. What is the government's strategy going to be? The immunisation rate of two-year-old Aboriginal children is 82.6 per cent. As the minister knows, those rates should be 95 per cent, and that figure for Aboriginal children is more than 12 per cent short of achieving herd immunisation. What is being done to pick up Aboriginal and Torres Strait Islander children if they are not compelled by the bill?

Mr R.H. COOK: That is right. I also draw the member's attention to the fact that for five-year-old Aboriginal children, the rate is over 95 per cent—that is, in fact, higher than the immunisation rate of non-Aboriginal children. That demonstrates clearly that by the time Aboriginal children enter compulsory school, school nurses are able to undertake that immunisation. That is the opportunity that the new legislation will provide. I will ask the Chief Health Officer to provide us with a bit more background on that work.

Dr A.G. Robertson: Although part of the change to the regulations will exempt that group from being affected, it will identify those members of that group. It is not designed to just exempt them from that requirement; it is designed to exempt them while we identify the group and their requirements, and work with them to put together a vaccination program to ensure that those numbers do go up. Over time we will bring that percentage of the population back to the required rate of 95 per cent.

Mrs A.K. HAYDEN: I refer to page 268 of budget paper No 2, volume 1, and the line item "Hospital Services—Revised Activity and Cost Settings" in the spending changes table. Can the minister explain why the funding for that line item decreases over the forward estimates and what impact that will have on service delivery?

Mr R.H. COOK: I thank the member for the question. I will ask Angela Kelly to initially comment on that specific line item.

Ms A. Kelly: The spending change is largely associated with the 2018–19 year. We had an increase in activity—the activity for this year increases and that flows through to next year—and our price has increased by one per cent. That is largely the spending change. Then there is a greater amount as we go through and look at total activity in price. It is based on population; so, age-weighted population growth and price growth.

Mrs A.K. HAYDEN: Does that mean that due to population growth, the department will receive more money so the cost to deliver these services will be less for the government?

Mr R.H. COOK: We have a trajectory on how we expect activity to grow over the forward estimates. If in the actual year there has been an uptick of, say, two per cent, they will all pop-up by two per cent. For instance, in dollar value that $36.2 million is less than the $44.7 million, but that does not suggest that is a reduction in growth; it is simply saying that on the basis of our current projections for activity we expect growth to now be around $36.2 million in that year. In 2019–20, there will be an another reconfiguration, or recalculation, of the base, depending on the actual activity in 2018–19, so the whole thing will jump again. That reduction does not represent a reduction in activity; it simple represents a way of managing the budget across the forward estimates, undertaking what is from today's perspective the most accurate calculation of the demand across the forward estimates. It is essentially a projection based upon the base, which in this case is the 2018–19 year.

The appropriation was recommended.

Meeting suspended from 1.00 to 2.00 pm