Division 22: WA Health, $5 975 582 000 —

Mr S.J. Price, Chair.

Mr R.H. Cook, Minister for Health.

Dr D. Russell-Weisz, Director General.

Ms A. Kelly, Acting Deputy Director General.

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

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

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

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

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

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

Ms K. Gatti, Acting Chief Executive, South Metropolitan Health Service.

Dr A. Robertson, Chief Health Officer.

Mr C. Dawson, COVID-19 Vaccine Commander.

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 close of business Friday, 1 October 2021. 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.

I give the call to the Deputy Leader of the Liberal Party.

Ms L. METTAM: I thank all the advisers for their attendance. I refer to page 307 of budget paper No 2, volume 1, and the total cost of services. Budget paper No 3 also highlights that the government has invested $1.9 billion into the state's health and mental health systems. Can the minister please explain why the total cost of services is decreasing by two per cent from $10.36 billion in 2021–22 to $10.15 billion in 2022–23?

Mr R.H. COOK: Thank you very much, member. I appreciate the question; it is an important one. During the COVID-19 pandemic there has been a lot of fluidity with many of the budget allocations. Essentially, the total cost of services reflects the allocation against WA Health, but that is separate from the allocation for the COVID-19 pandemic. At the moment, the allocation for COVID-19 is reflected in the consolidated accounts. It is not allocated against the total cost of services. At the moment, the COVID-19 response has a six-month allocation. The member will see adjustments to the COVID-19 allocation in the *Government mid-year financial projections statement*. The total recurrent expenditure for WA Health is budgeted to increase to $10.4 billion in 2021–22, which is 1.4 per cent over the 2020–21 estimated actual. That reflects an uplift to hospital services and budget for the vaccination program. Once adjusted for COVID-19, expenditure growth increases to 3.7 per cent.

The reduction in total budgeted health expenditure from 2021–22 to 2022–23 reflects the absence of any budgeted COVID-19 funding in 2022–23, along with a reduction of $201.1 million in time-limited funding. This includes, for instance, the timing impact of commonwealth program funding and specific project funding concluding in 2021–22—for example, the HealthNext implementation and the government's priority maintenance package. Adjusted after these factors, expenditure growth is 2.9 per cent.

Ms L. METTAM: Budget paper No 3 refers to the unwinding of COVID economic spending, I assume that this refers to all COVID spending in our hospital sector as we move forward.

Mr R.H. COOK: It may not reflect all of it, member. I will just invite the director general to make some comments.

Dr D. Russell-Weisz: As the minister said, the COVID-19 spending is for six-months this year, whereas going back it is fluid. The COVID-19 spending covers a suite of areas that we spend on. It could be for personal protective equipment, equipment, vaccinations or specific staffing. The latter can come through our State Health Incident Coordination Centre, the Public Health Emergency Operations Centre or our health service providers. We will go back in the midyear review and seek additional funding when we know more about the COVID expenditure for the next six months. We are not sure how it will look next year, but every time we have sought funding for specific COVID expenditure, we have got it. But funding moves around and for certain areas we get 50 per cent from the commonwealth. Under the national partnership agreement between the commonwealth and all states, the commonwealth pays 50 per cent of specific COVID expenditure, but not all COVID expenditure.

[9.10 am]

Ms L. METTAM: Just to clarify, is the director general anticipating that additional funding will not be required at this stage for the COVID response in six months' time? Is that what has been spelt out?

Dr D. Russell-Weisz: No; we expect there will be COVID funding. It may be required in six months, maybe even for the next financial year. But this is fluid. It is much better to liaise with Treasury every six months when we know what the commonwealth and the state are funding. That is why there is a six-month allocation. We expect another six-month allocation, and in addition, we would expect COVID funding in the 2022–23 year. I might just ask Mr Anderson to comment on whether there is anything I have missed out.

Mr R.S. Anderson: The 2022–23 production is primarily as a result of COVID expenditure not being budgeted, so it is not that we do not expect there will expenditure in the year, it is just too early to know what it will be. I think the member asked the question about whether it was hospital or non-hospital funding. It includes hospital expenditure such as personal protective equipment, pathology testing, COVID clinic activity and supply of medical equipment, but it also includes the hotel quarantine costs, the costs of the State Health Incident Control Centre and the vaccination program. We have an appropriation of about $301 million for this financial year that we estimated at the start of the budget process, which is probably about half of what we would need. As the director general said, we will go back through our midyear review, once we have a better idea of the expenditure for this year, and seek an appropriation for that.

Mr R.H. COOK: I might just add to that. Obviously, we will see a significant change over the next six months in the way we respond to COVID-19. We will be going into the tail end of the first vaccination program, but then we will have to look at a booster program. Obviously, the commonwealth will want to adjust international border arrangements. That will impact on our operations. Also, as we see Delta wash through society and the community, we will need to have a better line of sight on what we need to do in response to that. There are a lot of moving parts to this, so that is why we choose not to try to predict what it will look like in 12 months' time.

Ms L. METTAM: If recurrent funding provided solely for COVID-19 was removed from the total cost of services, in essence reflecting the removal of that one-off investment, what would the total cost of services be for the years 2021–22, 2022–23 and the forward estimates?

Mr R.S. Anderson: Sorry, I have to go back to the budget paper for the question. It is difficult, because we do not know the total appropriation for COVID, what the cost would be, for those years. Just to be clear, too, in 2022–23 there are time-limited funding elements that are not in 2021–22, and these include one-off funding for government programs for which sign-off has not been achieved at this point in time. We could make an estimate and tell the member what we think it would be.

Ms L. METTAM: Can we do that via supplementary information?

Mr R.S. Anderson: Yes.

Mr R.H. COOK: That will be supplementary information about forward estimates expenditure, excluding COVID-19 response expenses.

[*Supplementary Information No A13.*]

Ms L. METTAM: I refer to significant issues impacting the agency on page 309 of budget paper No 2, volume 1. The first point refers to the resumption of projects that had been disrupted due to the pandemic and measures to return service delivery to pre-pandemic levels, such as the elective surgery blitz. When was this blitz, how long did it last and how many surgeries were performed in that time?

Mr R.H. COOK: That is a cracking question, member! It essentially started in the second half of 2020. I think we anticipated it going through to early 2021. I will ask the director general to provide specifics. My recollection is that it was around a $26 million investment to basically to catch up on that elective surgery that was suspended in the first half of 2020. I think we made a great recovery on the elective surgery waitlist.

Dr D. Russell-Weisz: The minister is correct: the investment was around $36 million and it was to recover from that two-and-a-half-month—it may not have been two and a half months—lockdown period that we had in WA. That was a focused elective surgery blitz at all our centres, both rural and metropolitan. I will probably have to take on notice the exact number of surgeries related to the blitz, but obviously we did significantly more surgery. We have been doing more surgery year on year if we just take out that three-month period. There has been a significant focus on improving performance in elective surgery. On the most recent figures published by the Australian Institute of Health and Welfare, we are still the second-best performing state on elective surgery. The way we are measured is on the percentage of cases that are over the boundary or with a wait longer than the expected time.

Ms L. METTAM: Is that for all cases across the board?

Dr D. Russell-Weisz: Yes, it is. There are two groups of cases. Unfortunately, they are clunky words. One is called "reportable" and the other is "non-reportable". We measure everything. A non-reportable case is like a gastroscopy or colonoscopy. It is basically a procedure room–type of surgery. The reportables are everything, from the most complex cardiothoracic surgery right down to simple day surgery. We obviously aim as high as possible; that is, we are doing in the 90 per cent range, so between 90 and 100 per cent, of surgeries in the recommended time. Category 1 surgeries have to be done within 30 days, category 2 within 90 days and category 3 within 365 days. As at 31 August 2021, 11.6 per cent above those cases were waiting over-boundary, but, as an example, the number of patients admitted for elective procedures in August 2021 was 14.7 per cent higher than the previous month. We are trying to do as much surgery as possible, and we have made significant improvements in what would call our "non-reportable over-boundary cases", because they are as important. These are diagnostic procedures for patients to know about whether they need surgery for cancer or anything else. We basically focus on getting our waitlist down and making sure we are getting as many done within boundary as possible. As the minister said, the blitz ended in January, but we then went back to trying to do as much elective surgery as we could. The indicative figures we are looking at at the moment show that over the last three years we have been using an extra 147 beds across our whole public health sector for elective surgery work. We are doing more and we are doing more complex work.

[9.20 am]

Ms L. METTAM: How many elective surgeries were cancelled or postponed last month?

Mr R.H. COOK: Through the director general.

Dr D. Russell-Weisz: This is from 1 August and weekly; I will not try to add it up in my head. The cancelled planned surgeries in the primary metropolitan area for the week ending 8 August was 269; for the week ending 15 August, 266; for the week ending 22 August, 258; and for the week ending 29 August, 258 as well. That is about 1 000 surgeries, remembering that these are not 1 000 additional surgeries that would have happened in comparison with another month. All health services will decide on what surgeries they can do in relation to their bed pressures. Also, certain surgeries will need intensive care and other care, and if those beds happen to be taken up with other urgent or emergency work, there will be some cancellations. We would have to compare that with other months, and, obviously, in August we had significant pressures on our emergency department and in relation to staff sickness because of significant respiratory illness at that time. We do not like cancelling surgery—nobody likes cancelling surgery—but we must have the capacity to do that surgery. Those are the numbers for August.

Ms L. METTAM: My understanding is that those figures are just for metropolitan hospitals. Were there any cancellations in country hospitals, and does the minister have those figures?

Mr R.H. COOK: Director general.

Dr D. Russell-Weisz: I do not have those figures on me. We can provide them. There would have been some cancellations. Maybe Mr Moffet would like to make a comment.

Mr J. Moffet: We have had cancellations each week. We have been recording those and reporting them through. I do not have the specifics of those numbers, but similar to the director general's comment, it is usual to reschedule depending on ICU capability, surgeon availability and also patient readiness for surgery. It is ordinary for us to have some rescheduling each week, but it has been higher particularly in the past month. I do not have the specific figures for country health on me.

Ms L. METTAM: Could that be provided by supplementary information?

Mr R.H. COOK: Yes, cancellations of elective surgery for August in the WA Country Health Service.

[*Supplementary Information No A14.*]

Ms L. METTAM: When are elective surgeries predicted to resume, or have they resumed?

Mr R.H. COOK: Director general.

Dr D. Russell-Weisz: We took down some of our non-urgent categories 2 and 3 in September, which the member is referring to. The teams met yesterday and we will be uplifting those come October. Usually our elective surgeries, nationwide, drop during school holidays, but post the school holidays we will be lifting them up. Obviously, we will concentrate on the category 2 surgeries because they are more urgent than category 3 and then all health services will start rebooking depending on workforce, capability and capacity in the elective surgery area. I can say that there is a significant amount of effort in recruitment drives and on workforce strategies to supplement our workforce to make sure that we can do as much elective surgery as possible. Post the school holidays, they will resume with a focus on category 2 and then category 3 surgeries.

Ms L. METTAM: Will the department seek to implement another blitz to attend to the increased number of patients on the waiting list?

Mr R.H. COOK: I do not think we will need to do a blitz specifically, because the suspension was for a matter of weeks as opposed to a matter of months as took place in 2020. The department will reschedule those operations that had to be postponed and basically utilise the flexibility of the rosters and theatre times to reschedule those.

Ms L. METTAM: Given that there have been restrictions on elective surgery, can the minister see that this may lead to other challenges with acuity? I note the minister has spoken about the different levels of acuity that we are seeing in our health system.

Mr R.H. COOK: There is no hard evidence about the postponement of elective surgeries or other treatments and the presentation of acute cases in subsequent months. The Royal Australian College of General Practitioners hypothesised that it is more about people not getting to their GPs—that is, being able to check out that lump or pain for an emerging issue—rather than the scheduling of the operation. I stress for members' information, no category 1 and urgent category 2 operations were rescheduled. We are really looking at the lower end of the clinical program in terms of acuity and only rescheduling those when it will not have a negative clinical outcome. It is more about the deferment of treatment in primary care, and that is not picking up those early signals of a more chronic condition. That is why, I guess, people hypothesise that we are seeing such high numbers of category 2 triage presentations at emergency departments now, because people did not get to their GP in 2020.

I should say that there is a level of constraint around GP availability in 2021, because a lot of GPs are dedicating resources to the vaccination effort, which, of course, we support. From that perspective, I do not think from the elective surgery program there would be any adverse health outcomes from these deferred operations. It is more about whether people got to see their GP earlier or got on a treatment program earlier for other conditions which then tip into more chronic situations.

Ms L. METTAM: What is the current average waiting time for patients in the two categories of elective surgeries, categories 2 and 3?

Mr R.H. COOK: As the director general said, category 1 is for 30 days, category 2 is for 90 days and category 3 is for 365 days. From that perspective, depending on the categories, there can be different waiting times. It is perhaps easier to talk about it in relation to over-boundary surgeries. For instance, in August 2021, there were 1 171 over-boundary cases out of 7 094 total admissions. That gives the member an idea about what that looks like. For instance, of the 1 921 category 1 elective surgery operations in August 2021, 246 were over-boundary. That gives the member an indication that they waited slightly longer than the 30 days. In relation to category 2, there were 2 340 operations undertaken—of those, 630 were over-boundary; that is, they were people who waited longer than 90 days. Total admissions in category 3 were 2 833, of which 295 were over-boundary, which is 365 days. That gives the member an idea of where and to what extent those delays are happening.

[9.30 am]

Ms L. METTAM: I have a further question.

Mr R.H. COOK: Sorry; was that helpful?

Ms L. METTAM: Yes, that answers it. Thank you. Has the private sector been utilised at all to undertake any elective surgery to reduce waiting lists, and has that been a consideration?

Mr R.H. COOK: Yes; it has certainly been a consideration. The director general has continual conversations with the private hospital sector in terms of its capacity to perhaps lend a hand. My understanding is that the private hospital sector is going gangbusters and does not have a lot of capacity to spare for this. I might ask the director general to provide further comments.

Dr D. Russell-Weisz: Thank you. Through the minister, I think the minister has really said everything. Occasionally, we have used the private sector over the last few years to do some elective surgeries, but it is extraordinarily busy. Our main discussions with the sector have been over the last 18 months and we have worked very closely with it in relation to COVID-19 response, because we had to do this using all our stakeholders, be it the private sector or the community. As the minister said, the private sector is extraordinarily busy. Usually, we can transfer some patients

for elective surgery. That is certainly one of the strategies that we may use in any acute surge or COVID-19 response. Unless we are doing it on a longish-term basis, it is quite disruptive for patients because we might have to refer to a different surgeon when the surgeon in the public sector has actually seen that patient in outpatients and quite clearly wants to operate on them. But the private sector is always in our consideration, and I think if it were sitting here, it would say that it was extraordinarily busy in dealing with private patients. The private sector obviously had a lockdown at the same time, which was for about two and a half months last year, so it had a lot of private surgeries to make up.

Ms L. METTAM: The private day surgeries have spoken to the media about what the opportunity might be to address some of the elective surgery backlog. What is the minister's comment on that opportunity, and why has it not been taken up?

Mr R.H. COOK: It is a good question, member. Perhaps we should have covered this when we were talking about the suspension of some elective surgeries over August. We focused on multi-day surgery because we were trying to free up the beds, not necessarily the workflow of operations. If we have people coming in for a single day procedure, that does not take up overnight beds, which means that the opportunity to build capacity into the system is not as great. Therefore, in terms of any rescheduling of elective surgery, we really made sure that we focused on multi-day beds. I will ask the director general to make a further comment.

Dr D. Russell-Weisz: Thank you. Through the minister, that is correct. We have not gone out and suspended the day surgery or even the procedure room surgery. The member's question was about why we have not used the private sector, and I saw that in the media when a very small day surgery provider offered some of its capacity. We have done a lot of work on short, sharp day surgery such as gastroscopy and colonoscopy. Although we could go to the private sector, we have made huge improvements in our own hospitals. Health services providers who are here today can contract with the private sector should they wish to, and we have done in the past. But we also have to look at the patients, and if the patients have complexity or acuity, a lot of the smaller private sector providers do not want to take particularly complex patients. Therefore, those patients need to stay in either our outer metropolitan hospitals or our tertiary hospitals, but that is not saying that we would discount it, and we are always happy to talk to the private sector.

Ms L. METTAM: I refer to budget paper No 2, volume 1, page 310 and paragraph 17.1 regarding Joondalup Health Campus. Can the minister confirm that the McGowan government's original commitment for this project was $160 million?

Mr R.H. COOK: I cannot recall now what we estimated the cost would be prior to the 2017 election. Oh! Here we go. Yes, I can, apparently.

Ms M.J. DAVIES: Here is one I prepared earlier!

Mr R.H. COOK: In 2018–19, $160.7 million was initially allocated for the expansion of the hospital, which was in line with our election commitments. An additional state investment of $96 million was approved in the 2019–20 *Government mid-year financial projections statement* resulting in a total project budget of $256.7 million, of which $158 million is funded by the commonwealth's WA hospitals infrastructure package. In terms of the member's question, yes; the original price was $160 million, but that was basically the best estimate of an opposition at the time. Upon coming into office, we wanted to make sure that we delivered on the election commitment, and so that required us to adjust upwards the actual cost for the project.

Ms L. METTAM: But, minister, is this not a broken promise? The election commitment, as I read it, actually changed. Not only did the state government's commitment go from $160 million down to $96 million, but the scope of the project changed as well. Eight operating theatres and a medihotel were mentioned, but now the project has been scaled back and there is one operating theatre. I would like to know what stage the medihotel is at.

Mr R.H. COOK: It is true that we adjusted the scope and size of the development. In relation to the medihotel, it remains part of the vision for the hospital, but it is part of what is called stage 2 of this development. We committed to the people of Joondalup in the northern suburbs a vastly expanded hospital, which included an expanded car park, emergency department and extra beds and, in particular, making good on a promise that I made in 2013 for a significant expansion of the mental health facilities. From that perspective, we are substantially delivering on that election commitment. It is slightly iterative, I guess, in terms of extra beds here and maybe we did not necessarily need an extra theatre there, but by and large we have delivered on that election commitment. I think the people of the northern suburbs really appreciate the significance and increase of services that we have there. It includes the construction of 215 staff car parking bays, which will be completed by late 2021, and the construction of a 565-bay multistorey public car park that will commence in late 2021. We have development approval for a new 110-bed mental health unit, which is obviously going to be a significant contribution to mental health services in the area. We are building capacity for an extra 90 inpatient beds as well as extra operating theatres. Whenever we do these things, we come to it and we confront technical and service delivery imperatives, and adjust the commitment on

that basis. But we have significantly delivered on that election commitment, and I think the people of the northern suburbs would agree with us.

[9.40 am]

Ms L. METTAM: A medihotel was clearly mentioned as part of that election commitment in addition to the eight operating theatres. Can the minister clarify where the medihotel is at, how many beds it will contain and when it will open?

Mr R.H. COOK: It is a fair question. Different medihotels have different requirements, depending on the hospital and the leadership at that hospital. The medihotel that we are developing at Fiona Stanley Hospital is about a 60-bed facility. That is being constructed at the moment, whereas the medihotel at Royal Perth Hospital is a four-bed facility. It depends on the needs of the particular hospital.

Initially, I do not think our private partner, Ramsay Health Care, was as excited about a medihotel as we were. I am sure it would not mind me saying so. It has looked at what has been developed at Fiona Stanley and changed its thoughts about that development. We decided to get onto the hospital-based services at Joondalup Health Campus as a priority but we have ambitions to make sure we can get a medihotel at that site.

Ms L. METTAM: When is the medihotel at that site expected to open?

Mr R.H. COOK: We do not have a date yet.

Ms L. METTAM: When is construction set to begin?

Mr R.H. COOK: As I said, we are focused on the current redevelopments at the moment with the expansion of the mental health and inpatient beds and the expansion of the ED and operating theatres. That is occupying the project team at this stage. We will get to the medihotel once we have reached the end of the current works.

Ms L. METTAM: Can I confirm that the scope of the Joondalup Health Campus project, as promised in 2017, does not include a medihotel?

Mr R.H. COOK: The scope of the current works do not, but the medihotel will be developed as part of the ongoing redevelopment of the hospital.

Ms L. METTAM: The department indicated at last year's estimates that 10 designated youth inpatient beds would be open this year. Can the minister provide a further update on whether this has happened?

Mr R.H. COOK: Is this in relation to Joondalup?

Ms L. METTAM: It is in relation to Joondalup Health Campus.

Mr R.H. COOK: Is the member referring to the specific 10-bed adolescent unit?

Ms L. METTAM: Yes—10 designated youth inpatient beds.

Mr R.H. COOK: I will ask the director general to answer.

Dr D. Russell-Weisz: I might have to take that on notice.

Mr R.H. COOK: Member, were they mental health beds?

Ms L. METTAM: The reference was "youth inpatient beds" but they could well have been mental health beds.

Mr R.H. COOK: I will ask Tony Dolan, the acting chief executive of the North Metropolitan Health Service, to handle that one.

Mr A. Dolan: There is a plan for the Joondalup mental health expansion of beds to have youth services within them—the additional beds.

Mr R.H. COOK: Is that part of the development of those mental health beds?

Mr A. Dolan: Yes.

Mr R.H. COOK: My apologies, member.

Ms L. METTAM: That is okay. Just to clarify, I understand that the mental health beds are part of the scope. Can the minister clarify what stage that is at in terms of time frame?

Mr R.H. COOK: Is that in terms of the construction?

Ms L. METTAM: Yes.

Mr A. Dolan: Hopefully, the construction of the additional beds will be completed by about February 2025.

Mr R.H. COOK: The director general has some other comments.

Dr D. Russell-Weisz: As the minister said, the emergency department is being expanded, along with the significant expansion of mental health beds and the expansion of inpatient beds that are all planned over that period. The actual hospital beds in the emergency department areas are the first cab off the rank. The government had already opened—I am going to get the term wrong—a mental health observation area or a specific mental health ward in Joondalup about two or three years ago.

Mr R.H. COOK: Further, we opened the MHOA in 2019. That obviously provided extra beds. An extra 12 bays are being developed as part of the current rebuild of the emergency departments. That is just about completed. Then we will move to other aspects of the redevelopment.

Ms L. METTAM: In terms of the scope of the project for the emergency department expansion, is that what was originally promised?

Mr R.H. COOK: Yes, that is right; we promised an expanded ED. We have landed on 12 bays. That has been bolted onto the current ED in a configuration that will allow us to deal with infectious diseases more effectively. In the event that we have an outbreak of COVID-19 in the northern suburbs, it is anticipated that we will use these 12 bays specifically as part of the response. We can separate this ED from the other parts of the ED. It has negative pressure and, from that perspective, it would meet those needs. The early parts of this redevelopment will see those bays completed in the coming months and the staff car bays completed in the next couple of months as well. Then we will move to the visitor car park and other aspects of the redevelopment. Essentially, as far as the timetable for the process is concerned, obviously we are in the construction phase. Construction of the whole project is anticipated to be completed by 2025. Obviously, there are a lot of complex parts to that because it is a fairly extensive redevelopment.

Ms L. METTAM: Is the government still committed to a medihotel at Joondalup Health Campus?

Mr R.H. COOK: Yes.

Ms L. METTAM: I refer to the completed works under "Asset Investment Program" on page 327 of budget paper No 2. I wanted to confirm that the Royal Perth Hospital medihotel is a four-bed facility at a cost of $1.6 million.

Mr R.H. COOK: It is a four-bed facility with room to expand to an eight-bed facility. It has been operating for the best part of the last year. I will ask Liz MacLeod, the chief executive of East Metropolitan Health Service, to provide extra information.

Mrs E. MacLeod: Our four-bed medihotel at Royal Perth Hospital opened on 4 August. Primarily, the people who have been using the medihotel are from regional and rural areas. We are utilising the medihotel to provide some additional accommodation for their inpatient episode at Royal Perth Hospital.

Ms L. METTAM: Can the minister explain how a four-bed medihotel goes any way towards freeing up 54 tertiary beds a day, which is what the government's 2017 election material claimed?

Mr R.H. COOK: I cannot recall what the election material contained and specifically what was promised. We certainly said that we would develop a medihotel at Royal Perth Hospital. We have done that and we are constructing a medihotel at Fiona Stanley Hospital. The Fiona Stanley facility will be a 60-bed facility. We are very much looking forward to those works being completed.

[9.50 am]

Ms L. METTAM: Can the minister give a figure on how many tertiary beds a day a medihotel bed would free up; is it just four beds?

Mr R.H. COOK: It depends on what the medihotel beds are being utilised for. Sometimes they are utilised for patients who have to come to Perth prior to a procedure or surgery, and in that context they might go into the medihotel the night before rather than occupying a hospital bed. At the other end of their inpatient stay, they might stay an extra night. I was given an example of a woman who had had her procedure and was about to be discharged at about 6.00 pm, but she would have had to travel back to Toodyay that night, so rather than pushing her out onto the streets, we accommodated her in the medihotel. That freed up that inpatient bed for someone else who needed it given their acuity, and this person was allowed to spend the evening in a more relaxed environment before travelling. It really depends on the circumstances in which the medihotel beds are being used. I do not think there is a direct correlation between medihotel beds and beds being freed up, but they provide that flexibility for clinical leads to make sure that they can accommodate someone not only appropriately, but also cost effectively.

Ms L. METTAM: How many patients have utilised the Royal Perth Hospital medihotel since it opened? How many were regional patients?

Mr R.H. COOK: I will ask Ms MacLeod to respond.

Mrs E. MacLeod: I have numbers for the first six months. We had 124 people come through. I can provide additional information, because the service was scaled up as we were getting the model right. I can certainly provide additional information for the full 13 months that we have had the medihotel open. Certainly, of those 124 people, 118 were from regional areas. I cannot do the maths in my head, but I think that is over 90 per cent.

Ms L. METTAM: Can we have that information and a breakdown from a regional point of view provided by way of supplementary information?

Mr R.H. COOK: What specifically is the member asking for?

Ms L. METTAM: I am specifically asking for information on how many patients have utilised the medihotel since it opened and a breakdown of the regions from which the patients have come.

Mr R.H. COOK: Perhaps, chair, I will commit to providing the number of patients who have gone through the medihotel at Royal Perth Hospital and whether they come from regional or metropolitan areas.

[*Supplementary Information No A15.*]

Ms L. METTAM: Going back to the government's 2017 election material, it was stated that a Murdoch medihotel would be the first built in the state. I am unable to find any mention of the Murdoch medihotel in the budget papers. Can the minister provide an update on that commitment? Has there been any progress on that medihotel to date?

Mr R.H. COOK: Chair, we are just trying to assist the member for Vasse by finding a budget line item to allocate this question to. There is a reference on page 326 to redevelopment at Fiona Stanley Hospital but I do not know that it relates specifically to that. The development at Fiona Stanley Hospital is a privately funded development. I will ask Ms Gatti, the acting chief executive at South Metropolitan Health Service, to comment on that.

Ms K. Gatti: I am not across the detail of the medihotel; it is a private development. I can say that there is rapid building underway and it is going up very fast.

Mr R.H. COOK: If I may, in relation to that, the development application for the medihotel was lodged at the end of April 2020, with the construction tender package issued in June 2020. Building permits were issued in 2021 and construction commenced in February 2021. The developer is Aegis Health and the builder is Multiplex. The clinical models at the medihotel have been co-designed with stakeholders, including the Department of Health and Fiona Stanley Hospital. This is consistent with the sorts of principles we talked about in the sustainable health review, having more appropriate clinical settings for people who are either convalescing or about to go into the hospital environment.

The member will remember that the development of that site at Fiona Stanley Hospital is being undertaken by a private developer. The developer is putting a range of specialist clinics, an aged-care element and mental health primary care service on that site. As part of that development, it is putting in a medihotel facility. It is an innovative way of developing pieces of hospital infrastructure, essentially taking advantage of the opportunity presented to us when we came to government. LandCorp, as I think DevelopmentWA was known then, had allocated this parcel of land to the private developer, so rather than intervening and interfering with that process, we engaged with the private developer and negotiated including a medihotel as part of that multi-health precinct. We are really pleased that it has been considered as part of that precinct. It will have linkages both into and out of the hospital, and will allow people to get pre-admission care and to convalesce in a more appropriate environment as well.

The CHAIR: Member, before you continue on your line of questioning, I appreciate what you are trying to extract by asking about the government's 2017 election commitments and where they are at, but beyond what is contained in the budget, you are starting to stretch the boundaries. The minister and the advisers are being quite accommodating and are trying to answer some of your questions, but could you focus on particular areas within the budget.

Mr R.H. COOK: I am incredibly accommodating—such a nice person.

The CHAIR: Member, it might just mean rephrasing some of your questions.

Ms L. METTAM: I will seek a final clarification on this. I think I am restating what the minister has said already. To clarify, is it a private medihotel?

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

Ms L. METTAM: Will it integrate with the public health system?

Mr R.H. COOK: It will integrate with public health services. There will not be a charge to the individual; it will simply be seamlessly part of the health care that they get as a patient at the hospital.

Ms M.J. DAVIES: I refer to page 311 of budget paper No 2, volume 1, and paragraph 21.3 relating to hotel quarantine. I asked the Premier this question the other day and he advised that it came under the minister's portfolio.

Mr R.H. COOK: That is a nice hospital pass. He did not even give me a heads up!

Ms M.J. DAVIES: He handballed it across to the minister.

My question is about the Quarantine Advisory Panel in particular. What has it been tasked with, how many meetings has it held and what has been achieved since those meetings?

Mr R.H. COOK: I might ask the director general to respond with the details on that question.

[10.00 am]

Dr D. Russell-Weisz: I think the Quarantine Advisory Panel has now met on three occasions. If I am wrong, I will correct that, but I am pretty sure it is three occasions. I meet regularly with the chair of the advisory panel. The panel has been focusing on some areas of assurance. The member would remember that one of the recommendations of Professor Weeramanthri's recent report was to establish a quarantine advisory panel.

When the Quarantine Advisory Panel first met, it looked first at our progress on Professor Weeramanthri's recommendations, and also at the lie of the land at that stage, because things have changed and are changing rapidly in hotel quarantine. I think its first role was to make sure that we had addressed not only his recommendations, but also a number of other recommendations. There were Professor Jane Halton's recommendations; she did a review on behalf of the commonwealth. There are a number of other recommendations. We are consistently doing our own reviews on hotel quarantine. There was a lot of ventilation work in relation to our hotels and also work on specific areas of policy.

I should say first of all that, obviously, the Quarantine Advisory Panel has a very varied membership. It has Professor Allen Cheng from Victoria, who has lived through some significant experiences over there—obviously, we call on his wisdom quite a bit—and other experts on the panel. I think that the panel has put out two or three communiqués. The recent meeting, which was only this week, concentrated on two areas. One area was how we can improve the care of unaccompanied minors. That might seem a very small area to focus on, but it is an area that I think not only Western Australia but all jurisdictions have had to grapple with. When a parent with a young child becomes sick and has to be transferred to hospital, what happens to that unaccompanied minor? We also have unaccompanied minors coming into hotel quarantine from other states or internationally. That is an example of some of the more difficult issues on which we are seeking advice from the Quarantine Advisory Panel.

In addition, the panel looked at two specific areas—our assurance process and the end-to-end process. The Quarantine Advisory Panel is there to provide advice to me as the director general of the Department of Health and also to the Chief Health Officer on how to constantly improve and manage our hotel quarantine. Our hotel quarantine does not start from the front of the hotels; I like to think that it starts when the person gets on a plane in another country and then arrives at the airport. It is that whole journey. The Quarantine Advisory Panel is now very much looking at our own assurance processes. That could be the reviews I have just mentioned, because all the reviews picked up either potential gaps or areas of improvement, and we are constantly tracking all the areas that we have addressed. I will finish now, but the Quarantine Advisory Panel is looking at our assurance processes. To be honest, we cannot mark our own homework; nor should we. At the moment, the panel is looking at our own assurance processes, and it will be picking out areas that it will want to do deep dives into to make sure that we are risk mitigating to the greatest extent. We cannot get rid of every risk, especially when we are dealing with COVID, but the panel is looking at where our greatest risks might be, and also how quarantine or hotel quarantine might potentially look in the future, because it might look very different. Other states are now looking at other potential methods of quarantine, and obviously we are looking at those.

Mr R.H. COOK: To go to the specifics of the member's question, it has met five times.

Ms M.J. DAVIES: The director general mentioned just then two or three communiqués that have been produced on those meetings or the work that has been progressed. Are there minutes that will be available publicly, or is it only the communiqués that the government intends to publish; and, if that is it, where will they be published?

Mr R.H. COOK: I might ask the director general to speak specifically to the communiqués. I know that we have provided the minutes to I think a member in the other place in answer to a question on notice. Obviously, they do not include inappropriate information. From that perspective, they are publicly available by a question on notice.

Dr D. Russell-Weisz: Through the minister, a specific website is being developed at the moment—I think it is very close—for the Quarantine Advisory Panel, so the communiqués will be there, and I think any other activities, but I can provide more details on notice. Through the minister, I am happy to provide how we are doing the Quarantine Advisory Panel website and what will be on it.

Mr R.H. COOK: No, tell them nothing! Sorry, did that come out? Yes, that is fine. Use your inside voice! Chair, the supplementary information will be to provide information with regard to the QAP website and publicly available information.

[*Supplementary Information No A16.*]

Mr R.H. COOK: We are handing out more information than I have ever heard of before! They never did that for me in opposition!

Ms M.J. DAVIES: Is the minister able to provide the minutes for those five meetings that have been held by way of supplementary information?

Mr R.H. COOK: I might get the member to put that on notice.

Ms M.J. DAVIES: Given that the minister has already provided them through the Parliament, is there a reason they cannot be provided by way of supplementary information?

Mr R.H. COOK: Yes; I just do not know, that is all. I think the minutes of two meetings were provided. Not having a working knowledge of what is in those minutes, I would prefer the member to put it on notice and I will make sure that we can provide the appropriate information.

Ms M.J. DAVIES: The director general and the minister just mentioned the advice that is coming from the Quarantine Advisory Panel. Is there advice or has there been specific advice from the Quarantine Advisory Panel on keeping the cap at 265 in our hotel quarantine system?

Mr R.H. COOK: Chair, I have to refer that to the director general.

Dr D. Russell-Weisz: Member, no.

Mr R.H. COOK: I think that the decisions on the current caps were made by national cabinet, so it may be that it was subsequent to discussions between the commonwealth and the state, but I do not think it is something to which the Quarantine Advisory Panel has specifically referred.

Ms M.J. DAVIES: Can I clarify that, because I was under the assumption that it was a state government decision to reduce the cap of the numbers in our hotel quarantine system. I think it was around the time when the issues were occurring in India and concern was ramping up in relation to intake. The Premier, I think, made the announcement that there would be a reduction in the number of hotel rooms available for quarantine, and that has never been increased since. I am trying to find out whether the Quarantine Advisory Panel has a role in providing advice, or what has informed that decision.

Mr R.H. COOK: No, it would be informed by advice from the Chief Health Officer rather than necessarily from the Quarantine Advisory Panel. The member will recall that national cabinet recently made the decision to significantly reduce the number of people coming into Australia, and that has allowed us to significantly lower the risk associated with the quarantine arrangements. Specifically, it allows us to implement what is called the zipper model, which is to place guests not opposite each other and not next to each other, and take that configuration throughout the hotels. That significantly reduces the number of people who can stay in the hotel—it essentially halves it—but it makes sure that we have a very much safer quarantine facility. The member will note that since that has come in, we have not had a single incident in hotel quarantine.

Ms M.J. DAVIES: Is there no intention to increase the cap on hotel quarantine that we have at the moment?

Mr R.H. COOK: That is above my pay grade, member. The Premier and national cabinet will make that decision.

[10.10 am]

Ms M.J. DAVIES: I am still on paragraph 21.3, which refers to mandatory quarantine of international and other high-risk travellers. Can the minister provide the total value of the invoices that have been sent to people who have stayed in hotel quarantine and, further to that, the total amount of the invoices that have been paid?

Mr R.H. COOK: We have raised 25 532 invoices against the services provided to 45 595 guests to the value of $83 322 613.

Ms M.J. DAVIES: How many invoices that have been raised have been paid?

Mr R.H. COOK: We have received payment for 15 561 invoices to the value of $42 525 441.

Ms M.J. DAVIES: What action is the minister taking against those who do not pay their hotel quarantine bill?

Mr R.H. COOK: Obviously, we work with the guests to make sure that we can get payment for that. Currently, 4 926 invoices are outstanding by more than 60 days and we have referred 80 invoices to debt collection agencies and another 2 586 are on instalment or payment plans.

Ms M.J. DAVIES: Is there an allowance from a compassionate perspective if people cannot afford to pay?

Mr R.H. COOK: There is a waiver arrangement that is administered by, I think, the Department of Communities, or it assists us to assess the request for waivers. Currently, there have been 3 489 waivers to the value of $8 323 710.

Ms M.J. DAVIES: Does the amount that the minister just referenced sit within the total amount of invoices raised?

Mr R.H. COOK: I am watching people nodding, so I assume it is, yes.

Ms M.J. DAVIES: This might be an open-ended question, but how long does the minister anticipate these hotel quarantine facilities will operate? Obviously, he needs to be able to budget for that, so it needs to be reflected in

the budget papers. With discussions around the quarantine facility at Bullsbrook, when does the minister see hotel quarantine coming to an end, or will he continue to use the hotels once that facility is in play?

Mr R.H. COOK: I can answer that precisely: it will be the exact length of the average piece of string! It is a great question. We do not know what is going to happen over the next six months. I think there will still be a level of quarantine for international arrivals. We have already heard the Prime Minister talk about international arrivals perhaps being able to quarantine at home if they have been double vaccinated and have returned a negative result. We are managing the risk stratification. I imagine that, depending on where the person comes from, there will be different arrangements.

Until the quarantine facility at Bullsbrook is completed, it is difficult to understand or appreciate what the world will look like. I think there will still be a need for a quarantine facility, particularly for overseas workers, because the countries that we draw a lot of our agricultural workers from may not have a sophisticated health system, so we will need to assist them to come into the country to provide invaluable services, particularly to our horticultural and agricultural industries. Hotel quarantine might be replaced by the quarantine system at Bullsbrook or it might be supplementary to it but at a lower scale. We really just need to build a greater appreciation of what it will look like as we start to explore what a more globally vaccinated community looks like.

Ms M.J. DAVIES: So that I have an understanding, how has the minister budgeted for that piece of string in the state budget? Obviously, the government has contracts with hotels and it needs to account for it. It could be for the next two or three years. I do not know when the government is planning on breaking ground for the commonwealth quarantine hub and how that will be staffed, and obviously there will be overlap with those issues. How was that accounted for in the budget?

Mr R.H. COOK: That goes to the very first question we had. We will take a view of that in the midyear review, when we will again look at what is going on, where we are at with vaccinations and the anticipated workload into the future. We can also anticipate that at some point the commonwealth might want to lift the number of people coming home, so that will impact on the number of hotels that we need for that process. From that perspective, it is another one of the things for which we simply have to undertake a regular review of the costs and work with our hotels to give them some understanding about the commitments into the future.

Ms L. METTAM: I refer to page 309 of the budget papers and the significant issues impacting the agency. Under the heading "Delivering Core Services to the Community", paragraph 8 refers to opening 332 new beds across Western Australian hospitals, supported by additional workforce. Can the minister outline how many of these beds are new and how many are physically within the system but are not being used at the moment?

Mr R.H. COOK: I might ask the director general to provide a detailed response to that question.

Dr D. Russell-Weisz: I will go through line by line the 332 beds that are open. In the East Metropolitan Health Service, at Royal Perth Hospital, 36 beds were announced and 36 are open. At the time, 10 beds were announced in relation to the East Metropolitan Health Service, which uses Mt Lawley hospital beds. They are not open at the moment, but they were for a short period. In the North Metropolitan Health Service, at Osborne Park Hospital, 18 of the 26 beds are currently open, and the reason that those other beds are not open is workforce pressures, but it can scale up to 26. In the North Metropolitan Health Service, 22 beds are due to open in October, which was always planned after the capital works had been done. They are not open now but will be open very shortly. At Fremantle Hospital, 24 beds were opened and they are currently open. At the Child and Adolescent Health Service, eight medical beds were announced and eight medical beds are open, and two oncology beds were announced and two are open. In the high dependency unit, 10 beds were announced but they are not open at the moment. Plans are being made to recruit workforce to them, so they will be open once we have workforce.

Going back to the North Metropolitan Health Service, we use South Perth Hospital through an arrangement with it. We announced that we would be opening 10 of those beds for our elderly acute patients and we have actually opened 14 of them, so we have more beds than we announced at the time. Some of these beds were amongst the original beds that the government announced in March 2021 and some of these beds are within the government's budget announcement this year. At Bentley Health Service, eight beds are due to open but are not open at the moment, and another three beds are surgical beds but they are not open at the moment.

[10.20 am]

As part of the government's budget announcement this year—this is not part of the original announcement of 117 beds—24 beds will open at Sir Charles Gairdner Hospital. Those beds will need capital works and will open towards the end of this financial year. In addition, other beds will open at Fiona Stanley Hospital, 16 beds are due to open at Fremantle Hospital, 18 beds are due to open at Royal Perth Hospital and eight mental health beds are due to open. At Bentley Health Service, where there will be a secure extended care unit, 12 beds are still due to open because they need capital works. At the mental health emergency centres in Armadale and Rockingham, nine beds and 10 beds respectively are due to open and need new builds. They were both announced in the budget. In this

financial year, we are opening 40 beds in what we call a transitional care unit at East Metropolitan Health Service. We have already opened 30 hospital-in-the-home beds for mental health patients between South Metropolitan Health Service and Selby Lodge. Hopefully that all adds up to 332 beds.

As we speak today, out of those beds, because some were only just announced in the budget, 118 physical beds are open plus the additional 30 hospital-in-the-home beds. Obviously, some of those need capital works and we are working with the health service providers to get that done as soon as possible.

The CHAIR: Would you like the director general to repeat all that?

Ms L. METTAM: I will be reading the *Hansard* as well. I note that 30 of the new beds are hospital-in-the-home mental health beds. How much has been allocated to implement this model, including administration costs, on a cost-per-bed basis?

Mr R.H. COOK: We will try to give an answer.

Dr D. Russell-Weisz: I may have to take that question individually because the robust hospital-in-the-home model is a critical component used by all our health services. These beds were not in place when they were announced and are an expansion of our current model. The chief executive of the South Metropolitan Health Service at the time came to us and said, "We're getting a lot of mental health demand. We can actually put more funding into hospital-in-the-home beds and that would require staffing rather than physical beds in a hospital, but they are essential." I do not have the exact figures for hospital-in-the-home beds—unless Mr Anderson is looking for them. If we put the hospital-in-the-home beds to one side, the activity that goes into any of the beds that we have announced will be funded by government through activity-based funding. That has been a method of funding for all hospital activity. We have been funded for the beds that we have opened from March last year, and the beds that we plan to open will be funded because of the activity going into them.

Two elements were announced this year: an extra 18 beds are going into Fremantle Hospital and an extra 24 beds are going into Sir Charles Gairdner Hospital, which I spoke about just now. They both need $5 million and $12.5 million respectively for capital works and we have secured that funding.

Ms L. METTAM: I will refer to a question on notice to assist me here and I will also have to look at *Hansard*, but can I clarify that in order to open, 140 of the new beds will require construction works to existing buildings?

Dr D. Russell-Weisz: Some of the beds are in current buildings. For example, the beds I just announced at Fremantle Hospital and Sir Charles Gairdner Hospital are not current beds and will need some capital works on a disused ward. If the minister is happy, I will refer to Tony Dolan, who can talk about those 24 beds and what they will replace because that is a good example. Some of the beds are brand new, as announced by government, and part of the mental health emergency centres—MHECs—at both Armadale and Rockingham. Those 19 beds will be ostensibly new builds. It is a mixture of new or expanded, and old being refurbished.

Mr R.H. COOK: I will characterise that. Some of these beds are in wards that have not been used for a while. They are perfectly good wards but they need extra paint, new beds and fittings, essentially, as opposed to what would be considered to be major construction works.

Ms L. METTAM: How many of the beds will be in regional areas?

Mr R.H. COOK: All those beds that the director general just read out are in the metropolitan area.

Ms L. METTAM: Can I confirm that the total of the 332 beds are in the metropolitan area?

Mr R.H. COOK: Yes, member.

Ms L. METTAM: With that breakdown, when is it anticipated that all 332 beds in the metropolitan area will open?

Dr D. Russell-Weisz: I will put the beds at the mental health emergency centres at Rockingham and Armadale to one side because they will need fresh builds and will not be done in this financial year. We expect the majority of all the other beds that I have just gone through to be open by the end of this financial year. Depending on capital works, some might extend a little longer than that.

Ms L. METTAM: I appreciate that there is a physical bed, but, most importantly, staff are attached to the bed to enable a closed ward or a new bed to open. How many additional full-time equivalent staff will be associated with the 332 beds?

Mr R.H. COOK: There is not granularity in terms of X beds and X staff, but as we increase the number of beds, we increase the staffing to make sure that we have doctors and nurses to stand next to those beds. We are in the middle of a big recruitment drive at the moment to provide better capacity for current staff to take leave as they continue to work in a COVID-impacted environment. For instance, between 2016 and 2021 we increased the number of nurses by 12.9 per cent or just over 2 000 FTE. So far this year, we have recruited 750 qualified nurses and onboarded

1 290 new graduate nurses, 190 of which are in COVID-19 roles including in our vaccination centres. In 2019, 763 graduate nurses were employed by the WA Health system. The member can see that there has been a significant uplift in the recruitment process.

[10.30 am]

Ms L. METTAM: I refer to paragraph 10 on page 310 of budget paper No 2, volume 1, the lead-in to which is "WA Health's workforce are also being implemented with", and targeted initiatives. How many resignations has the department received since announcing that vaccination is mandatory for all health department staff? I wonder whether a breakdown could be provided by doctor or nurse and area of health service.

Mr R.H. COOK: I am not sure we would have any insights as yet, given we have only just made the announcement. There are clearly two nurses who are pretty unhappy with the situation, because we saw them at the rally on the weekend—not nurses, but midwives, I should say! I might ask the director general to make some general comments. I am not sure that we would have any granularity in relation to that at this point.

Dr D. Russell-Weisz: I think the best thing to look at is the aged-care sector. When mandatory vaccinations were announced for the aged-care sector by the government on advice from the Chief Health Officer, the aged-care sector was pretty low in its vaccination status, but by the end, as at 17 September, I think around 98 per cent of people had had their first dose in the aged-care sector. It was a phenomenal result, and actually WA was leading all other states, but had been a bit of a lagger for some time in aged care. It was a really good result. The health services are obviously working really closely with their staff and their managers in those areas about making sure their staff have all the information about mandatory vaccinations, but, to be honest, everybody should have seen this coming. We are healthcare staff; it does not matter where we work. I have had discussions with my own staff at 189 Royal Street. It does not matter where they work in the health sector, they should be vaccinated unless they have one of the very, very rare exemptions.

The vaccination status is pretty high. It is in 80 or 90 per cent range for our 1a or those cohorts of staff on the front line. As the member knows, there is a tiered approach being put in place by the Chief Health Officer, which is tier 1, tier 2 and tier 3, but it basically means that by 1 January 2022 everyone needs to be vaccinated. It might be prudent to ask one of the health service providers to see how they are going with their staff.

Mr R.H. COOK: Does anyone have any thoughts or feedback so far?

Mrs E. MacLeod: We are progressing with the mandatory vaccinations and obviously at this stage focusing on the first group. From an overall perspective across east metro, we have 88.7 per cent of all of our staff vaccinated. Of that, we have 191 people who are still to be vaccinated within the tier 1 group. At this stage we are working on that. Within an organisation of our size, that is a relatively case-manageable cohort. We are really doing some direct communication and facilitation to encourage and enable people to attend and get a vaccination, making sure they are fully informed. We understand and are aware of some of the cultural issues for some of our staff who may not have English as their first language. We are trying to support our staff through the process at this stage.

Ms L. METTAM: Could we get an idea of the vaccination rates of other health service providers? The figure of 88.7 per cent is pretty good.

Mr R.H. COOK: Chair, with your indulgence, we might start with Mr Moffet, unless there are some consolidated numbers.

Mr J. Moffet: One thing that is a little different for the country is that that we are a registered aged-care provider as well, so we have around 500 aged-care residents and the rules around mandatory vaccination came into play last Friday on 17 September. We have been through a fairly rapid period of ensuring that mandatory vaccination has been in place in order to continue aged care consistent with the Chief Health Officer's direction. As I have said, our broader workforce will be affected in phases from 1 October, 1 November and so forth as well. Talking about aged care generally, since last Friday all of our currently working are vaccinated. That is the requirement. The record is around 97 per cent, because we have 42 staff on leave. A small number are taking leave because they are pregnant or are unvaccinated, excluded from work and seeking medical advice. There are small numbers currently working through some issues with us. A couple have chosen to resign and not stay with the service, but it is only a very small number, and that has not been adversarial at all. Just to give an idea, in that workforce there are 1 526 staff defined as needing to be vaccinated for the aged-care program across country WA, and, as I say, all working are currently vaccinated.

In answer to the member's question about the broader workforce, as at yesterday we have 84.3 per cent vaccinated for a total workforce of 10 834 people. Tier 1 is obviously required to be done by 1 October. There are 3 406 of those 10 000 people who have been identified as meeting the tier 1 mandatory criteria, with 91.9 per cent currently vaccinated. That converts to about 306 staff who are required to be vaccinated between now and 1 October or to have alternative arrangements in place. There is more data there, but I hope that gives the member a bit of a feel.

Ms L. METTAM: It certainly does. We could have the rest—vaccination rates for each health service provider—just as supplementary information, if that is okay.

Mr R.H. COOK: That is vaccination rates for staff by HSP.

[*Supplementary Information No A17.*]

Ms L. METTAM: This is a further question about paragraph 10, but specifically paragraph 10.1. I refer to the $35.6 million allocated towards a workforce package to uplift staffing across emergency departments. How many extra FTE nurses have been employed at Perth Children's Hospital emergency department since April?

Mr R.H. COOK: I will make some initial comments and perhaps Dr Anwar would like to make some comments subsequent to that. We would be happy for him to do so. Perth Children's Hospital has recruited an additional 17.4 FTE emergency department nurses since May 2021 to enable several additional actions, including ensuring the waiting room and triage are always staffed, increasing clinical nurse specialist and staff development nurse FTEs to support education and upskilling, and increasing backfill to account for personal and parental leave. Further, 25 FTEs were approved in August 2021 for the provision of a dedicated resuscitation team of three nurses every shift and increased staffing for the emergency short-stay unit to increase capacity. Junior medical officer FTEs within the PCH ED were approved to increase by 12 FTEs in June 2021 to take the total junior medical officer FTEs to 56. That enables ED rosters to provide increased staffing in peak activity times, cover for unplanned leave and the development of a supervised medical practitioner pathway. Additional consultant FTEs were approved in August, with agreement to employ an additional 11.6 FTEs immediately, and that includes four FTEs for backfill. As the member can see, there has been a significant increase in the number of clinical and nonclinical staff engaged at PCH. I might just ask Dr Anwar to make additional comments.

[10.40 am]

Dr A. Anwar: Thank you minister. I think that covers the increase in FTE. Some of the FTE is obviously absolute in terms of increasing the ratios of mix of staff on the front line, but the second increases the model in which the staff are deployed; that is, we have increased the cover for leave and also for parental leave, hence the expansion in the staff base. The latest figures show that the emergency department currently has a vacancy of 3.53 FTE, but we are building that base in order to meet the model delivered.

Ms L. METTAM: There is an outstanding need for an additional 3.5 FTE?

Mr R.H. COOK: Dr Anwar.

Dr A. Anwar: The staff basis is being altered because we initially expanded the staff base by 17, as the minister mentioned, then we introduced a larger base in order to allow for a dedicated resuscitation team. That recruitment is ongoing at the moment.

Ms L. METTAM: What is the outstanding number of FTE required to meet the additional FTE objectives for Perth Children's Hospital's emergency department?

Mr R.H. COOK: Dr Anwar.

Dr A. Anwar: Can I come back to the member as a supplementary answer outside session—just to marry up the absolute number approved and the current vacancy with the gap that continues to exist?

Mr R.H. COOK: The supplementary information is current outstanding FTE to be recruited at Perth Children's Hospital emergency department.

[*Supplementary Information No A18.*]

Ms L. METTAM: How much has been allocated to recruitment incentives to attract national and international nurses?

Mr R.H. COOK: As the member would be aware, we are undertaking a significant amount of recruitment at the moment, both nationally and internationally. We are about to launch a $2 million local, national and international recruitment campaign, which will begin imminently, to support the current drive to bring health professionals to Western Australia. So far we have brought in 274 doctors from the United Kingdom and Ireland, who have either commenced or are due to commence work in WA from August 2021 on 12-month contracts.

Ms L. METTAM: Did the changes to the state's skills list have an impact on the overall challenge of the recruitment of health workers that we are seeing now?

Mr R.H. COOK: I do not think we are in a position to advise that, member.

Ms L. METTAM: I refer to paragraph 10.2 that states —

> $36 million to increase annual intake of graduate nurses and midwives …

How many FTE graduate positions will be provided? I should also add that there is concern that many of these new staffing positions will be allocated on a 12-month contract basis. Can the minister clarify that?

Mr R.H. COOK: To the specifics of the member's final point, it would depend on the individual and the basis on which they are recruited. We have the biggest recruitment campaign of graduate nurses in the state's history. We will see a significant number of extra nurses onboarded. In 2021, we will onboard 1 290 new graduate nurses, 190 of whom will be in COVID-19 roles. In 2019, to give the member an idea of what sort of uplift this looks like, there were 763 graduate nurses employed in the WA Health system. That is a significant increase that is not only recognition by the department that we need to have more nurses in our system, but also part of an election commitment for an extra 400 nurses to expand the nursing and midwifery graduate program. I think the Chief Nursing and Midwifery Office has done a great job in also broadening the exposure for a lot of nurse graduates in relation to their time in the hospitals, particularly in relation to mental health, so that we have more people specialising in mental health nursing. One of the key needs at the moment is to ensure we have the workforce we need, particularly in our community mental health sector.

Ms L. METTAM: I appreciate the minister's response about the 12-month contract for these new graduates, but can the minister give us an indication of whether they are mainly 12-month contracts? Is that a standard?

Mr R.H. COOK: I will invite the director general to answer, but he looks like he is about to flick pass it to someone else as well.

Dr D. Russell-Weisz: I might invite, through the minister, Kate Gatti to say what they would do in the South Metropolitan Health Service, and then James Williamson may have something to add.

Ms K. Gatti: Thank you. In the last few months we have put on about 120 graduate nurses. Our aim is to have them all permanent as they desire, particularly to encourage people to take annual leave and to fill the beds that are being secured.

Ms L. METTAM: Given the uplift to the workforce, why has the budgeted cost of services decreased for 2022–23?

Mr R.H. COOK: I ask the director general to address that one.

Dr D. Russell-Weisz: Through the minister, I think this relates potentially to the earlier question about the drop between total cost or total funding. It has dropped because there is no allocation for COVID-19 resourcing at that time, which there obviously will be when we know a little more how 2022–23 will look. There is also cessation of some commonwealth and state programs, such as the HealthNext program, which I think the Minister for Health outlined earlier in this session. It is the drop in overall cost of service.

Mr R.H. COOK: As the member observed, total cost of services is a global budget number that basically picks up the entire activity of the health system. It was a significant part but not the whole part of the delivery of hospital services. It does not necessarily reflect the staffing. Again, staffing is a big component of that, but as I said, it is a global allocation.

Ms L. METTAM: I refer to page 314 of budget paper No 2 under "Sustainable Healthcare" and the sustainable health review at paragraph 41 where the government claims it is continuing to implement its recommendations. I see there are a few more funding announcements that total just $16.3 million in this financial year. How much exactly has the government spent to date on implementing this recommendation? Will the minister provide a breakdown of that expenditure by program and year?

[10.50 am]

Mr R.H. COOK: I thank the member for the question. The *Sustainable health review: Final report to the Western Australian government* is a key document, as the budget papers suggest, and a blueprint for underpinning our reform and transformation of the WA Health system. As the member will be aware, it is an extensive review of the health system to look at how we can get it on a more sustainable footing. The member will recall just some years ago that we had double-digit growth in the overall health system budget year on year with significantly increasing burden on acute services as opposed to what would otherwise be considered to be the mission of health, which is to keep people healthy without the need to go to a doctor or health service.

The sustainable health review is oversighted by the independent oversight committee, and its responsibility is to steward reform and programs to change the way we deliver health care, and do so in a more sustainable way. It is essentially made up of a range of initiatives. Some initiatives are about discrete pieces of work, such as the review that we undertook into climate change and the impact of both the health system on the climate but also the impact of climate change upon health services and the challenges that will be created for us in relation to that. We are implementing a range of associated reforms, including the appointment of a sustainability officer.

Other parts of the sustainable health review are about diverting existing resources into new programs, and this is probably the larger part of the program and one of the most challenging parts because it is about challenging people who are undertaking clinical services or programs in one particular way and getting them to reform that so that they can do it in a more sustainable manner. A third element of that will be discrete allocations of funds to change the way we deliver health care specifically, and they are probably the types of programs that the member has

highlighted in her question. Therefore, it is not simply a matter of throwing money at it to create change; it is also creating change in itself.

One of the key aspects, though, of the delivery of reform in the health sector is the development of an electronic medical records system. The member will be aware that we have allocated $8 million towards that business case. That is a significant piece of work. It will be transformative in how the health system will work. We have a long way to go. This body of work around the sustainable health review will go beyond my time in the role or, indeed, any specific government's time in the role. It is a long, ongoing process of modernising our health system to make sure that we can keep people healthy and out of hospital care.

Ms L. METTAM: Regarding increasing the investment in public health, with prevention rising to at least five per cent of total health expenditure by July 2029, which as I understand is a goal of the sustainable health review, how much of the health budget is currently spent on prevention in the 2021–22 reporting period, and how does that level of expenditure compare with last year or 2019–20?

Mr R.H. COOK: It is a tricky one to answer because people have different interpretations of what is prevention and what is, for instance, chronic disease management. However, I know that a lot of work has gone into understanding what prevention looks like in the mental health sector and the health sector. But I will ask the director general to respond to the specifics of the question.

Dr D. Russell-Weisz: Thank you very much. Through the minister, one of the things in the sustainable health review that we did very early was to concentrate on that target, which was a key target to take us up to 2029. Based on the 2018–19 data, the Department of Health, the Mental Health Commission and Healthway combined spent 2.8 per cent of their total budget on prevention in line with the agreed definition. As the minister has said, we were very, very clear, and we worked with both the Chief Health Officer and his division, about what is "prevention". It cannot be chronic disease management; it is prevention, so you do not include chronic disease management. In 2019–20, as the sustainable health review was getting underway, spending was increased to 3.3 per cent and it represented a 0.5 per cent increase on total budget spent on prevention from 2018–19. Some of the expenditure both here and outside is a bit related to COVID, but it has gone up, so we are seeing an increase. The most important thing is how we measure it and what is in that definition of "prevention" and that it does not bring in chronic disease management.

One of the strengths of the WA Health system is that we have a whole division that concentrates on public and Aboriginal health, and it has prevention as one of its core goals. Obviously, it is a target that we have to make. Things such as hospital care, shiny intensive care units and shiny new hospitals do take some of the focus, but, as the sustainable health review said, we have to make the focus on prevention, and that is why the five per cent is there. We are on the way, so we have made some increases.

Ms L. METTAM: I will just pick up on the—is it the Care Opinion platform?

Mr R.H. COOK: Yes.

Ms L. METTAM: How much would it cost to open this platform to not-for-profits and other wraparound services? Further to that, would it not make sense for our ambulance service, Ramsay Health Care and other medical groups to be integrated, which would align with the strategies 4, 5, 6, 7 and 8 of the sustainable health review?

Mr R.H. COOK: I would observe that this is a bit of a stretch in terms of budget papers, but I will entertain the question because I am a nice person!

Care Opinion is not very expensive at all. It is a great service and one that I wish people would use more because it provides real-time feedback to the health service providers in terms of both the good and bad about the services they provide. Western Australia, under the McGowan government, was the first state government to implement Care Opinion right across its entire system. To the best of my knowledge, I think that Ramsay Health Care uses it for its public health service delivery, consistent with that mandating of the service.

In terms of not-for-profits, they are the master of their own destiny. I guess that we could, via contract arrangement, insist that they use Care Opinion, but I think the real potency and value that we get out of Care Opinion is in those larger health settings in which we can see trends emerge through the data-driven feedback mechanism.

Ms L. METTAM: I will just pick up on the minister's point about not-for-profits being masters of their own destiny. Is one of the objectives of the sustainable health review to ensure a more integrated health service, and, to that end, would the use of this platform in allowing those opportunities for our ambulance service and other health operators help achieve that goal?

[11.00 am]

Mr R.H. COOK: That is a fair observation to make. Primarily, we have utilised Care Opinion to inform our health service providers in the way they go about their business. It is an interesting point.

Ms L. METTAM: I refer to the service summary on page 315 of budget paper No 2, specifically the line item "Public Hospital Emergency Services". How much money has been allocated from state government funds as a result of ramping at our hospitals? How much has been paid to St John WA through that unique contract between the state government and St John?

Mr R.H. COOK: I do not think that is the right budget line item in relation to St John Ambulance. That line item relates to the delivery of emergency department services from within the hospital—the engagement of doctors, nurses and equipment in an emergency department setting.

Ms L. METTAM: I turn to paragraph 29 on page 312 of budget paper No 2, which refers to the government's commitment to put patients first and bring services back to the public sector. Can the minister outline how much it will cost to transition these non-clinical services back to the public sector, and what is the breakdown?

[Mr D.A.E. Scaife took the chair.]

Mr R.H. COOK: I assume that the member is referring to bringing services back to Fiona Stanley Hospital. I am very happy to provide some information about that. A total of $12.9 million was allocated to WA Health to undertake the delivery of the project to transition employees and services from Serco Group Australia to the South Metropolitan Health Service by August 2021. The project budget includes provision for project employment costs, information and communications technology development, equipment procurement, training, uniforms and the Serco transition payment. No additional funds will be requested from the government for the transition of the delivery project. The budget allocation for the removed services before being transferred to the state was $316 million over six years. In order to deliver the same services as Serco, the government approved additional operational funding estimated at $50.3 million over six years to cover any additional costs to the state.

The CHAIR: It is a little self-indulgent of me because I have been sitting here for only two minutes, and I understand that everyone else has been sitting here for more than two hours, but I thought I might offer a five-minute comfort break.

Meeting suspended from 11.04 to 11.12 am

The CHAIR: Members, we are dealing with division 22. I give the call to the Leader of the Opposition.

Ms M.J. DAVIES: I refer to paragraph 22 on page 311 of budget paper No 2, which refers to achieving sufficient levels of vaccination across the Western Australian population.

Mr R.H. COOK: Good! Excellent.

Ms M.J. DAVIES: The Premier recently said that the aim is to get WA significantly above 80 per cent two-dose vaccinated, and then set a date. Can the minister provide advice on the latest information about when we are likely to get to 80 per cent two-dose vaccinated?

Mr R.H. COOK: That is a very good question. I will invite either the Chief Health Officer or the Vaccine Commander to have a go at that.

Mr C. Dawson: The current rate of vaccination in Western Australia for the eligible population—that is, those aged over 16—is 63 per cent and the rate of double-dose vaccination is currently 44 per cent as of close of business yesterday. The target for 80 per cent double vaccination has been stated publicly and we are presently tracking towards that for the end of this year—that is, obviously, at the end of December 2021.

I would note that there are concerns with the level of hesitancy that is about, particularly with the AstraZeneca vaccine—that is a known fact. We are not seeing as many people now presenting and asking for AstraZeneca. To offset that, only this week, we expect pharmacies will receive a new vaccine, Moderna, and I expect we will see a greater take-up by people who are concerned about the vaccine.

The other element of caution is regional distribution. We live in the largest state in Australia and we have geographic challenges with distribution and supply and the number of remote communities. We are on target, but I add some caution because of the geography of the state and some of the supply issues.

Mr R.H. COOK: I might ask the Chief Health Officer to make some comments, particularly on the vaccination rate we need to get to.

Dr A. Robertson: To build on that, we are looking at getting to a vaccination rate of the eligible population of 80 per cent as a minimal. We are on track but it varies day by day on when we are likely to complete that. It depends on the rate and the supply of vaccines. At the moment, we are looking at hitting 70 per cent around mid-November and 80 per cent in the first weeks of December. That could vary depending on vaccine hesitancy, as the commissioner has outlined. We would look at 80 per cent as a minimal vaccination rate because the state is highly susceptible to an outbreak. Having had no community spread and having moved to phase 5, which has allowed us to mix and congregate in large numbers, has made us very susceptible particularly to an outbreak of the Delta variant. As a consequence, if we were to get an outbreak, it is likely that we would get quite a serious outbreak quite rapidly.

We need to get to 80 per cent for it to really mitigate the impact of the issues that have occurred because of the Delta variant.

Ms M.J. DAVIES: The Premier has said that he wants to be at a vaccination rate somewhat higher than 80 per cent. Has modelling been done on whether that is achievable? I have seen some advice from University of Western Australia professors saying that they do not believe it is achievable to get a vaccination rate of 90 per cent or above. What advice is the department and the government using for how to achieve that higher than 80 per cent vaccination rate?

Mr R.H. COOK: I will ask the director general to comment.

Dr D. Russell-Weisz: A lot of work is going on nationally on acute surge or living with COVID—however one would like to put it—but the Doherty Institute model has been the basis for most of the modelling to date. There is lots of different modelling out there. Even last year when the pandemic hit, we had to plan for any major surge capacity. We planned in relation to intensive care beds and general beds and how we would scale up both public and private. That informed our initial response to what we saw happening in Italy and France—as everybody did. Like everyone, we were very fearful of what could happen here.

Our methodology has been basically that we have modellers within the Department of Health who have been working with us for some time now and it is very much based on the Doherty modelling. We base it on an established susceptible–exposed–infected–recovered model—SEIR model. It is a well-known compartmental model for infectious diseases that is very, very similar to Doherty and is used by Imperial College and other institutions. We have been modelling a number of scenarios, and that is also based on the two premises of Doherty. One is TTIQ, which the member would have heard about. There is high or low TTIQ. We are obviously aiming for high—that is, really good tracing, testing, isolation and quarantine. At the same time, it is whether there are high public health social measures, with higher restrictions; or low public health social measures, with some restrictions but people basically live a much more normal life, as we have been doing in Western Australia.

We have then been doing some work on what that looks like at 70 per cent, 80 per cent and 90 per cent vaccination rates, and that informs us on what we would need bed-wise not necessarily just in an acute surge, but also more in the future in relation to living with COVID. The modelling takes into account the Delta variant, because it has changed things over the last few months, and what is happening in New South Wales and Victoria. We look at their hospitalisation rates, intensive care unit rates and death rates. New elements are constantly being fed in. At the moment, we are in the process of saying, "What does that look like?" Then, as we all do, we work very closely with the Chief Health Officer, and that then informs a decision around 70 per cent, 80 per cent or 90 per cent. But it is only a model.

[11.20 am]

Mr R.H. COOK: Just to add to that, if I may, obviously it is an iterative process and we learn as we go along, particularly by watching what has happened elsewhere in the world and in Australia. To re-emphasise the point just made by the director general, it is assuming that we have strong TTIQ, which we do, and strong public health social measures. In other parts of the world, those measures are by and large the wearing of masks, particularly indoors, and also reducing the number of people who can be in a venue such as a pub, otherwise referred to as the two and four-square-metre rules. We have a very effective public health social measure as well; we have the almost unique ability to restrict who comes into the state from other jurisdictions that might have greater outbreak of the disease.

By and large, people continue to talk about Western Australia being in lockdown. We are not in lockdown, but we have the capacity to restrict people from COVID high-risk areas from coming into WA. The point that the Premier has been trying to make is that that will continue to be part of our suite of public health social measures in the event that we have to protect the Western Australian community. As we continue to grow our vaccination rates, the amount of public health social measures that we will need to use will start to fall away. I think the point that the Premier has been at pains to make is that we should not be afraid to continue to use one of our most successful public health social measures, which is to restrict the entry of people from higher risk jurisdictions.

Ms M.J. DAVIES: I thank the minister. What percentage vaccination rate does the modelling show is needed so that we do not overwhelm our health system?

Mr R.H. COOK: Again, it is iterative in the sense that it would not matter if we had 100 per cent of our mainstream population vaccinated if we did not have a significant majority of our Aboriginal population vaccinated, for instance. It is a question of not only vaccinating a large proportion of the community, but also, of course, saturating vaccinations in vulnerable cohorts such as aged care, Aboriginal communities, immune-compromised folk and so on. I guess we have used the number of around 80 per cent as characterising the first point we have to get to before we can be really serious about releasing some of the other public health social measures, but we really just need

to see what it looks like when we get there, which is the reason we have appointed the Vaccine Commander, because we really need to get a hop along in getting those vaccination rates up.

Ms M.J. DAVIES: I refer to the 80 per cent or above vaccination rate. Is that a total of our population, or is a lens being put over that so that it is 80 per cent of each community; and, if so, how do we break that down? As the minister said, we have vulnerable communities and we have regional communities in which there is a lack of access to the level of health services that I presume is required for intensive care units and things of that nature. How do we give confidence to people in regional WA that the government will not get an 80 per cent vaccination rate in Perth and Peel and say, "Off you go", and we will all be stuck out in the regions in lockdown by ourselves?

Mr R.H. COOK: I think the member's question really characterises quite well how complex this is. We do not want a situation whereby there is a party going on in one town and another town is in lockdown. We really need to make sure that we get not only a good spread of specific communities, but also, overall, a high vaccination rate amongst all communities.

Ms L. METTAM: The health system is currently facing many challenges, such as the postponement of elective surgery, patients being diverted away from hospitals and record levels of ambulance ramping. Are those considerations and the challenges that the system is facing with staff and bed shortages in the mix? Are those challenges part of the consideration when we look at the vaccination rate and what the transition will be going forward?

Mr R.H. COOK: I will ask the director general to make some comments shortly in addition to mine, but I think the response would be, yes, that is obviously part of the consideration. All hospitals in the country are under pressure at the moment. I participated in a meeting of health ministers just last week during which we considered a paper that really exposed just how difficult it is in each of the states at the moment in terms of the high levels of demand in our hospitals. I see that, just this week, elective surgery has been postponed in South Australia, for instance, because it is experiencing the same levels of hospital demand that we are experiencing. Obviously, we have to factor that in when picturing how we will respond in the event of an outbreak. Can I just say, drawing upon the experience of previous outbreaks, that what we have seen is that people by and large stay away from hospitals, so hospital demand drops away significantly. We also have the opportunity to postpone elective surgery, and we have obviously talked about the short pause we have put on elective surgery this month, but that is in relation to multi-stay. We would then look to a more extensive program around that. In addition, we need to be aware of the fact that, drawing from the experience of New South Wales, we may have staff who will need to be furloughed; that is, they will have to go home for two weeks if they have been exposed to a positive patient. That is the reason we need to mandate vaccinations for our healthcare workers; they become a crucial element of any surge response. We also need to understand what would be the increase in demand on our hospital system. Vaccination rates, public health social measures and TTIQ all feed into what the impact would be on the hospital system. I might just ask the director general to provide further detail.

[11.30 am]

Dr D. Russell-Weisz: Thank you. As the member has quite rightly said, we are under significant pressure, but like all jurisdictions—I have been speaking with my colleagues in the eastern states and right across Australia—everybody is in the same situation. We have a program of work that focuses on the system demand. It has a number of workstreams, such as ED avoidance, patient transport, patient flow, hospital processes, a focus on mental health, long-stay patients, our workforce and, obviously, capacity. Out of those, I will just pick capacity.

The member talked about beds, and she will have seen that we are bringing 332 beds online, some of which are already online. There is a huge focus on workforce and recruitment, especially in particular specialities where we are short. Actually, we will potentially get more recruits by making sure that we recruit more people than we need, because we know that there are specific areas in the WA Country Health Service and other health services that are short. There is a huge focus on workforce and on capacity and, I have to say, there has to be a huge focus on long-stay patients. We are finding it more and more difficult to get both mental health and non–mental health patients out of hospital. At the moment, I think about 120 patients have stayed longer than 150 days and some patients have stayed some years. We have a program in place that literally goes through them patient by patient. We are buying packages off aged-care providers, disability-care providers and other providers, which is not our core business. That is the commonwealth's core business, but we believe we have to do that to free up beds, because if we free up current beds, we free up current staff. We have a couple of examples of some really good disability-care providers that are really struggling. We do not want them to discharge their complex patients back into the hospital sector. That then feeds into COVID readiness and our whole response to any acute surge and also to the capacity we need in the longer term.

The other thing that is being prepared is personal protective equipment. We went from being at the end of the food chain for PPE to now having four or five warehouses full of PPE and having sometimes a year's supply of specific areas of PPE. We want our staff to be safe. We want them to look at those warehouses and say, "You have got enough if we get a major outbreak here", and we do have plenty.

Ms L. METTAM: And ventilators?

Dr D. Russell-Weisz: We have plenty. We bought 363 ventilators, which our staff use and the intensive care physicians were involved in procuring. Again, a lot of them are just housed at the moment; they are not being used, but they will go out under any surge plan. We have a surge plan that will use both public and private capacity. We have about 250 ventilators, or maybe a few more, in use in the sector, with another 363 on stand-by.

Mr R.H. COOK: With the member's indulgence, I might just follow up on the point by the director general. The fact that patients are sitting in our hospitals awaiting National Disability Insurance Scheme assessment and cannot access the packages that they need is really an extraordinary failure of our system. We mentioned earlier the extra beds that we are bringing on, and I think the director general mentioned 40 transition care beds. It is for the complex patients who simply are not being accommodated by the commonwealth's program around the NDIS. Until we get the commonwealth to do some of the heavy lifting to make sure that we can transition patients from an acute hospital bed setting to a community setting with the appropriate supports, our system is going to continue to be under pressure. As the director general said, over 120 people have been in hospital beds for more than 150 days; that is almost six months, or half a year, lying in a hospital bed. We all know how unpleasant being in a hospital bed is in general, but to be a long-term resident in an acute hospital is really unforgivable, so we need the commonwealth to basically get on with it.

Dr D.J. HONEY: The Chief Health Officer indicated that the modelling was looking at a range of vaccination figures up to 90 per cent. My understanding is that the best vaccination rate in the world is about 82 per cent. It seems as though 90 per cent is a completely unachievable target. Is there any reason to believe that we will ever get to 90 per cent in Western Australia, given the hesitancy that seems to persist?

Mr R.H. COOK: I might ask the director general to respond from a medical point of view.

Dr D. Russell-Weisz: We have higher vaccination rates in some areas; childhood vaccination rates are over 90 per cent. This is about a rate of 90 per cent of 16-plus-year-olds. Obviously, we are now heavily targeting 12 to 15-year-olds and work is now coming out of the United Kingdom on vaccination efficacy and safety in children under 12 years. I think a 90 per cent rate may be a challenge, but I am an optimist and we should recognise it as a challenge and try to reach it, because the higher we can make it, the freer we will be. I think every effort can be made to reach 90 per cent. We know—I will ask the Chief Health Officer to comment—that some of our childhood immunisation rates are in excess of 90 per cent. This is a global pandemic of an extremely dangerous disease. We should be encouraging a rate of over 90 per cent, if we can get there.

Dr A. Robertson: There are obviously some challenges in us getting to a rate of 90 per cent for the whole population, but I will make the point that currently, 94 per cent of 70 to 79-year-olds, 91 per cent of over-80-year-olds, 82 per cent of 60 to 69-year-olds and 76 per cent of 50 to 59-year-olds have had their first dose. We are well advanced, particularly in the more vulnerable age groups. Obviously, we are picking up with the 16 to 40-year-olds; that is now underway. I think we can get up towards those figures. We usually sit around a rate of 95 per cent for our childhood vaccines. Although we have not achieved those sorts of high rates above 80 per cent in the past, I think it is possible. If we were to get an outbreak, and that is certainly a possibility, that would obviously further encourage people to get vaccinated.

Dr D.J. HONEY: It is certainly admirable to hear that certain sectors are getting there. Is there an estimate of when it would be possible to have a vaccination rate of 90 per cent of the population, not individual groups?

Mr R.H. COOK: As in everyone 16 years and over? I might ask the Chief Health Officer or the Vaccine Commander to comment.

Dr A. Robertson: At the current time, we are tracking at 80 per cent for early December. I have yet to see modelling for when we might get to 90 per cent or even 85 per cent. We are looking at that. Part of our modelling is for what the time frame might be to get to that percentage, but I cannot offer too much more at this stage.

Mr C. Dawson: I might add that in the last seven days, in both the state and commonwealth primary care sectors, we have been able to vaccinate just under 150 000 people. If we continue tracking in that way, as the Chief Health Officer has said, we will achieve that target of 80 per cent by early December. As to the last 10 per cent, a number of variables have only recently been introduced. One is that pharmacies are about to get Moderna. There have clearly been some damaging hesitancy issues affecting AstraZeneca. A new vaccine is available, but we do not yet know the take-up of that. There is also an increase in the Pfizer vaccine being supplied through the commonwealth's procurement process. As that becomes more readily available, coupled with a broader take-up by primary care services, GPs and pharmacies in particular, we would see that the opportunity for people to walk in or make a booking will expand the possibility of increasing the totality from the present target of 80 per cent upwards towards 90 per cent.

Dr D.J. HONEY: I guess the minister can understand my concern and where I am heading. If opening the borders requires getting to a vaccination rate of 90 per cent, I would surmise from what is being said that it would be well into the new year before that could possibly be achieved. The concern is that if the policy is based around that, it

is a policy to, in fact, stay locked down, or at least have the borders closed, for a considerable period. I appreciate that eventually we might get there, but it is obviously an asymptote as we get into those higher levels.

[11.40 am]

Mr R.H. COOK: I thank the member for the question. Borders and other public health social measures are not binary propositions—we are not sitting in glorious isolation from the world one day and then having tourists from France and New South Wales running through the streets the next day. We will see a transition to a more open arrangement with our interstate and international borders. I offer the prediction that, in the first instance, travel within Australia will require someone to be vaccinated and to probably have returned a negative test result, most likely utilising at that point technology that produces instant negative results. For travellers from high-risk jurisdictions whom we currently require to isolate for 14 days, we would allow them to enter but they would have to meet certain requirements—to have a certificate of a negative test result and to isolate at home for three or six days. I am sure that the member is not trying to simplify the policy response, but, as he suggested, opening up does not mean that tomorrow everyone can come in. At the moment, as soon as New Zealand gets its situation under control, that international border could essentially be opened. I suspect that the commonwealth will then entertain the idea of opening the international border to other safe jurisdictions. I have seen some media that suggests that the United Kingdom, the United States and Singapore could be part of that arrangement. I appreciate that the member has said that even if we reach a 90 per cent vaccination rate we will never open, but as the vaccination rates go up from 70 and 80 to 90 per cent, as I explained before, the public social health measures will come down and we will see that dance, if you like, continue to go on for some time.

Ms L. METTAM: We hope to move to mental health soon. I refer to page 321 and the sixth paragraph on public and community health services. I refer to efficiency indicators and the appropriation for the line item "Cost per trip for road-based ambulance services, based on the total accrued costs for these services for the total number of trips", which has gone up. How much has the state government paid under the ramping fine system and has that contributed to the increase in costs associated with that line item?

Mr R.H. COOK: I will ask the director general to respond to the detail of that question.

Dr D. Russell-Weisz: That individual payment to St John Ambulance may have a minor effect on this figure, but it is probably just an increase in the cost of providing services year on year. I could not say how much that actual line item will contribute to the cost because it goes to that particular indicator, and the contract payment to St John has gone up over the years. The member must remember that we run three contracts—not one—for ambulance services.

Ms L. METTAM: I refer to the total appropriations under WA Health —

Mr R.H. COOK: Total cost of services.

Ms L. METTAM: — or the total cost of services on page 307 just to get an indication of how much has been paid through the ramping fines system, an arrangement between the state and St John Ambulance.

Mr R.H. COOK: I appreciate the information that the member seeks to access. As the member would appreciate, when it comes to commercial contracts, there are sensitivities that limit the information we can provide. I refer the member to the report from the Office of the Auditor General back in 2019 when it undertook an assessment or a review of ambulance-based services. That report pointed to a number of recommendations that went to the issue of modernising the contract in a way that responds to the various service dimensions. I think that is what the director general referred to when he talked about three different contracts related to different aspects of St John Ambulance services. One of the responses is that we have some correctional capacity within the contract that responds to service demands. The member described that as a fine, but it is not a fine, as such; it is simply the way that a modern contract works to make sure it contemporises the level of demand that St John is experiencing. We have seen those demand levels increase. St John tells me that it has recorded at least a 10 per cent growth in its call-outs, just like the Royal Flying Doctor Service has experienced a significant increase in the number of evacuations or transport episodes of care. I will ask the director general to provide further comments.

Dr D. Russell-Weisz: As the minister said, we have three agreements, one of which is with St John for the provision of ambulance services. We have not only reframed the contract that we have with St John—I will go to that particular question in a minute—but also modernised our response based on some of the feedback from our health service providers. In the area of mental health, transport was happening not just between 8.00 am and 5.00 pm but at all times of the day. We have a particular mental health patient transport contract that is operated by Wilson Medic One. We also have non-emergency inter-hospital patient transport services in the metropolitan area, which is a panel contract that involves the three providers of ambulance services.

The St John contract covers the emergency road-based patient transport services, community transfers and inter-hospital transfers. We agreed to a deed of variation back in September 2020 and that takes the service agreement to June 2022,

so we have another contract to negotiate with St John. We transitioned from a very old type of block-funded agreement, with no clear link to performance or demand for services, to a pricing mechanism framework—very much like how we pay for hospital services. In the old days they were block funded. There was really very little transparency of what we got for our dollars from a commonwealth or a state perspective. We now use the activity-based funding model and can see exactly how much we pay for the services that we procure.

The deed variation at the time also established a foundation for the WA Country Health Service to progress the implementation of the country ambulance strategy. As part of that, we reached an agreement with St John Ambulance on the commercial principles around baseline levels for ambulance services. This captured additional payments that allow St John to invest in additional capacity, especially in times of high demand when St John does not have the flow of ambulances because patient flow is affected.

Mr R.H. COOK: I will chuck in some numbers there. St John Ambulance has received funding of around $175 206 000. This is estimated to go up to $188 434 000 in 2021–22. That estimate is based across all those contracts.

[11.50 am]

Ms L. METTAM: In relation to what I commonly call the "ramping fine system", which the director general referred to as payments made during high demand, can I clarify whether the minister is able to provide what the payments were in the last reporting period or is he refusing to provide that information because of commercial confidentiality?

Mr R.H. COOK: Yes; that is why I am giving the global numbers. The member can probably extrapolate the quantum from those numbers.

Ms L. METTAM: Given that the efficiency indicators of the cost per service are increasing, can we then assume, and is it understood, that the reason there is an increased cost of service is what I would call "bed block" or beds being shut and challenges in the hospital system in times of high demand?

Dr D. Russell-Weisz: The general service payment to St John WA will go up anyway because it is doing more work as it goes up to hospitals. Maybe there is a small component of that payment that we have paid to St John, but it would be nowhere near the total reason, because there are other increases in the St John contract and they go up year on year. St John is seeing increased demand anyway. The member is right that there are pressures in hospitals, with the increase in emergency department attendances, the acuity of those attendances and bed block with long-stay patients that flows back at the other end that the minister and I have talked about. I can say that we are working very effectively with St John Ambulance. We worked effectively with it over the COVID-19 pandemic. It has been an excellent stakeholder to work with, as has our Royal Flying Doctor Service and others. We continue to work with St John in these times of significant system demand.

The appropriation was recommended.