EDUCATION AND HEALTH STANDING COMMITTEE

HEARINGS WITH THE DEPARTMENT OF HEALTH

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 4 AUGUST 2021

SESSION ONE

Members

Mr C.J. Tallentire (Chair)
Ms L.L. Baker (Deputy Chair)
Mrs L.A. Munday
Ms C.M. Collins
Mr K.J.J. Michel

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Hearing commenced at 10.14 am

Dr DAVID RUSSELL-WEISZ
Director General, examined:

Dr DUNCAN JAMES WILLIAMSON
Assistant Director General, Clinical Excellence Division, examined;

Mr ROB ANDERSON
Assistant Director General, Purchasing and System Performance Division, examined:

Dr DENISE SULLIVAN
Acting Assistant Director General, Public and Aboriginal Health Division, examined:

The CHAIR: Thank you very much for making this time. We really appreciate that and how incredibly taxed the agency must be at this time as well. I would like to begin by acknowledging the Whadjuk Noongar people, the traditional owners of the land on which we meet, and pay my respects to their elders, both past and present. On behalf of the committee, thank you for agreeing to appear at this agency review hearing today. My name is Chris Tallentire. I am the member for Thornlie and Chair of the Education and Health Standing Committee. My deputy chair is Lisa Baker, member for Maylands. I have with me Lisa Munday, member for Dawesville; Caitlin Collins, member for Hillarys; and Kevin Michel, member for Pilbara, forming this standing committee team. We also have Wendy Wells from Hansard who is doing all the recording, and Rachel Wells—no relation—and Catie Parsons, who is our principal research officer. Thank you again for joining us. It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege. However, this privilege does not apply to anything that you might say outside of today's proceedings.

If I can just kick off by saying that we are very aware from the budget and your last annual report of the challenges facing the department. Before we move into more general matters, perhaps we can address the COVID-19 pandemic, which is clearly one of the most significant public health issues that the WA health system has ever faced. Your last published annual report noted the activities undertaken by WA Health to help Western Australia respond to COVID-19. Could you talk us through some of the biggest drains or challenges on the agency's capacities at the moment?

Dr RUSSELL-WEISZ: Thank you, chair. I think you have to go back to February 2020 when we saw this virus emerging out of China and we saw the first cases here. The Department of Health has a standard incident response when we respond to any incident. It could be as basic—sometimes they are not basic—as an IT failure across the system. It could be a response to another virus outbreak. There is a standard procedure that we go through. We understood at that time that this would be something that was long lasting—probably longer now than we ever thought, because I think everybody thought that by June 2021 we might be out of it; I think that we are in this for some time to come—and that we needed to set up a structure that would actually see us through. The agency responded. The way we did this was that this was basically a public health issue. We are the hazard management agency. Luckily, we had the new Public Health Act 2016. The hazard management agency comes under the director general. I delegate that to the Chief Health Officer and he then runs the hazard management response, obviously in unison with me, and there has probably been a trifecta between Chris Dawson, as the police commissioner, under the Emergency Management

Act, and Andy Robertson and myself in relation to how we manage the hazard, which is COVID. Normally, the response would be a pure public health response in relation to understanding the virus and understanding what it would land on our hospital system. But we also needed a very strong operational response, so we set up two arms under the Chief Health Officer. One was a public health arm led by the Deputy Chief Health Officer, Public Health, Paul Armstrong and led by a Deputy Chief Health Officer who is the incident controller in relation to the operational incident.

[10.20 am]

If we all take ourselves back to March or April last year, we saw what was happening in Italy and right around the world. James, on my left, used some other local modelling expertise, and Rob as well, to model what we would see if we really let the virus come. We were all very scared about it. We had some very immediate responses. In March and April last year, significant pressure was put on the agency to get its governance set up and get the response set out—make sure we had our testing capacity, contact tracing capacity, our isolation, our quarantine. We had to set up hotel quarantine literally over a weekend. We also wanted hospital capacity. One of the things that dried up was PPE. Our PPE supply basically dried up between two nights. We thought we were getting PPE and we thought we were getting testing kits, but we were at the end of the supply chain of Australia, and Australia was at the end of supply chain of the world. One of our major focuses was PPE because we wanted our staff and our hospitals to make sure we were safe—are you safe? We went from one warehouse to four and a half warehouses of PPE. We got our own supply. I will be very open with you. We did not rely on the commonwealth; they had enough to do. We wanted to get our own supply and we actually ended up getting three planes full of PPE across from China and we set up new supply routes. Our first focus was PPE and it was hospital capacity: how many ICU beds could we free up and how many intensive care places? We bought ventilators. It was really about responding to what was coming. At that stage, we did not know that there was going to be a vaccine. All of the information coming out of public health expertise was that the coronavirus vaccines were very hard to make. Then throughout the year we obviously had a very strong public health response. What we learnt very early from the WHO was to go hard, go early. I think that has been the mantra from the Department of Health and the government, which has served us really well. Over the years we have had outbreaks and issues with hotel quarantine, like everybody else, and we are trying to be a constant learning organisation.

But your question, chair, was about the pressures it puts on the organisation. I describe is as running, in a sense, two parallel but intertwined Departments of Health. A lot of time our time is spent dealing with the pandemic, yet we are still dealing with a system that has to deliver services safely and we are undergoing significant system pressures. I have been in the system a long time. It is the busiest and the most pressured I have ever seen the system and, yes, that is because of COVID, but also because of some of the system pressures, which are being felt Australia-wide. We have also had to pivot to vaccinations and setting up a team to actually get the vaccinations out. That comes under our incident controller as well. Eventually, we would hope that becomes business as usual for the public health team because they are very, very experienced at working with GPs and getting measles or MMR vaccinations out and all the others. But in this case, it worked slightly differently because the commonwealth wanted to do it slightly differently. They are in control of supply. They obviously supplied primary health care and some of the commonwealth clinics as well as the state, and we have had to work closely with them.

I could wax lyrical about COVID for longer but I will not. The pressures on the agency—we are now going through our third iteration and we are meeting this week now that the Doherty modelling has come out. That is critical to what our response will look like while delivering services to the community in WA in the next six months, but, more importantly, what will happen if and when we

get to 70 to 80 per cent vaccination rate and what does that mean? We are looking at the UK very closely, and others may want to comment. The UK has got to about 67 per cent double vaccines and they are seeing quite a Delta surge, not so much in the ICU or in deaths but certainly in their hospital capacity. We are now thinking what will the next six months look like and, following that, what will 2022 look like and how do we get people vaccinated? What bothers me the most—this is a personal view—is this anti-vax movement. We actually have to get it above 80 per cent and we have to do everything possible to do that. I might leave it there because I do not want to over-talk this.

The CHAIR: My deputy chair has some more questions on that.

Ms L.L. BAKER: My questions are structured a little more around the sustainable health review. Given that you have been combating this pandemic and you have also committed to reforming the system, how the hell are you managing all of that? More specifically, have you had to park things, have you had to prioritise, and what have you done to try and manage the two agendas?

Dr RUSSELL-WEISZ: I might start and then I will pass to Denise, and maybe Rob, to talk about two areas.

With the sustainable health review obviously things have not progressed as they could have because we have had to concentrate on the pandemic. However, certain things have been delivered more quickly than they would have been without the pandemic. I am not advocating for a pandemic, but things have had to change. Telehealth made a huge jump during March to June last year. A lot of our clinicians came on board. While some of it now has reverted back to business as usual, there is more telehealth in the system than there ever was. That is one of the real positives. The other one is the focus on public health. While there are eight enduring strategies and 30 recommendations, the team has already prioritised tranche 1 and tranche 2 ones. We have an independent oversight committee that really gave advice to the minister about how we were going. I could name a couple here that have probably not moved as much as they would have done, but spending on public health and the focus on public health and on COVID protection has meant that public health spending has gone up and we are moving to that five per cent. I think a greater focus on climate change came out of this review. Some of work that Rob's team has done on data linkage, which was very much focused on in here, has gone forward in leaps and bounds that we would not have thought would have done so. Just on our electronic medical record strategy, we have delivered a digital health strategy and we are now delivering a business case to government on an electronic medical record. Without the pandemic, we would have gone in a more structured way. Now that the independent oversight committee has been reformed, we are presenting to them. I have said to them that we need to prioritise on SHR and to make sure that the minister and government are happy with what we are prioritising because we cannot do everything. I might ask Denise or Rob to comment on the SHR briefly.

Dr SULLIVAN: COVID has been both an enabler and disrupter in terms of progressing the recommendations of the sustainable health review. In terms of public health, we have carriage of the first five recommendations. One is around boosting investment in prevention over a 10-year time span as well as addressing obesity, alcohol and looking at how we can better improve equity of access to services for Aboriginal, CALD and lower SES populations. In addition to that we have climate and health. We have very much focused on some of the foundational works that need to be done. In terms of sustainable health review recommendations, we have been looking at how to best calculate and capture investment in public health prevention and we are starting to do some work around the glide path to five per cent, recognising that that is a longer term goal and we are going to be looking at change over a long period of time. Investment in COVID has enabled a boost in investment, but also distorted, to some extent, the investment in infection control disaster

management, which means it is a risk to other public health priorities such as obesity and alcohol.[1] Some of the COVID response has also helped to cement some relationships with other government agencies that we need to work quite closely with particularly when it comes to addressing issues around Aboriginal health, CALD communities and low SES populations. It has also enabled some work to progress across around the climate and health inquiry. That report was completed and released in late 2020, and we are now in the process of setting up the sustainable development unit, which was one of the major requirements. I suspect that the pace of the rollout may not be at quite the rate that we were hoping for pre-COVID, but certainly we have been slogging away to ensure that we maintain some momentum.

[10.30 am]

Ms L.L. BAKER: Are you thinking of putting some public reporting into place, following up on *Foundations for a stronger tomorrow*, which was released by Infrastructure Western Australia, calling for that?

Dr SULLIVAN: Yes, there will be public reporting as part of the sustainable health review and there is work that has been happening in Rob's area. We have not settled on time frames for when that will commence, but there will be public reporting.

Ms L.L. BAKER: Super, super.

Mr ANDERSON: Just to follow on from Russell's comments—both Denise and Russ were quite correct—it has been a disrupter. We have to be honest: we are not as advanced in some areas of the sustainable health review as we would have been if we had not had the last 18 months occur the way it has. I always liken it to something like a period of war, where you see technology and medicines and science leap forward because there is suddenly an imperative and everybody is working together for this greater good. I think we have seen that in so many areas, which actually link back into the SHR.

To take the linkage example that Russ used, we can now link private pathology data to our patient index—so, patients within health to our health datasets—in almost real time. We are talking within a couple of hours—three or four hours. This used to be something where to build new linkages would take up to eight weeks. If anyone has got any experience in research, you would know that to try and get linked data was exceedingly tough for a number of reasons. If we just focus on the linkage part, we have now managed to speed that right up to the point we can now get data coming through and being linked in very fast time, and we are now working with models using artificial intelligence and machine learning models to try and automate that. We take out as much as we can from the human element and then we can almost get to real-time linkage. What this will do for Health, for the government, for the state, for research, is enable us to link disparate datasets across, for example, government. We will bring them all together and you can start to look at the whole journey of a person through our systems in health. We have done it in mental health; we can now see where patients come in and out of emergencies, how often they are doing that, and when they are going into outpatient space and inpatient space. A layperson would probably think we should always have been able to do that, but it actually was not simple. COVID has actually now pushed us to develop these models to support the response to COVID, so we can see real-time data testing and who is positive and who the contact tracers have to follow up very, very quickly. We can then apply that to other elements, and we have done that. It really has been an enabler in so many ways.

[1] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

Ms L.L. BAKER: Just a follow-up question to that; you are obviously the right man to ask this question of. Looking at what is going around at the moment federally around the passport notion, there are huge challenges in data matching and confidentiality.

Mr ANDERSON: Yes.

Ms L.L. BAKER: Is that something that you guys have started to turn your minds to?

Mr ANDERSON: Absolutely. Not necessarily solutions, but we definitely have that on our radar, yes, absolutely. I mean, if passports or some form of identification are the way out of this, then we have to turn our attention to that.

Ms L.L. BAKER: Work with police and Foreign Affairs and Trade?

Mr ANDERSON: Yes. Not so much the commonwealth space, but we certainly work with all the state agencies, and we already link data from Transport, Police, Education—the big agencies. We still intend to get into the space of less population-based agencies such as Landgate and so forth. But the commonwealth is a totally different ball game, but we are certainly working closer with the commonwealth now than we ever have. That is probably another enabler that we have seen through COVID.

Dr RUSSELL-WEISZ: Just to add, the other thing that has happened which is really positive is the IT support. We have created systems here. Our contact tracing system, PHOCUS, has been used by other jurisdictions. We have SafeWA, we have VaccinateWA that we built ourselves, as well as other systems. I have a team of contact tracers in at the moment who are contact tracing for New South Wales. They are doing around 40 to 50 patients a day for New South Wales. That does not sound a lot, but they are doing all their contacts. We have our own team now supporting New South Wales; they were supporting Victoria. You know, last year we sent nurses to Victoria. We very much assist the other states and, if we have got contact tracers who are not working on issues here—we obviously have ships, as you know, at the moment—they are there to assist other jurisdictions.

Dr WILLIAMSON: I might pick up on a couple points following on from Rob. I would just like to acknowledge the role of the research community in our initial response to COVID.

Dr RUSSELL-WEISZ: Yes.

Dr WILLIAMSON: Russ has mentioned the modelling that we did with UWA and, to an extent, Curtin University with Rob's team too. In a very rapid discussion with Russ, we released $3 million to the research sector very quickly in order to really stimulate a good response, and we got that. I suppose they would be disappointed that we did not have more COVID for further studies, but we put ourselves in the best possible position to actually contribute to the COVID response, and we have been doing that. There have been some very significant papers that have come out of WA, particularly in collaboration with the UK. We are sharing samples, and we have got the expertise over here to do the relevant analysis. That was very gratifying. I would also just like to pay my tribute to government for assisting. It was really important to get the funding established; the future health research and innovation fund legislation was passed at the height of COVID. Also, there were various important changes made to the Guardianship and Administration Act which allowed people who potentially would have been in an intensive care unit unconscious with COVID to participate in trials should we have been in that situation. I would just like to remind you that probably the single most important advance in the treatment of COVID was the recognition that dexamethasone, a very simple drug used in intensive care for the sickest patients, is probably our most effective intervention. Those are the sort of trials that we were, after that change, ready to contribute to. The future health research and innovation fund would be an example where we were able to really respond quite quickly.

A couple of other things—our end-of-life program. You would be aware of the VAD legislation being passed and the 18-month period that we had to implement it. Well, at the beginning of COVID, I probably lost about a quarter of my staff to the COVID response, but we were able to keep the lights on in that program, which was obviously very time critical and important. I would consider the VAD component of that an extreme success.

Ms L.L. BAKER: Well said.

Dr WILLIAMSON: I have reported back to this committee and others on how we are progressing with palliative care—30 additional FTE in country WA, basically all the regions now covered, we have got good contracts for education in residential aged care, we have got in-reach into residential aged care, we have got additional beds. There have been enormous changes in palliative care and what we can offer there over the past 12 to 18 months. One of the other streams that we have, of course, is advance health directives. Very early on we boosted up our goals of care program within the hospitals and then within residential aged care, so that people can say what the limits of care are going to be in advance of serious illness. We are now linking that into My Health Record, which is the patient-controlled electronic health record that is run by the commonwealth. Currently, the changes to the advance health directive template have been made and are now back with Justice. There is quite a lot of stuff there. Telehealth has been mentioned with our outpatient reform program. There are other aspects of that that have had to take a back seat, but generally there has been good progress. I would just like to emphasise how important the EMR work is that our colleague Nicole is responsible for. That is going to be vitally important to bring us up to basically all of the other states in our ability to manage patients efficiently.

The CHAIR: Just before we go to climate change—Caitlin is going to lead off there—I just want to ask a question about the SafeWA app. The Auditor General's report came out yesterday and $6 million was the general cost. I imagine, though, there is a bigger cost for the test and trace program. I do not know if you can tell us a rough figure on that.

Dr RUSSELL-WEISZ: I am happy to come back to you rather than guess. I mean, COVID has been expensive. Obviously, we get fees back from hotel quarantine. Our own pathology services, PathWest, do a great deal of that testing and that would be covered, but then when we do have an outbreak or we need to step up we do use private labs, like everybody else does, and we pay them. Rob can correct me if I am wrong, but we get 50 per cent of most costs from the commonwealth. Under the national partnership agreement with the commonwealth we do split 50–50—not hotel quarantine, but everything else. That is a bit of a moving feast at the moment. We are here for the long haul; we go back to them and say, "Are you covering this or not?" We could get you an actual figure on what the contact tracing team and also the testing does actually cost.

The CHAIR: If that is possible.

Dr RUSSELL-WEISZ: Yes, absolutely.

The CHAIR: Just picking up on an issue you touched on: comparisons with other jurisdictions. I am aware that the UK has spent somewhere between £20 billion and £37 billion on their test and trace scheme. I think the general view is that they have wasted an incredible amount of money, or misused money. Is there a need for us to be a little bit cautious when it comes to looking at how other jurisdictions are not doing as well as us and in fact spending vast amounts of money for poorer results?

[10.40 am]

Dr RUSSELL-WEISZ: Yes, I would agree, chair. In the UK at the moment, certainly in the early days, their response—I am very cautious about being critical because this is not a risk-free environment

for many. A book has not been written on how to deal with this. We are obviously learning the whole time. I think there were probably some mixed messages very early on. I think that their vaccination program has been probably one of the real successes, in trying to get the vaccination program out. I think with their contact tracing, certainly, they might have spent a lot of money. In Jodie McVernon's recent report from Doherty she is actually saying that you probably need a higher tracing system even when you get to 70 to 80 per cent so that you are ready to respond at all times. What happens now is we have a group of people who are always available, always there, and then we surge up. We can surge up to around about 300, even higher sometimes, but we do not have them all the time. But I think we will need to invest in a contact tracing system probably for the next 18 months to two years, depending on how the virus goes, and the testing will always be there. We can get you the figures. We have certainly not misspent money in our testing and tracing to date, I just do not think we need to be brought into a false sense of security. We will need that capability into the next two to three years.

Ms C.M. COLLINS: Aside from COVID, another key factor that your department has identified as a health risk to Western Australians has been the impact or implications of climate change. We are actually getting evidence later this week from Dr Weeramanthri about recommendations made in the climate health WA inquiry. We will leave the bulk of those questions for him, but we may have some questions after that for your department. But that said, we were wondering if you could briefly tell us how WA Health is responding to this inquiry, and also, from WA Health's perspective, what sort of broad impacts will mitigation strategies to reduce climate change have on public health outcomes.

Dr SULLIVAN: One of the key recommendations was that the department, as a first order priority, set up a sustainable development unit. We are now in the process of setting that up. We have recently advertised for the position to lead that unit. The primary role of the sustainable development unit will be providing technical expertise but also coordinating, supporting and promoting system change so that the WA health system is better able to respond to future demands as well as better managing its own significant contribution to emissions and waste. Part of the work of the unit will also be some funds to support mitigation strategies and adaptation. That will include some seeding money for health services in terms of exploring options as to how we can reduce our greenhouse gas emissions footprint, for instance, and reduce waste et cetera. That is part of the longer term plan for that particular unit. That being said, there is also work that precedes the climate and health inquiry. All of the WA hospitals are members of the Global Green and Healthy Hospitals network, which is an international community of practice based very much around sharing information resources and best practice in terms of how to reduce greenhouse gas emissions, waste et cetera. Most of the health services have also set up their own sustainable development unit, be it identified positions or a smaller team of people, but we are still probably in the early stages in terms of new work to commence, and that is partly because of the disruption that has been caused by COVID. Also, what does happen across the health system will probably vary from one health service to the next. You cannot really compare a modern hospital like Fiona Stanley Hospital with Royal Perth Hospital in terms of what they are able to do. In addition, we are also working closely with the Department of Water and Environmental Regulation. They have carriage in providing support to their minister around implementation of the state climate policy. Some early work is now commencing around measurement and monitoring of greenhouse gas emissions and obviously some work is being determined around targets, and then how the system is best able to meet that.

As a system we are very mindful of the impact of climate change on the community and also on the health system, both in terms of a higher risk of disaster and the effect of airborne diseases et cetera, and then what impost it will create on the health system in terms of how we respond to that.

Certainly part of the work going forward for the sustainable development unit and work that we do collectively as a system is around what we do to ensure that the system is well placed to deal with what comes, but also what is our role in reducing our own contributions. There will also need to be some work around public education in terms of understanding the impact of climate change and what we can do as individuals and communities. That is part of the bigger program of work that we are still to really commence.

Ms L.L. BAKER: You just touched on the thing I was about to ask you quickly about. Pardon me for this being a personal interest of mine—the public health aspect that you were talking about at the very end there and doing some public education. I know that most other developed countries that are dealing with climate change have dealt with the issue of food consumption patterns and health and the interplay between climate change, agribusiness and meat consumption in particular—meat-free Monday at schools and all that kind of stuff. Is that the kind of program that you might think about in the future?

Dr SULLIVAN: I have not got down to that detail but I have to say that there are a lot of interconnections as well. On the one hand, work needs to happen around climate change, but also, in my other job role, I have responsibility for chronic disease prevention, and obesity sits within that. That is also about the promotion of healthy eating. Equally, environmental health sits within the division, which is also about food security and sustainability et cetera. There are a lot of intersecting policy agendas and we will certainly be optimising those over time.

Ms L.L. BAKER: Lovely, thank you.

Mrs L.A. MUNDAY: I think this one is for you, too, Denise, when you talk about chronic disease and obesity. We are talking about the prevalence of chronic disease and injury and how it is one of the leading causes of illness and death in WA, and probably Australia and the world. I note the *Western Australian health promotion strategic framework 2017–2021* and the strategies in there. We understand that there has been some evaluation of that framework. Could you let us know where that evaluation came from or how it looked? You can take this on notice, by the way.[2]

Dr SULLIVAN: The health promotion strategic framework is a five-year strategic plan and it more or less sets a strategic direction for the health system. We have just come to the end of a review of the framework and are making preparations for the next iteration of it. What we have found is that, relatively speaking, the majority of Western Australians enjoy good health, but there is certainly a lot of room for improvement. Obviously, chronic diseases and injury continue to be major causes of premature death and disability in the community. There is a cluster of risk factors that contribute to that, such as obesity, smoking et cetera. We have seen some good trends on some risk factors. Smoking is probably less than half of what was way back in 2004—it is less than 10 per cent in terms of daily adult smoking—but then some other trends are not going in the right direction. In the case of obesity and being overweight, it is actually getting worse. Around 71 per cent of the adult population are overweight or obese, and in the case of children it sits around 25 per cent, but there has been no change since 2004. Based on current trends—estimates are based on some previous research that has been done—we would be looking at the treatment of illness that is a consequence of overweight and obesity costing the system as much as $610 million by 2026.

Mrs L.A. MUNDAY: Like type 2 diabetes and that kind of thing?

Dr SULLIVAN: Yes, through type 2 diabetes and some cancers et cetera. There is certainly a need to redouble efforts in terms of tackling obesity, not only through the work that the department does with the community, but also our work with other state government agencies and work that is

[2] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

happening at a national level. As well as the health promotion strategic framework, which certainly has a strong focus on obesity, we are also working with other state government agencies whose policy agendas are not about health, but, in actual fact, with Planning and Education, some of their policy work reinforces a preventive health agenda. There is also a national preventive health strategy and a national obesity strategy that are hopefully close to finishing and will be coming out in the near future. It is just a case of getting a few states across the line to sign up to it.[3] Certainly, the sustainable health review identifies obesity as being a key area for focus. I can mention a few other things that are underway in that space as well.

Dr SULLIVAN: At a system level, we have had a major change to our healthy options policy, which relates to the food and drink available to the public that access our hospitals. We have recently made a change that took effect from July of last year or this year—I cannot remember now. It becomes a blur after a while. Sugar-sweetened beverages are not available within our hospital health system, and we have had good compliance across the health services, which is great.[4]

In addition, we are going to be working with Healthway, looking at the feasibility of removing junk food advertising from state government assets, with a focus initially being on public transport assets. That is a piece of work that, obviously, government committed to during the election, and we are just in the process of standing up the task force that will be advising the minister and, obviously, cabinet in the future about how that will be progressed.

[10.50 am]

Mrs L.A. MUNDAY: Fantastic. Thanks, Denise. I was just wondering—did you say that since 2004, child obesity has not changed?

Dr SULLIVAN: No. It sits around 25 per cent.

Mrs L.A. MUNDAY: Okay. Great.

Dr SULLIVAN: It is good that it has not got worse, but at the same time—

Mrs L.A. MUNDAY: I actually thought it would have. That is good. That makes me feel moderately better. Just wondering—has the pandemic impacted your ability to deal with this because it has taken your vision away from the framework?

Dr SULLIVAN: No, it has not. We have managed to keep work going in the background, but I have to say it was certainly disruptive in the early days, particularly during the early lockdown. It had a major impact on quite a few of the community service providers that deliver programs for us. For instance, things like the LiveLighter campaign, the school breakfast program and a number of other programs that the NGO sector is funded to deliver suddenly had to re-point staff to working from home. It did mean a bit of a disruption and delay in services.

That being said, the NGOs are very quick to adapt and step up work that could be done through social media and other platforms, really, seeing the COVID outbreak and lockdown as an opportunity to further the importance of trying to live well and healthy over this time so we do not see a backsliding. It probably did allow some time to do a bit more background preparation because some things could not progress. If anything, it has probably slowed the pace at which work could be done because—similar to James—Public and Aboriginal Health as a division did lose some staff to the COVID response and so that has had a bit of an ongoing impact.

[3] A letter of clarification about this part of the transcript can be accessed on the committee webpage.
[4] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

Ms L.L. BAKER: A quick question through the chair before we lose you, Denise. The focus on children is something I am really, really interested in. Has Health given any thought to doing some research into the impact of COVID on children particularly? Yes? You are onto it?

Dr WILLIAMSON: Again, I think that was one of the extraordinary stories of the early stages of COVID. From the time of its inception to the time of actually enrolling the first child into our study, called the DETECT schools study, was about between five and six weeks. We did a large study. Initially, it was going to be 80 representative public schools across WA. In fact, one backed out at the last minute, so it was 79. We were going to be looking at the impact of COVID itself on schoolchildren, anticipating that we might, obviously, have an epidemic to deal with, but that never eventuated. All of our swabs—and I think we did about 18 000 of them as part of that study—were negative. There was a very detailed and scientific approach to what we would do in the event that we got positives and how we would track through families et cetera. That component did not take off for obvious reasons.

On the other hand, we also did a psychosocial survey of parents, teachers and children across all of those schools that were involved. Those results are about to be published, but they were mentioned in the press not so very long ago by Jonathan Carapetis from TKI, which was our research partner in this. That showed significant levels of psychosocial distress in our schoolchildren, which increased through the teenage years, when compared to a similar study done probably about six years ago. Using basically the same methodology, we could compare rates of psychosocial distress. I think that was one of the most significant findings and, of course, it was consistent with a number of other studies that have come out elsewhere about mental health problems in adolescents. We are seeing that in referrals to our child and adolescent mental health system. We are seeing it in an increase in eating disorders et cetera. This gives us an extraordinary baseline against which we can then measure any interventions that we might plan. We do have a number of thoughts. This was a very important collaboration with the Department of Education, our research partners, as well as CAHS—Child Adolescent Health Service—WACHS and PathWest. This was a major collaborative effort, which potentially will give rise to very important studies going forward as to how we can intervene to improve this.

Dr RUSSELL-WEISZ: I think, just add to that, we are also seeing—we saw it pre-COVID, but we saw quite a large increase in mental health demand coming from adolescents, and we have seen that much greater within COVID, especially a spike right across the country, if not the world, in eating disorders, and areas and growth in demand that really is out with any population growth. It does not relate to anything that we would have normally expected to see in previous years. Obviously, there is a task force at the moment looking at child and adolescent mental health services, but it is going to be a huge focus, I think, for every health jurisdiction around the world in the next five to 10 years.

The CHAIR: Kevin, you can lead us off.

Mr K.J.J. MICHEL: Thank you, chair. My question is directed to Dr Russell-Weisz, the director general. It is in regard to the Public Health Act 2016. I will just come straight to the question. Where the Department of Health is planning to give local governments the opportunity to be part of the health planning and take it over. Is there any reason as to why we want to give the local governments this power or transfer the powers to them?

Dr SULLIVAN: It is not so much a power as a requirement of local government. Part of the change to public health legislation in the introduction of the Public Health Act was a shift in focus on the promotion of health and wellbeing. Embedded within the legislation—which I have to say was developed over probably more than a decade to actually get to a point where we had legislation

that eventually passed through Parliament—was a requirement for local governments to undertake public health planning. They can either produce a public health plan as a separate document or they can integrate it within existing planning that they do for their community.

Local governments already have to do planning under the Local Government Act, so this is more around making sure that there is sufficient attention given to the health status of their community and what it means in terms of services and needs et cetera. That being said, it is not mandatory at this point in time, but the reality is that quite a significant proportion of local governments have wanted to push ahead with that. As a consequence, a couple of years ago, the department put out an interim state public health plan, which could be used as a reference document by local governments. We have also provided tools and resources to support local government in developing plans. We have arrangements through our health services with the local governments that sit within their catchment area to assist with providing data on health status of their particular local population. In addition, we have also established an advisory reference group—which does include the WA Local Government Association and others—in some cases dealing with any misperceptions about what local governments might think the department is requiring of them. In addition to that, our environmental health directorate has regular face-to-face forums, webinars and communiqués with local government. It is very much about shaping the extent to which the work that is being done on public health planning to the capacity that sits within that particular local government. Clearly, what Wanneroo can do might be very different from a small regional or remote local government.

Mr K.J.J. MICHEL: Chair, just another question with regards to that. When you look at the regional areas as such—the lack of facilities and the lack of all that—this could have been got already from the health department, looking at the population and trying to direct more facilities that have been neglected over the years. How does that come into the planning scheme of things?

Dr SULLIVAN: The idea behind the public health planning is just to inform—ensure that there is a clear understanding of the population health needs of their particular community and what it needs in terms of forward planning for that local government, as well as other support that might be required from other agencies that they traditionally or ordinarily would work with. What a public health plan may look like will differ from one local government to the next. There will probably be a set of common health issues that are shared across local governments, but then there will be many other local governments that may have issues around mosquito-borne diseases, feral animals et cetera. It is going to look a little bit different depending on the local government.

[11.00 am]

Mr K.J.J. MICHEL: Just a last question, chair. You have the WA Country Health Service as one body and then you have WA Health as another body. Does the local government have to be part of both?

Dr SULLIVAN: In the case of regional local governments, the WA Country Health Service will provide support to the relevant local governments, but they can also come directly to the department or their primary health network if they are needing some additional support and advice. We have also been working quite closely with the Western Australian Local Government Association and they also have some public health promotion committees within WALGA, so if there are particular issues that are coming up that are common to local governments, we can try to work out how best to advise or support or maybe, as I said before, address any misconceptions about what they think they are being asked to do.

The CHAIR: So by the time we get to the implementation of stage 5—that is, I think, the local governments all being involved—do we expect to see a decrease in the cost of chronic diseases and injury? Is that the aim of this?

Dr SULLIVAN: We will not see it by the time stage 5 comes into effect, so we are looking at around June 2022. It is more about the role that local government also plays in helping to address and reduce the incidence of chronic disease and injury.[5]

Dr RUSSELL-WEISZ: Even attenuate it as well. If we continue at this pace, we have seen the intervention on the smoking, but if you look at obesity and chronic disease that is related to that, what we are trying to do, not just with local government but with every arm of health and non-health—it is not all health—is to actually attenuate or stop the increase of chronic disease that will end up needing us to build more hospitals. It is about intervening at an early stage. We will never stop it completely. For example, Fiona Stanley Hospital was built and had specific rooms to deal with very, very obese patients, whereas other hospitals were not. That is a sign of the times; that they had to have gurneys to hold many, many kilos. We have sort of responded, but we do not want to get to that stage in hospitals; we want to try to attenuate it at a local and a public health level.

The CHAIR: So thinking of objective 1 of our state health plan—a more active WA—is it seen that local governments are well placed to make sure that we are being more active?

Dr SULLIVAN: Local governments are certainly engaged and see themselves as playing a role. Certainly, they have some levers that they control in terms of planning within their local communities and the facilities that they provide, be it recreation facilities or parks and other facilities that people can draw on. Local governments are very much engaged and working with the agency, so there is not really a sense of conflict, other than we all feel this sense that we are being asked to do more than we have the resources to do, so it is a case of what we can do with what we have got.

The CHAIR: I suppose a part of that activity level—this is something Denise and I have worked on—is countering the serious decrease in the number of people walking and riding to school and work. What is the role for the department in that? I have had the chance to hear briefings from them.

Dr SULLIVAN: Yes, we certainly have a role in that through our Health Promotion Strategic Framework. Clearly, it is very much a part of the sustainable health review, which is also about promoting a more active community. That is certainly central to the Health Promotion Strategic Framework. It is also embedded within a number of community services that are provided through the NGO sector. The LiveLighter campaign is outwardly addressing the issue of unhealthy weight, but part of that is also promoting a more active WA. We are also working quite closely with other government agencies. As you are aware, I am on the Bike Riding Reference Group, which brings together Transport, Parks and Wildlife and a whole range of others, including the Road Safety Council. It is looking at how each of us, in our own way, can help promote a more active community, be it around improving the safety of people on our roads through to planning decisions, and also creating bike-riding infrastructure for instance. So, yes, there is certainly a lot of joint policy work that is happening.

The CHAIR: Do you think in things like the *WA healthy weight action plan* we need to be sometimes more explicit and say that the problem is our sedentary lifestyles? The big problem there is our car-dependent lifestyle. Do we need to be a bit more explicit about naming what the problem is?

Dr SULLIVAN: Yes, we are. As I mentioned earlier, the current Health Promotion Strategic Framework expires at the end of this year, so we are in the process of working on the next iteration. The next iteration certainly gives greater prominence to climate change and health, for instance, and infrastructure, work across other government agencies et cetera. The intent is to have a draft of that out for wider public consultation within the next few months.

[5] A letter of clarification about this part of the transcript can be accessed on the committee webpage.

Ms C.M. COLLINS: I am not sure who this is for; it might be for you, Denise. One of the goals of the sustainable health review was to reduce the inequality experienced by Aboriginal people in relation to health outcomes and access to healthcare services. The *WA Aboriginal health and wellbeing framework 2015–2030* was intended to help with this. We understand that this framework was informed by a group of Aboriginal stakeholder groups. I just want to check that that is correct. If it is, has there been any ongoing consultation with this group since the framework was developed?

Dr SULLIVAN: The framework was developed by Aboriginal people for Aboriginal people. I do not know whether the specific individuals who were involved with the first development of this way back in 2014–15 are the same individuals who are engaged, but I would expect the same organisations would have a continuing role. The framework covers a period from 2015 to 2030 and it gets reviewed every five years, so we are in the process of coming to the end of the latest review. That has certainly involved consultation with a whole range of stakeholders, with, obviously, a strong emphasis on Aboriginal community–controlled organisations and other stakeholders, as well as looking at what is happening within the health system. My understanding is that we are close to a near final report on the evaluation, which, hopefully, will be coming out in the next couple of months, and then what that means in terms of the next iteration of the framework.

But certainly the framework has been a key guiding document for WA Health as a system. You have, obviously, had the opportunity to look through it. It highlights six domains and covers everything from the WA health system's own Aboriginal workforce and growing that, and also cultural competency within the general workforce. It also looks at how we better embed Aboriginal health as part of our broader policy, programs, work and services. We have seen some great initiatives that this has been the catalyst for.

In terms of the Aboriginal workforce, it sits at around 3.2 per cent. That is based on some figures that I think are set by the Public Sector Commission. That is going to be increased to 3.8 per cent. We have a number of programs, including a cadet program. We are now also looking at a graduate program, which is about growing the Aboriginal workforce within the WA health system as a whole. We have a number of grants with the university and registered training organisation sectors, which is about encouraging young Aboriginal people when they are going through undergraduate degrees to consider health as a career. That has actually led to a significant increase in the number of Aboriginal people applying for cadetship and graduate programs within the health system, including nursing and midwifery, to a point that we have actually taken on greater numbers than we would normally have had funded for cadetships, which is really pleasing.

The other is that we have also been looking at improvements in data, so the better capturing of Aboriginal identification as part of the data that we capture through the health system. There is a strong emphasis on co-design across a lot of the services, policies and programs that we work on these days.

In terms of cultural competency, I think Simon Millman, the parliamentary secretary, was involved in launching a new Aboriginal e-learning package just a couple of months ago, which is absolutely fantastic. I would certainly recommend having a look at it. There has been great uptake by the health system.

A probably more recent example in public and Aboriginal health is that we have had a set of grants with different Aboriginal community–controlled organisations and other service providers around Aboriginal environmental health. It is all about healthy homes et cetera. They have been in place for about 20 years, with a slight change of service providers over time. We are now going through a major review, and that review is very much a co-design. We are working quite closely with AHCWA and we also have an Aboriginal consultant on board, UWA et cetera, looking at what the next phase

of services needs to look like in the coming future. There is certainly a lot of good work that is being done, but it is not to say that there is not more work that we need to be doing.

[11.10 am]

Ms C.M. COLLINS: Would you say that a shift to some of these e-programs is a result of the COVID-19 era that we are in? What impact do you think COVID-19 is having specifically on the department's efforts to improve health outcomes for Aboriginal people?

Dr SULLIVAN: If anything, COVID has probably highlighted the extent to which the disadvantaged are disadvantaged. The greater and more intensive attention that those groups have been given in the COVID pandemic response has, if anything, provided some learnings and connections and a heightened awareness of the need to do more and to do better.

Mr K.J.J. MICHEL: Is it also taking into consideration the nurses and doctors that come up there to provide these services—their accommodation and various things? I travel throughout the communities and the biggest issue they have is with these nurses and doctors staying there. They are staying in some really bad conditions.

Dr RUSSELL-WEISZ: That always has been an issue. I used to work up there when I was in clinical practice and the accommodation was still an issue in the late 1990s. Sometimes it falls on the local shires to actually provide accommodation for private practitioners. If they are salaried doctors or nurses, then accommodation can be provided by the health service. The WA Country Health Service is involved here, and it is one of the issues that we are consistently facing about how do you recruit people and retain more people in rural and remote locations, especially in those locations that you are not necessarily going to recruit people for a long time and they are not going to potentially want to stay there for a long time, but they will want to work and they need good accommodation. Sometimes it is the fact that there is not enough accommodation or it may not be to the highest standard. The WA Country Health Service does own quite a few properties through rural and remote areas. It is probably a more significant issue in the north west than it is elsewhere. I know it is a focus. One of the negatives of COVID has been the real difficulty in us attracting rural and remote specialists and doctors to remote locations. That is not just internationally; that is nationally. With borders going up and coming down, people are probably happy to stay at home. We do bring doctors and nurses—especially doctors—out of Queensland and other areas in Australia. That has been more challenging with COVID. I think it is a bit of a double whammy. You have had that difficulty to recruit and attract anyway with COVID, and some of the challenges in rural and remote areas will remain in relation to accommodation.

Mr K.J.J. MICHEL: I think this was happening before COVID anyway.

Dr RUSSELL-WEISZ: That is true.

Mr K.J.J. MICHEL: In 2017, I visited the Jigalong clinic, and the floorboards in the accommodation were all rotten. It took until 2020 for them to think about doing something about it. They stay for one month in these areas looking after the communities up there. If they have at least good accommodation, they feel part of the community. I think the delays in trying to get these things done in regional areas—it is good to have all the other programs that we want to bring forward, but if they do not have the proper facilities for the staff, it is sad. I walk into people's homes and I walk into the doctor's office just to find out what they are going through, because, at the end of the day, they are facing the community, not me. We address these issues with the minister in Parliament, but where is WACHS sitting? We even spent $1.8 million on refurbishing the clinic and when we had heavy rains it leaked in and out.

Dr RUSSELL-WEISZ: I cannot talk necessarily on some of the issues affecting some of the Aboriginal communities, but WA Country Health Service will be absolutely responsible, as is the department, for looking after the accommodation that it provides. I think the Aboriginal medical service based in Newman —

Mr K.J.J. MICHEL: Yes, PAMS.

Dr RUSSELL-WEISZ: PAMS looks after the clinic at Jigalong and Cotton Creek.

Mr K.J.J. MICHEL: No, I think the one in Jigalong is looked after by WACHS.

Dr RUSSELL-WEISZ: Okay. Certainly, I take it on board that we need to do as much as we can in relation to making sure that the accommodation is welcoming for our practitioners. We would argue that the Aboriginal medical services need to go to their funder, which is the commonwealth, to do the same.

Mrs L.A. MUNDAY: I notice that you have answered a few of my questions through Kevin's question. Specifically—this is less about accommodation and more about retaining and locating actual staff as in specialty groups—it says here that WA Health has noted shortages in small but critical groups of medical and health science specialties. What are these specialty groups that you have found?

Dr RUSSELL-WEISZ: I might go straight to James, and James can lead us through it.

Dr WILLIAMSON: In the medical sector—you know, doctors—we have got a shortage of general practitioners, but, probably more importantly, we have a maldistribution of general practitioners. Obviously, there are significant shortages in the regional areas. In particular, there are shortages of GPs who have got skills in anaesthetics and obstetrics, which are really required to support the smaller communities there. That is one of the things that we have been trying to work on. We have had a GP project running for a couple of years now to encourage more junior doctors into general practice. Obviously, we have the first tranche of graduates from Curtin Medical School coming out. There will be 60 of those in January, increasing to about 110 over the next three years or so. One of the raisons d'etre for that medical school was to increase the people who wanted to enter into general practice and actually ultimately move to regional areas. It will be interesting to see how that goes.

There are one or two critical areas in WACHS, particularly up in the Kimberley where obstetrics is under threat in terms of services because we are unable to get the staff. You would be aware, obviously, of the nursing and midwifery shortages that are well publicised. In addition to that, we have got a few other critical areas. We have mental health. We certainly have a shortage of child psychiatrists. There are some other psychiatric specialties which we need to expand. The other one that comes to mind is consultation liaison psychiatry, which goes within general hospitals and provides the oil, if you like, that smooths the transition of patients through medical and surgical specialties who might have coexisting mental health problems. We know that those two areas—that is, child and adolescent and consultation liaison psychiatry—are two of the bottlenecks for our trainees. Unless you have sufficient senior people in those positions, you cannot get the next generation through because they are stuck at those points. There are a couple of other pressure points in nursing, apart from mental health and midwifery that I have mentioned. There are some specialty areas like peri-operative, emergency, critical care; these would be areas where nurses are needed. We have a number of strategies in place now to address those issues—upskilling existing staff and probably being a bit more flexible in how we engage staff. Paediatrics was another area where we had to expand staff quite rapidly. We dropped the requirement that applicants have previous paediatric experience and, as a result of that, we had over 100 applicants and our appointees are now being upskilled in paediatrics so that they can enter the workforce more rapidly.

I have not really touched on allied health. What we are seeing—Russ would be very much across this—is a significant proportion of long-stay patients in our hospitals. These are patients whose medical treatment has been completed but who are waiting usually for accommodation or social support. Probably about 50 per cent of them might have mental health issues and some of those would be very long-stay patients who have not had the places to go over many years. Allied health plays an absolutely critical role in facilitating the discharge of those patients. Of course, NDIA in the community, as a provider of funding for services, is reliant on those providers. We know that there are very thin markets in some areas, particularly in regional areas, so it is very difficult, even if you have a package approved, to get the providers in place and to get the services. Accommodation and services are absolutely critical. It is the support staff and the assessment staff in the community that we are struggling with.

Mrs L.A. MUNDAY: Thank you, James. That goes to as far as the Kimberley and the Pilbara and also to my electorate of Dawesville, which is peri-urban and sort of misses out for the exact same reason. It is close but not close enough. Can the research innovation office or WA future health research and innovation fund help educate or support professionals to fill these specialties?

[11.20 am]

Dr WILLIAMSON: That is not the predominant role of the fund. Something that we are debating at the moment is fostering research into workforce or research into sustainable workforces. Those would be legitimate areas of research and innovation. I am not at liberty to make announcements as to what sort of work might go on in future in that area, but we have now got an advisory council. That advisory council has approved our strategies and determined what the priorities are going to be and is in the process of making recommendations about specific programs and initiatives to the minister. Some of those will potentially address those areas. But we do not use that source of funding to actually train people into those areas.

Mrs L.A. MUNDAY: Is that the organisational development program that you are talking about?

Dr WILLIAMSON: The organisational development program tends to be an internal Department of Health program, but we have got a whole range of initiatives that we are using with the HSPs to try and upskill people in certain areas. We obviously work with the colleges. One of the difficulties we have got is we do not have a good mechanism of linking the needs of the health service to what is coming through the colleges in terms of employment prospects. There was a period where we got a bit out of sync with emergency physicians, for instance, and we had a bit of an oversupply of emergency physicians and of course a shortage of psychiatrists, for instance, or general practitioners. What we are doing is we are trying to influence choices made relatively early in careers to get people into the necessary specialties.

Mrs L.A. MUNDAY: Are Aboriginal people being included in that in the workforce as well?

Dr WILLIAMSON: Yes. Our workforce planning very much includes Aboriginal health workers and encourages them to participate in other areas too.

Mrs L.A. MUNDAY: This next area is a bit of a personal interest for me. I have been a paramedic for 20 years prior to getting into politics. As a psychologist as well, EMDR was something that really worked for me from seeing things that normal first responders have seen—like police, fire, ambulance. Have you got any information about initiatives or programs in place across the WA health system that train first responders, whether it be prison officers—I mean, across all aspects?

Dr WILLIAMSON: We looked into this, but the paramedics are really the—you would have to really address that to St John and the universities. I am not across any specific programs that have introduced those techniques into those who might be subjected to stressful situations or post-

traumatic stress. We do not have any programs within Health, but whether St John has, I do not know.

Dr RUSSELL-WEISZ: We certainly have employee assistance programs for our—I was going to use the words first responders, but everybody on the front line. St Johns would probably be better placed to respond to that. There are obviously other smaller providers of paramedics as well, as you would well know.

Mrs L.A. MUNDAY: I was employed by St John Ambulance, so, yes; thank you.

The CHAIR: Caitlin, could you lead us onto the state spleen registry?

Ms C.M. COLLINS: Sure. We understand that without a functioning spleen, people have an increased lifelong risk of developing life-threatening infections. We were hoping that you could tell us what measures are in place to identify people who present often to ED who may not be aware that they do not have a functioning spleen. What kind of management is there for these patients?

Dr WILLIAMSON: People who have a splenectomy or who have got an underactive spleen would usually be identified before they present with overwhelming sepsis. Obviously, if you have had your spleen out, that is more commonly the case than if you have an underfunctioning spleen from some other condition. If you have your spleen out, there are usually two circumstances that could happen. If you are involved in a road traffic accident and the spleen has been ruptured and is bleeding, you might have an emergency splenectomy. If, on the other hand, you have got lymphoma and your spleen is very enlarged or has to be taken out for other reasons, then that would be an elective procedure. In both cases, education would be provided to the individuals concerned. If it is an elective procedure, then the necessary immunisations against encapsulated bacteria would be given in advance of the spleen being taken out, because obviously the spleen, as a lymphoid organ, is responsible for generating the immune response. They would be encouraged to get a bracelet and they would be given written information. There are health pathways that have been developed for the management of people who have their spleen taken out. In terms of the recognition of sepsis, obviously that is very topical at the moment. You would probably be aware that we are currently rolling out through the state a paediatric sepsis pathway to assist in the recognition of clinical deterioration, and particularly sepsis. I am aware that there are a number of sepsis pathways in emergency departments throughout the state. Once we have the paediatric one rolled out, we will be looking to systemically engage with the adult emergency departments to look at some more mechanisms.

Ms C.M. COLLINS: At the moment, I think Spleen Australia is the organisation that provides education kits and creates those individual vaccine and antibiotic plans. Currently, WA patients are not eligible to register with Spleen Australia. Has the department considered funding the registry; and, if not, why not?

Dr WILLIAMSON: I think there have been two approaches to the department over the past three years—the first in about 2015 and the second in 2019. On both occasions, the proposal was analysed by our health networks branch in consultation with the necessary clinical expertise. At the time that was initially put to them, there was a misunderstanding that this was actually a clinical registry, but in fact it was just the provision of some reminders, if you like—some information leaflets. Most of our information over the past few years has become available quite widely on the web and, as I say, we have access to our own health pathway as part of a suite of similar health pathways which specifically address that. I suppose, given the cost, which was put to us as around $100 000 per annum, we did not feel that that was the best use of resources at the time. There are probably about 2 000 people in Western Australia who either have had their spleen removed or who have got an underactive spleen and would fall into that category.

Ms C.M. COLLINS: Is Western Australia the only state that does not have a registry?

Dr WILLIAMSON: I am not sure about that. I do not know. I would have to ask.

Ms L.L. BAKER: I have an entirely different question. I have been approached recently—in the last 18 months—by a number of parents of transgender children, who have expressed concern about what they say are delays in accessing stage 2 hormone treatment. This question is cut from my personal experience in this. I know the legal ambiguity that seems to be around this Australia-wide. Provided you have been appropriately diagnosed as a youth for stage 2 hormone treatment, under what conditions can you actually get that treatment? Is a court case required in every case at the moment?

Dr WILLIAMSON: I think, from January, there was a change made in response to various legal judgements made both in Australia and in the UK as well. It was thought at that time that we needed to put in additional safeguards until the situation had been properly reviewed. That review, I understand, is in progress, but I do not have any firm dates as to when it might be completed et cetera.

Ms L.L. BAKER: Excuse me, the review that is in progress is being reviewed in Western Australia?

Dr WILLIAMSON: Yes, that is my understanding. The Child and Adolescent Health Service is conducting a review.

Ms L.L. BAKER: Lovely.

Dr WILLIAMSON: I do not have further information, but if you wanted further information about that specifically, I could take it on notice.

Ms L.L. BAKER: I would appreciate that, yes.

Dr WILLIAMSON: To answer your question more directly, if children were already in either stage 1 or stage 2 of their program and both they and their parents or guardians felt that it was appropriate to continue that, then there would be no need for a court opinion; they would continue that. But from around January, I think new referrals who came into the system would have to have a court decision before being entered into the program.

Ms L.L. BAKER: Thank you. The second part to my question is that we have received, as I mentioned, anecdotal evidence that access to stage 2 hormone treatment for transgender youth who meet the diagnostic criteria is being halted or substantially delayed. That would be under the context that you have probably just given—the new arrangements for January. But there is no clinical reason. Is it purely an administrative delay based on the legal threat?

[11.30 am]

Dr WILLIAMSON: Well, sometimes there might be a capacity issue. You know, usually if you are in the program, you progress through the program. I know that sometimes there are difficulties and delays in accessing the program in the first place, so there might be a three-month delay, for instance, before you get your comprehensive mental health assessment. There is a triage process conducted by a nurse, who will phone up new referrals to get some of the basic clinical information to try and determine the best approach. But I am conscious that we do have a couple of business cases, both from CAHS and from East Metro, which is trying to formalise an adult service, and at the moment no funding decisions have been made about those.

Ms L.L. BAKER: Would you also be in a position to tell us what clinical benefits you think might be associated with providing the treatment in a timely manner to those who meet the diagnostic criteria?

Dr WILLIAMSON: Yes, well, we know that this particular group are at increased risk of mental health problems. That is very well recognised. So I think in order to prevent that, you are going to give timely treatment where it is appropriate. The other thing that we have seen is that sometimes people have so-called "timed out". This is a time-critical service; you know, you are obviously ageing as you are waiting for the service, so they might get past the age where they can be dealt with by the paediatric service, and perhaps there is not good access—well, there certainly is not good access—to the adult service, so we can miss that clinical window of opportunity; so there are significant implications.

Ms L.L. BAKER: My final question—I am trying to put this in a way that is acceptable; you will understand in a minute—is: do you think that, from the government's perspective, we are seeking to provide the policy clarity on the issue quickly enough, or is that something that your agency sees itself being responsible for driving policy clarity on this issue? Who is ultimately responsible for fixing this situation, which I think is broken?

Dr WILLIAMSON: Yes, so there are issues regarding policy, particularly into the LGBTQIA+ group.

Ms L.L. BAKER: Just call it rainbow; I do!

Dr WILLIAMSON: All right. You will know that there are a series of probably about six election commitments that address that, which we are picking up—that is, my division is picking up, specifically the health networks branch. We will work with other agencies in the development of the particular policies, you know, including the Mental Health Commission, NGOs et cetera. That is the policy element. I suppose the main issue is how do we fund these services, because there are substantial increases in FTE that are being required and there are going to be substantial funding implications. I am going to cast to my colleague, because we have actually just been discussing this very recently with respect to the East Metro adult proposal.

Mr ANDERSON: Yes; thanks, James. Notwithstanding the issues that CAHS are reviewing as a result of the UK experience recently, the adult proposals are being currently reviewed by the department in terms of setting up a more comprehensive adult program. The funding that would be required for that is not—I will go back a step. The decision about whether we implement the program is not based on funding. The funding will flow from the clinical decision. The decision is based on the needs, so the needs assessment is currently being undertaken. Once we determine the appropriate model that needs to be put in place, then the funding will follow that. So whilst there has not been a funding decision, that is not holding up the service.

Ms L.L. BAKER: Sure. That is for adults, though.

Mr ANDERSON: That is for adults, yes.

Ms L.L. BAKER: So the whole issue of the youth is contingent upon the decision to either continue with the hands-off approach due to the UK decision—I understand that decision is being appealed at the moment, too, in the UK—and whatever work you are doing in WA around this issue. When are we likely to get something from Health that would clarify the policy position? Any idea?

Dr WILLIAMSON: Well, at the moment, we have just taken on the election commitments and we are trying to allocate internal resources to addressing some of those questions. We would have to take it on notice. Usually you want the turnaround of those questions very quickly.

Dr RUSSELL-WEISZ: I think we could ask the Child and Adolescent Health Service, because I think they would be across when that review that James talks about will be complete. We will just take that on notice and we can come back to you with an approximate date.

Ms L.L. BAKER: Yes, thank you. That would be helpful.

The CHAIR: Thank you. Moving now to type 1 diabetes.

Ms C.M. COLLINS: Yes. We, as a committee, recently had a hearing with the Department of Education and we asked some questions around the impact of type 1 diabetes in schools and how that impacted students' experience and whether there was a need for more funding, because we believed it stopped at about year 2. But we had some questions around wanting to know about the statistics of how many students or children presented to doctors or emergency departments because of episodes in schools, and they suggested that you would be much better placed answering that question. Do you have any stats for us on —

Dr RUSSELL-WEISZ: Not that we could refer to now, but certainly—I might ask Rob to answer this—if you could particularise your question about whether it is schoolchildren presenting to our emergency departments with diabetic complications or diabetes, or exacerbations of their diabetes, we could very much give you that information. We probably do not have whether they come from a school or they are just presenting, but, also, they may not all present to us. A lot of those will present to general practice, because they will be taken to the general practice, but I think, Rob, we could provide —

Mr ANDERSON: Yes, we could provide you with the numbers of any age group that attend ED as a result of a diabetic incident or with a diagnosis of diabetes, because that is coded as well. But as Russ said, we could not tell you whether they are coming because of an incident at a school or not. Again, there would be a large proportion that would go to GPs as opposed to us in that instance. If it is an emergency, obviously they would not. But can I just make another comment on the funding elements, and it actually goes to a few questions. I think it would be remiss of us not to mention the work we are doing in the sustainable health review around funding and commissioning reform as well. A lot of the questions you have been asking on diabetes, and your questions as well, Kevin, are around preventive health models more than pumping more money into hospitals. SHR really has a big focus on this. There is an enormous piece of work that we are undertaking at the moment, and this will be iterative over a number of years, to start to put more money into preventive health models as opposed to just continuing to grow hospital funding. Hospital funding will always grow and there will always be a demand for hospitals, but the more we can do around obesity and diabetes and up in the north west with disadvantaged children, the more we can do with primary health and community organisations, the more we can impact those obesity rates and diabetes rates. As you said before, diabetes is not just diabetes; it then can affect basically every organ in the body. You know, some of the things we see in hospitals from people with lifelong diabetes are horrendous. If we can get to them at an early age and prevent some of this, that is our focus. There is an enormous amount of work we are doing now to change the way that health is funded, and how we fund, and how we partner with non-health organisations to address that.

Dr RUSSELL-WEISZ: If I can add to that, I think it is a critical point, because some of the questions you have answered about these services do not fit into—whilst they may be seen in hospitals, a lot are seen in the community. We get funded on activity-based funding, or block funding. I will not say it is basic, but it is quite binary. It is funded from the commonwealth. It is a not local Treasury issue, but it affects every Treasury. Every health service is funded out of activity-based funding. But it makes it quite, in a sense, unique in that you cannot easily move funding from a hospital into a community service. In this world today, we have to be much more diverse in how we fund things. There is a lot of work going on on that, but we also have to influence the commonwealth, who actually fund us. We do now understand our business a lot better. Over the last few years we have got our budget under control. The days where health would overspend and not know its business have gone, I am pleased to say, because of a lot of work. We have governance reforms. We have boards. They understand their business, but they are still funded in quite basic terms—activity based

and then block funded. Yet some of the really good questions you have asked today of us is that some of those services do not really fit into activity-based funding. We know for rural and remote with activity-based funding, when a patient in, say, Port Hedland has an episode of care, under how the commonwealth rates them, it could be the same patient that is in Bendigo. I am just giving you an example. There is no way you can compare Bendigo with Port Hedland. We know that care in rural and remote areas costs a lot more, and, again, does not quite fit into activity-based funding. We have done a lot of work with the commonwealth over the years to get loadings for rural and remote, but there needs to be the next iteration.

[11.40 am]

The CHAIR: Thank you. There is one final area, but we have not got much time, so we might end up putting some of these questions on notice. It is just about medical research. We note that the department supports numerous funding programs for medical research. Has there been any significant increase in this area of funding due to the emergence of COVID-19?

Dr RUSSELL-WEISZ: I would say yes, both in non-COVID-19, both through the election commitment of the Labor government over the last four years through the future health research and innovation fund, but also, yes, COVID research. I might ask James just to take us through where it has gone.

Dr WILLIAMSON: Yes. I mentioned that at the very early stage, I think back in March at the beginning of COVID, we released $3 million into the health and medical research program specifically for COVID research in order to fund specific projects to allow people to participate in international trials and also to support infrastructure that might be required, say, for biobanking specimens. That was one of the early initiatives. When the future health research and innovation fund legislation was passed, there was $6 million of additional funding into health and medical research that was specifically quarantined for COVID-related research. That has been allocated and is being used by the research community at the moment for various projects, some of which are looking at the consequences of, if you like, responding to COVID but not necessarily having it in the community. There has been an increase in funding because of the future health research and innovation fund and that legislation coming on board.

The CHAIR: All right. Final one: an overarching aim of the fund is to advance WA's standing as a leader in health and medical research. How is WA seen in the global rankings as a medical research centre?

Dr WILLIAMSON: Well, I think we have areas of undoubted expertise, but it is patchy. So, for instance, in the area of genomics, we have a couple of individuals, Al Forrest and Ryan Lister at Harry Perkins, who are leaders in their field, internationally renowned. I think even at the height of COVID, Al Forrest chaired the Human Genome Organization meeting, which was supposed to happen in Perth but was actually held by Zoom from Perth, so that gives you an idea of their standing. We have Elaine Holmes and Jeremy Nicholson at the Australian National Phenome Centre over at Murdoch, which undoubtedly has an international reputation in what is called metabolomics. We have some great stroke researchers; Graeme Hankey must be one of the most highly published stroke researchers. We have some real expertise in hypercholesterolemia; Gerald Watts would be an example of that. We have some fantastic epidemiologists. There is Jonathan Carapetis doing his work on rheumatic heart disease. We have attracted Peter Gething, a geographer from Oxford University, with a team of about 30, who are doing fantastic work on network analysis and helping with our work on equity and Aboriginal populations. We have Tobias Kollmann, who is doing systems biology research into vaccinology. You know, I could go on. These people are all of international standing. Steve Wilton, with his RNA technologies, and Sue Fletcher. You know, I could go on. We have some absolutely fantastic individuals. It is a matter of, you know, how can you shape the

ecosystem so that that is really translating into better success in national grants through MRFF or NHMRC, you know, nationally and internationally competitive grants. That is what we would really like to see.

The CHAIR: Okay. That is something we might look at later. Thank you very much. If I can make a closing statement, again, a formal one.

Thank you for your evidence before the committee. A transcript of this hearing will be forwarded to you for correction of transcribing errors only. Any such corrections must be made and the transcript returned within 10 working days from the date of the email attached to the transcript. If the transcript is not returned within this period, it will be deemed to be correct. New material cannot be added via these corrections and the sense of your evidence cannot be altered. If you wish to provide clarifying information or elaborate on your evidence, please provide this in an email for consideration by the committee when you return your corrected transcript of evidence. We will also write to you with some of the questions on notice that were taken as well.

Again, thank you very much. We really appreciate your time. An excellent presentation. Thank you.

Hearing concluded at 11.45 am