REGIONAL HEALTH — McGOWAN GOVERNMENT'S PERFORMANCE

Motion

MS M.J. DAVIES (Central Wheatbelt — Leader of the Nationals WA) [4.01 pm]: Thank you, Madam Acting Speaker.

Mr D.A. Templeman: About time!

Mr R.H. Cook: I thought you were never going to get to your feet!

Ms M.J. DAVIES: Oh, goodness me! Thank you, Madam Acting Speaker. This is a very serious issue that I am bringing to the Parliament, now that I am on my feet. I move —

> That this house condemns the McGowan government's ongoing failure to prioritise investment in regional health.

As I said, this is a serious issue and one that we have raised on a number of occasions in this place. I am sure the minister will be familiar with some of the issues we have raised. Through the diligence of our members of Parliament in the Legislative Council and this house, every time there is an update of some of those statistics that we have been following, we like to come back and ask the minister to explain what this government is actually doing to address some of the very serious concerns that are raised with us as we travel around the state. I know that every member will agree that health in general is just one of those things on which we should never compromise and that it should always be at the very top of the list for any government. From our perspective, it often feels like there is a different standard when it comes to providing services or infrastructure to our regional communities. It is hard to service those communities. We would be the first to acknowledge that delivering services and infrastructure to regional Western Australia presents some unique challenges—it is an enormous jurisdiction with a significantly spread out population, and we find that each region has its own unique variabilities when we drill down into them. Unfortunately, when we look at the statistics in a very broad way, regional communities are more likely to have chronic disease issues and comorbidity. My own electorate has a very high prevalence of heart disease and obesity, which means that we have significant presentations of diabetes. There are also mental health issues, with significant issues around anxiety and depression. That is a significantly increasing indicator right across regional Western Australia. When we overlay the fact that we have limited access to health specialists, and particularly mental health specialists, across regional Western Australia, it generates great concern for our communities. There is nothing worse than having a family member or friend present with serious issues, whether it involves physical or mental health, and not be able to access the services they deserve. It is a rich seam of discontent in regional Western Australia.

The Nationals WA made a commitment on coming to opposition that we would travel as a team to various parts of the state, taking with us the spokesperson roles we have allocated within our party and making sure that we meet with representatives from stakeholder groups and individuals right across the state. This enables us to all be familiar with the issues in local communities—not just the local member, but also the shadow portfolio holder and the rest of the team. The health issues in Kununurra can be significantly different from some of the issues that the member for Roe, the member for Geraldton, the member for Warren–Blackwood or the member for Moore are dealing with. That is the nature of the health portfolio; it is very challenging. It is always an issue that is raised with us wherever we are.

From our perspective, it was a very concerning start to the McGowan government's term when we saw cut after cut to what we thought was a very significant and important program of investment that had been put in place by the previous Liberal–National government. All of that available funding was cut from significant programs and infrastructure and funnelled into Metronet, which was and remains unfunded to a degree. Metronet was the centrepiece of the McGowan government's election strategy. From our perspective, how does this take priority over the provision of essential services like health care? How can a few kilometres of rail become more important than the provision of appropriate hospital facilities, aged-care facilities and access to GPs and primary and allied health professionals in regional Western Australia? It is the "need to haves" that should be at the top of the list for every government, rather than the "nice to haves". We do not begrudge public transport for our metropolitan cousins. We understand that there is a dollar that needs to be stretched across an entire budget, but we think the fundamentals need to be dealt with before the government starts dealing with some of these big and grand election promises.

We are nearly three years into the McGowan government's term and there are new and emerging health issues. One thing that gets raised with me is the position of the government on the patient assisted travel scheme. I raised a question with the minister earlier this week in question time on whether any work had been done on the recommendations from the 2015 parliamentary inquiry. That was a very solid piece of work by a number of members

of Parliament from both sides of the house during the previous Parliament. A number of recommendations were addressed by the previous Liberal–National government. The remainder of the recommendations that were unaddressed by the previous government were then taken by the National Party to the last state election as election commitments. Our party committed to implementing those recommendations in full. I will talk a little further down the track about some of those issues, such as the patient assisted travel scheme. The answer we got from the minister was less than heartening. I think anybody who was watching closely could have seen the soft shoe—I am going to get caught up again! I messed it up the last time, when I was talking about urgent care clinics! I need to pick a different analogy. There was a nice side step from the minister in his answer to the question on patient assisted travel! I truly hope that means that work is being done behind the scenes and that he will elucidate that to members in his response today.

A number of issues have been raised with us over time around the challenges faced by our health workforce. The number of code black incidents that are being triggered is increasing; it is occurring with frightening regularity. We have additional statistics on those triggers. Up until August this year, instead of going down or being ameliorated by any action that this government might be taking, that number has continued to rise, particularly in hospitals like Geraldton and Kalgoorlie. Up to this point, we have been unable to get an answer from the minister on where his $5 million to prevent violence against our hospital workforce will be spent. That, again, has been neatly sidestepped by the minister. We are obviously interested, from a regional point of view, in where that money will be spent. Given the complexities and number of issues faced by our tertiary hospitals in the metropolitan area, the analogy I used when I last spoke about this was that it is going to be like spreading Vegemite on toast—once we get through the metropolitan issues, there will not be very much left over, and our regional hospitals will not be at the top of the list. I hope in time that I am proven wrong on that, but in the meantime we have another two months of data—which I will go into in a minute—to suggest that those triggers are going up and not down. That is a very concerning trend when we are talking about attracting and retaining a workforce that we rely upon, when we are at our most vulnerable, to look after our communities, our emergency departments and our hospitals. We ask the minister, once again, to make sure he provides information to us on how that money will be spent and what will come beyond the $5 million that has been committed. Everybody talks about this in the context of the need for further work and investment, and this is only the down payment, from the state government's perspective.

I am recapping, because this is the third either matter of public interest or private members' motion through which we have raised this issue. Prior to the last budget being brought down, we asked the minister to ensure funding would be available to rectify the cuts the government made early in its term. The government set a very worrying trend when it came to government. There were a number of programs and infrastructure projects that were very well advanced and that had been committed to. Communities were expecting them to continue, but they were cut, presumably to funnel funding to the Labor Party's election commitments. The government came to office in March 2017 and by March 2018 it had stripped funding from projects that were in the forward estimates and were very well progressed. They included the Paraburdoo Nursing Post; the Turquoise Coast Health Initiative, which I am sure the member for Moore will talk about; the North West Health Initiative, which included funding for Tom Price Hospital and Meekatharra Hospital and the Mt Magnet and Paraburdoo nursing posts; and the Carnarvon aged care facility, which we have finally seen funded, but only after some serious campaigning and an enormous amount of grief for the community, given that it was ready to hit go, but when the government changed, that money was removed. There was also Laverton Hospital and Mount Newman Hospital. These were the projects that were put on ice when the government came to power. Regional people saw indications of the way in which they were going to be dealt with by an incoming Labor government. Funding was also discontinued for the Southern Inland Health Initiative.

I do not say that every project that was started under royalties for regions by the former Liberal–National government should have been continued in perpetuity, but there were certainly some programs, particularly under the Southern Inland Health Initiative, that warranted ongoing funding and support. I commend the minister for continuing to provide for the telehealth stream. I think that has revolutionised health care in regional Western Australia. We can safely say that we are leading Australia in the ways in which we utilise our telehealth services to deliver new services into regional and remote Western Australia. That was made possible by having a bucket of money in royalties for regions to allow the Department of Health to think outside the square. Anyone who has been in government will know that that is a very difficult ask. When we put some of these intractable problems to the public service, we are not normally given the opportunity to say, "If funding wasn't a problem, how would you resolve this? Why don't we step away from business as usual and think about this in a different way?" That is what we did with the Southern Inland Health Initiative, and the result of that groundbreaking investment into a network that stretches right across the state is that the minister and the government are able to extend those services.

One discontinued program within the Southern Inland Health Initiative provided funding for primary health care. From my perspective, primary health care is the bedrock of our health system. Our allied health workers, nurse practitioners, hospital providers and doctors are the ones who keep us well and away from the most expensive part of the health system, which the state government is responsible for. It was very disappointing to see that funding discontinued and not made a priority. From our perspective, some really poor decisions have been made by the government. Some really good traction was being gained in areas in which we had trialled and put into more permanent arrangements some of these allied health workers. It was very disappointing when the communities that had come to rely upon them saw them being pulled away.

We had a nurse practitioner working in the eastern wheatbelt. For a long time nurse practitioners were viewed with great suspicion by GPs; they did not like anybody encroaching on their turf, if you like, and it took some very solid work by the Department of Health and nurse practitioners to work in collaboration with our GPs in the wheatbelt to show that they could actually relieve some of the burdens in single-practice towns that doctors were servicing, under an enormous amount of pressure. Being able to work with nurse practitioners meant that they could better manage their patients' health, and there has been an amazing turnaround in acceptance from both the communities and the doctors working in that space. Unfortunately, there is no ongoing funding for that nurse practitioner role; I think it has now been transferred across to another funding jurisdiction. There was a lot of scrambling about, trying to ensure we did not lose something that was really starting to pay dividends.

When we talk about some of the things that have been cut, the programs we had in our forward estimates, there is normally predictable criticism from the government and members opposite saying, "Why didn't you fund it? Why didn't you get to it?" I remind the minister, members opposite and even some on our own side that when were in government we embarked on what could be considered the biggest investment in health in the state's history. We invested in major tertiary hospitals in the metropolitan area and rebuilt health in regional Western Australia. Yes, there were things that we did not get to in our term of government, but they were planned for and were in our forward estimates and funded. It was extraordinarily disappointing for those communities to see them being pulled out.

I probably speak on behalf of the community of the central wheatbelt, but having travelled the entire state, I have seen some interesting health facilities in the north west, great southern and south west. We dragged them into the twenty-first century. I speak from personal experience, having used those hospitals as a child, and my grandparents in the wheatbelt also having used them. Walking into some of these hospitals now fills one with confidence. It is amazing to have professional-looking and modern emergency departments that do not look like they were built in 1951. Staff morale has improved, and the attitude of being able to attract and retain new staff has improved. While they have gone through that process, they have upgraded all the safety procedures and standardised emergency departments so that if there are visiting nurses and consultants, everything is a standard procedure. It will probably surprise members to learn that every single hospital in the wheatbelt previously had a different procedure and process, which led to poorer patient outcomes if a transient workforce came through. There is a whole raft of things that sit underneath that investment into infrastructure and services as part of our royalties for regions investment that has undoubtedly improved outcomes for health right across the regions. There was more to do, and it is very disappointing that this government did not see that or make it a priority when it came to government.

I am sure the minister in his response will talk about maintenance funding for hospitals. He will be the first to say that our health system is more than just the hospitals, and that really, maintenance funding is something that we would expect a government to do. We welcome expenditure on education and health, and certainly there is funding going into some of my hospitals, but at the same time, the minister should not expect too many gold stars for doing what government is expected to do. I am not being overly critical, because we like the thought that there is money coming into our communities and that that will create opportunities for some of our local tradespeople. I think there has been a slight over-egging of the new jobs that are attached to this. They are not ongoing jobs; there will be a job for the duration of the project, and then presumably the contractor or the tradie who has been awarded the job will go on to another piece of work somewhere else. It will be interesting to interrogate some of those figures to understand better how the government has arrived at them, but that is for another day.

I want to spend a bit of time talking about a couple of issues I have raised before and then I have some new and interesting data that I think the minister should be aware of when he is making decisions about where to spend money. We have talked previously in this place about code blacks, and now we have additional data for the year to August. Alarmingly, the number of code blacks has continued to go up. For members who have not been tuned in, a code black is an emergency that is activated in a hospital in response to a person threatening harm to others or themselves. That can include violent altercations, verbal or physical aggression, threats made to staff, self-harm attempts or threats, and armed intruders; so it is pretty serious. I would not think that staff would trigger a code black if they did not really have a concern about their personal safety or that of patients and people working within the hospital. Certainly, the highest number of incidents recorded was at Kalgoorlie Health Campus, with 156 code blacks. That has actually gone up. We have had another 33 incidents. There were 156 code blacks activated

between 2017 and 2019. Putting that in perspective, minister, the number of code blacks recorded at the same hospital in 2015 and 2016 was two and 15 respectively. We are talking about 156 code blacks compared with two and 15. That is a significant jump. Certainly, the minister could understand why people are interested to know where that $5 million will be spent. The member for Geraldton knows that there has been a significant increase in the number of code blacks at Geraldton Health Campus as well.

From our perspective, we need to know from the minister how the government will allocate that funding and how it will prioritise who gets what. I understand that a forum has been conducted and that the government is working through the detail, but this is about the fifth time we have raised this issue in this place and we still do not have any details. The minister, obviously, at some point, needs to provide some information to not only the Parliament, but also the people working in those hospitals, because I think they want to know that the government is taking their concerns seriously and is not just going out early with a statement saying that it has $5 million of funding.

I have raised previously the midwifery issue, so do not want to spend too much time on it. I am certainly not pretending it is a cut-and-dried issue because the solution always requires more than just the midwife. We have talked about this previously, and I would very much like to know whether the minister has made any progress on the proposal put by the Geraldton Universities Centre. We are seriously concerned about the lack of midwives in our regions. A solution was put forward by the Geraldton Universities Centre to try to grow our own midwives—to try to tap into those people in our communities who would like to make sure that we have this service available. It is a reality that in a lot of our communities people cannot have their baby close to home. Certainly, if people had midwives in their community, it would mean that if they needed to go to Perth, they could go back home much earlier if there was a model there that allowed them to be engaged with a qualified midwife. I gather the pushback has come from the Department of Health basically being bullied by the universities because they do not want to disrupt the current arrangement they have for training. I think Curtin University and the University of Western Australia train midwives—I am not sure whether Edith Cowan University does it as well.

The GUC has put together a remarkable model to provide tertiary education in regional Western Australia. I do not think this government has done enough work to try to put this model in place when there is a good proposal on the table. The window is gone for next year, because to get the program up and running, the GUC needed the enrolments in, lecturers employed and placements in hospitals finalised. It is done for this year and the moment has passed, but I would like very much to know whether this government will make it a priority next year to work with the GUC to make sure that we have a solution for regional midwifery. I have quoted the numbers in this place before and they are on the public record. They are quite frightening. We see long-term vacancies for midwifery positions across the state. Something needs to be done. There needs to be some creative thinking and partnering with at least the one university centre that has put something on the table. I find it unacceptable. It is certainly something that people raise with me on a regular basis. We would very much welcome the minister's comments on that issue.

The last thing I want to talk about is general practitioner shortages. The government quite rightly says that this is not its responsibility; it is a federal government responsibility to provide GPs. However, that overlooks the fact that the majority of our hospitals—maybe not the biggest hospitals in our big regional centres, but certainly the majority of the remainder of them—are staffed by GPs. If a hospital has an emergency department, it relies on its relationship with the GP practising in the town. Without a GP in the town, the ED and the hospital are at risk of not operating effectively. Certainly, from a community perspective, it is totally unacceptable not to have a doctor in the town. The data analysis done by our health spokesperson, Hon Martin Aldridge, is dated 29 August, so it is a bit dated, but I do not think the figures have shifted much.. We have focused on hospital sites particularly in Merredin, Narrogin and Katanning. No doctors were available in those hospitals on 174 occasions. It is scary that over the same period, 415 patients were triaged at the hospitals—this is Merredin, Narrogin and Katanning—and classified on the Australasian triage scale as category 3 or less, which means that they required medical assessment and treatment within 30 minutes. There were no doctors at those sites on a number of occasions. Seven of the patients were classified as ATS 1, which means that they needed immediate treatment, usually resuscitation, and there was no doctor there to assist. How on earth would members feel if their family member presented at hospital in the middle of having a heart attack or a stroke and required resuscitation, and they found that that hospital, which they were told to go to because it was the closest, could not provide support or there was no doctor there to treat them? It is simply unacceptable to me and it is an ongoing issue.

Merredin, Narrogin and Katanning hospitals are considered hub hospitals. They are the base, and smaller hospitals rely on them. Quite often, if there is an issue in Southern Cross or one of the smaller communities, people go to Merredin, Narrogin or Katanning hospital. We are finding that people coming from that part of the world bypass those hospitals and go straight to Northam Health Service or directly through to Midland Public Hospital. This has a direct impact on presentations to tertiary hospitals in the metropolitan area, because people are bypassing our regional hospitals and landing on the doorstep of an overburdened metropolitan area hospital.

Currently, there are 109 GP vacancies in regional WA and the need for a further 31 locum GPs. The government cannot ignore this issue. The Western Australian Local Government Association has conducted its own survey and, in fact, the Nationals have started to survey local governments in regional Western Australia to see what they are doing to fill that gap. Local governments are filling that gap and doing what the state and federal governments should be doing. The challenges we see emerging from these surveys are, predictably, workforce, distance to travel to health professionals, access to health professionals and aged-care services for people to stay within their regions. Leaving aside the workforce, which I think has been well covered, and touching on the distance and access issues, the 21 local governments that responded to the WALGA survey advised that they have no medical centre in their community at all. Of those local governments that had medical centres, 16 had very limited hours, including the Shire of Cue, which has a doctor visit once a fortnight—one doctor, once a fortnight. Forty-two of the shires said that they had a nursing post and many advised that nurses worked part-time, with some areas having only one day of coverage a week. In the Shire of Carew, a doctor visits for 0.5 FTE, or half a day a week. In the Shire of Wandering, in my electorate, which is about 120 kilometres south east of Perth, there is no health service at all. Those are stark figures when we think about some of those complex health issues that I mentioned at the beginning of this presentation. We are more likely to appear in some of those really critical areas around chronic disease.

I want to get this on the record and then I am going to let the remainder of the team speak about some of the issues in their towns. I will also briefly speak about the patient assisted travel scheme. Although we are just starting to get some answers to a survey that we are running with local governments in regional Western Australia, there is already a trend. I think it will surprise many of our metropolitan counterparts that most of my conversations with communities, and local governments—who quite often get criticised for acting in spaces that they are not supposed to—are about trying to provide basic services that are not provided by federal and state governments. It is unacceptable to a community not to have a doctor. If state and federal governments cannot get their act together to provide that service, the local government bears the brunt. The shire president, the councillors and the communities say, "What are you doing to get this solved?" It is not unusual—I have nine examples here—for local governments to spend significant amounts of money and also to provide cars, houses, even the clinic and its support staff, out of a very small rate base.

The majority of towns in my electorate probably fall in the category of having under 700 people. Northam, Merredin, York and maybe Wongan Hills are in the thousands. After that, we are talking hundreds and certainly not multiples of hundreds—closer to 300 for some of them. The rate bases are not big. I will de-identify the responses because the councils did not want their information made public. It starts to give an indication of what councils have to deal with. Council 1 has one GP and spends $200 000 to $300 000—10 per cent of its rate base—plus provides a car and a house to attract a GP to the community. Council 2 has one GP with an FTE of 0.8 and spends $200 000 to $300 000 and provides a car and a house and the costs of the medical centre. Council 3 has one GP and spends $200 000 to $300 000 and provides a house, a medical clinic, an allowance in lieu of a car, and employment of non-medical support staff for that clinic. Council 4 has five GPs and makes no contribution. Council 5 has one GP and spends $50 000 to $100 000; a house and the medical clinic is also paid for. Council 6 has one GP. It pays the salary, car, and professional development and training for the doctor, and it pays for the medical clinic. Council 7 has four GPs at a cost of less than $50 000 and it pays for the medical clinic. At council 8, one GP visits each of its two towns once a week. The doctor is from a neighbouring shire. The council contributes $50 000 to $100 000, and provides a car for the doctor. Council 8 has no GPs, and has not had one for over a year. Council 9 has one drive in, drive out GP and it contributes $100 000 to $200 000 a year, and provides a car and a house for the doctor. I cannot imagine that anyone in the metropolitan area is having that sort of conversation with any one of their local governments. All of those councils have no choice.

When I started as a member of Parliament for the Agricultural Region, I vividly recall going to town hall meetings in my electorate where the entire town would turn up. The councillors, who were at the front, took the brunt of the ire of that community because there was no doctor in town and the hospital was at risk. They were prepared to pay anything to attract and retain a doctor. Shires compete against one another to keep a doctor in town. Doctors are running businesses, but it is a licence to print money in regional Western Australia. All these clinics have more than enough patients. They are overworked. One thing that every doctor would say if they lived in regional WA, particularly the wheatbelt, is they have more than enough clients and not enough staff. They are being underwritten by ratepayers in very small communities. When the government says it is not its responsibility, that it is a federal government responsibility, I agree. We are advocating in the federal space to make sure that the solutions being put forward are sensible. We have raised with federal ministers the changes they have made to visas and how difficult it is to get overseas-trained doctors. Those shortages are in play before we get the number of Australian-trained doctors up. Regional Western Australia will always rely on overseas-trained doctors. Unfortunately, most people go through the university system in Perth and move to the western suburbs. That is just how it is. An overseas-trained doctor was at a training forum that I attended last Friday with Hon Martin Aldridge. A group of councils in the north-eastern wheatbelt brought together representatives from the WA Country Health Service, the Royal Flying

Doctor Service, St John Ambulance, all the shires, Regional Development Australia Wheatbelt, and representatives from the community to talk about how they might solve that problem. The biggest challenge they see is in attracting and retaining doctors, and keeping their communities vibrant. The moment the doctor leaves, people start to get concerned. Elderly people will not stay. They are very concerned about keeping people in their community. The state has a responsibility because it is these doctors, particularly in the wheatbelt, who allow the emergency departments to operate. If there is no sinister motive to eventually close down some of these hospitals, I ask the Minister for Health to ensure the government redoubles its efforts to attract doctors and allied health professionals into our regions.

The last thing I want to touch on is the patient assisted travel scheme. It is a serious concern to us. I received no real answer to my question.

Mr R.H. Cook: That is not true. You said I sidestepped it really well!

Ms M.J. DAVIES: There was not a satisfactory answer to the question. Every regional member in Western Australia deals with PATS issues.

[Interruption.]

Ms M.J. DAVIES: Crickets!

Mr R.S. Love: That is what happens when we ask for things!

Ms M.J. DAVIES: That was the answer—crickets!

Mr D.T. Redman: And that is only a constituent!

Ms M.J. DAVIES: I have lost my train of thought.

A member interjected.

The ACTING SPEAKER: Minister, you cannot speak out of your chair.

Ms M.J. DAVIES: In his answer yesterday, the minister said that the government was moving into an investment cycle and that it was back on track. I remind the minister of his comments in 2017, in answer to a question in the Legislative Council, when he said the government was prepared to revisit increasing the PATS subsidy in the future when there was the financial capacity to do so. The minister told Parliament yesterday that the government is moving into an investment cycle, that the books are back on track —

Mr R.H. Cook: I feel verballed now!

Ms M.J. DAVIES: The minister made that statement. I recall from the minister's time in opposition that he was a particularly passionate advocate for improvements to the patient assisted travel scheme. When the inquiry reported in 2015, the member was very critical when not all recommendations were put into place by the Liberal–National government.

Mr R.H. Cook: I do not think the government responded to it at the time.

Ms M.J. DAVIES: Yes, we did—absolutely we did.

Mr R.H. Cook: I think it came out in late 2015.

Ms M.J. DAVIES: No. The government responded. I have it here and I can provide it.

Mr R.H. Cook: I am happy to stand corrected.

Ms M.J. DAVIES: It would be fair to say that the answer to the funding questions—that they required significant funding—were much in the same vein as the minister's answer in 2017 when he said, "When the financial situation allows us, we will revisit that." The Liberal–National government had quite a good record. In 2009, responding to changes that were recommended from a Senate inquiry when we were shifting from a commonwealth system to a state-based system, we went through all of those recommendations and adopted them. We increased the petrol rate per kilometre. The overnight rate increased from $35 to $60 a night. We removed the patient contribution requirement. We included residents from Northam and York because that was always a bugbear. I think the member for Moore will have something to say about his constituents, because people in those peri-urban areas sometimes find it very challenging to deal with.

The report is gathering dust. I remind the minister that the National Party took all those recommendations to the last election and said it would fully fund them. It needs to be revisited. The amount of travel and accommodation costs simply do not recognise the real cost of having to stay in Perth or a major regional centre if required to travel to access specialist services. This government has had three budgets and none has dealt with the reform of PATS. We are waiting and our constituents are waiting. We are very interested to see whether the passion

the minister had when he was in opposition has carried on. We have not seen very many signs of that to date. From our perspective, we would very much like to have that discussion. We will continue to raise these health issues in Parliament. They are the issues that our constituents talk to us about on a daily basis. Our members are regularly confronted with fairly challenging stories about people who have tried to access health services in their community and have found them to be wanting. The health budget is big. We understand that it is a complex jurisdiction. We believe that priority has been provided to other major election commitments and promises. There are some things that this government has just simply let go and put on the backburner. As a consequence, we are seeing regional communities without some of the things they quite rightly deserve given they generate a significant amount of the wealth of the state and even of the nation. They are very deserving of having access to reasonable and quality healthcare services right across the state whether we live in Kununurra, Albany or in the wheatbelt, which I represent.

MR I.C. BLAYNEY (Geraldton) [4.39 pm]: I will speak generally about a number of issues of health in my electorate. I will start with the patient assisted travel scheme, which is quite an appropriate topic to start with because it is where the former speaker finished. A steady flow of people with PATS issues come into my office, which is probably one of the biggest issues we deal with. Of course, issues differ in every regional electorate. Most problems with PATS can be solved reasonably easily in most situations. Obviously, it is better if people could see their specialist locally but what they really need—this is what has caused problems, so I hope it will improve a bit—is the reliability of the air service. Specialists fly to Geraldton for the day to see maybe 40 people, but if the plane is delayed for four hours, as it is sometimes, the snowball effect is that a heap of people lose their appointment. Some specialists have given up visiting Geraldton due to the frustration of the unreliable air service. My staff who handle most of the PATS issues are able to resolve most of them reasonably easily, although it can be quite difficult at times. I note that the minister is talking. I was going to pay him a compliment, so he should be listening because he probably does not get many compliments.

Mr R.H. Cook: I am all ears.

Mr I.C. BLAYNEY: As I have said publicly in Geraldton, one of my concerns with the change of government was that the service provided by the Minister for Health's office might change a bit. However, it was quite seamless and his staff have been just as helpful and keen to fix problems when we get in contact with them as was the minister's staff of the previous government. That was a huge relief to me because I did not want to go public to get issues solved, but rather just have them fixed. That is the compliment to the minister. As I said, that was a huge relief.

I will talk specifically about PATS. We have had some really weird and wonderful problems with PATS. I have wondered why. I guess it is due to budget austerity, which was probably the case under both governments. However, frequently, the people we send to Perth who use PATS are elderly and unwell. It is probably unreasonable that they cannot get a taxi slip to go to the hospital for their treatment; they are expected to use public transport. Some constituents literally cannot walk to the station or the bus stop to catch the bus or the train to wherever they have to go for treatment. When they get to the other end, for example at Joondalup, and are expected to walk from the Joondalup station to the Joondalup hospital, which I understand is some distance, it is probably quite unreasonable. Apparently, unless the doctor ticks a box to indicate that they need a taxi, they are not entitled to one. Another constituent is down here at the moment because he cannot get a dialysis chair in Geraldton. He therefore has to rent a flat in Perth at his own cost to enable him to have dialysis treatment three times a week. He can get a taxi—I cannot remember whether it is to go to the hospital or return from the hospital—but he is not allowed to use it both ways.

In another case, a constituent had to come to Perth using PATS to get to his treatment and was expected to use public transport to get from the airport to where the treatment was. However, it was not possible in the time frame. The time frame allowed would have just got them to the CBD and I think they had to go to Sir Charles Gairdner Hospital. I use the bus to come in from the airport occasionally, so I know exactly what the times are, and I said to my staff that that would get him to the CBD but not to Sir Charles Gairdner.

The other issue is, I guess, a government problem that will impact on the budget. Since the air service to Geraldton has become a monopoly service, businesspeople who travel there a lot have told me that the average fare they pay has increased by $100. That will obviously have quite an impact on the government's budget. Across regional Western Australia, over which, largely, QantasLink has a monopoly, I think people across the board are complaining about the cost of fares and how much they have increased in the last 12 months.

Another issue has just arisen; namely, before we can deal with anything in the minister's office or in health on behalf of a constituent, they have to sign a confidentiality form. This has become a real nuisance because frequently unwell elderly people have to come into my office to sign the confidentiality form before we can take up the issue with the department. I had to find the constituent who is in Perth having dialysis to get him to sign the form so that it could then be dealt with by the department. We can see the technicalities, if you like, of the PAT system. One of my staff reminded me of a constituent who has had to travel to Perth over nine years for specialist treatment. However, as part of the flight approval process, she was questioned and the doctor had to sign a form every time,

and that caused her quite a bit of stress because she was worried it would not be approved. Once again, she was elderly. Perhaps in those circumstances, the forms could be changed slightly so that once approval has been given for that treatment, the PAT system can accept it and not have the doctor sign it every time.

In the case of another constituent who comes down to Perth for treatment, it was suggested that the treatment could be done by a nurse. It was refused, so the constituent had to get it checked out again. They were seeing a specialist. They had made the mistake of suggesting they needed to see only a nurse, and then it was approved. I understand the issues around PATS because it is expensive; however, it seems to cause confusion and quite a lot of anxiety for quite a few of my constituents. Maybe there is no way to avoid that, but the point that came back a number of times was that the forms are difficult and confusing and they need to be looked at to see whether they can be made simpler.

A related issue that I have brought to the house a number of times concerns the sobering-up centre in Geraldton, which has closed. Another issue that flowed from that was the closure of an institution called Cameliers Guesthouse, the consequences of which have spilled over into hospital emergency and the police. We consider that in many ways the Geraldton Sobering Up Centre was singled out to be closed. It was said that it did not meet its targets so it was closed. However, it seems to us that it was singled out. Of the nine sobering-up centres currently operating in Western Australia, three centres achieved the target for the number of admissions a year in 2017–18, and the other sobering-up centres achieved 95 per cent, 90 per cent, 83 per cent, 57 per cent and 33 per cent. Due to some issues with the service agreement, the Roebourne Sobering Up Shelter did not have to meet any target at all, whereas Geraldton met about 50 per cent. The statistics show that one client had 143 admissions and the top 10 users accounted for 44 per cent of admissions. That may be the case but if those people are not in a sobering-up centre, where will they go?

I will quote Midwest Aboriginal Organisations Alliance chairman, Gordon Gray, who said —

> … the lack of funds would have a huge impact.
>
> "There wouldn't be an Aboriginal family in town that would not have had a family member in that building," …
>
> Mr Gray said for many people, spending a night at the centre was the first step in a process of beating an alcohol or drug addiction.

The then president of the WA Police Union, George Tilbury, said —

> … police would be left "babysitting drunks" in Geraldton if funding was not provided for the Geraldton Sobering Up Centre.

Of course, it was not. The local police union said —

> "It is an impost on the resources of the police when we should be running around looking after criminals,"
> …
> "Intoxication, from the Police Union's perspective, is a health issue and they need professionals to look after them."
> …
> Sergeant Gill said Geraldton police typically found themselves carting an intoxicated person around the streets for hours, several times a week. "Before when we had the sobering up shelter you'd just go straight to it and they would take care of them," …

There is a risk. The irony of all this is that the reason that the sobering-up centres were put there in the first place was the Royal Commission into Aboriginal Deaths in Custody. We seem to have delivered the problem back to the police and history has a horrible habit of repeating itself.

Another article states —

> The WA Police Union says drunken people sometimes sit in the police station all night because the police have nowhere else to take them.
>
> "There's a couple of regulars in town," …
>
> One is always intoxicated and she often attends the police station, sits in the foyer, and she has nowhere else to go.
>
> "She's quite elderly and the sober-up shelter would be ideal for her.
>
> She hasn't got a mental health issue; she's just got alcohol issues.
>
> …
>
> If we are driving people around from address to address to find a suitable relative, it is a risk to the officers that that person has some sort of medical episode.

Unfortunately, the closure of the sobering-up centre has had quite an impact in the community. I have twice presented petitions on it—the first had 453 signatures and the second had 52 signatures—and I presented a grievance in November 2017. It is mentioned that often the same people attended there, so I frequently wonder where they attend now. What has happened to them, apart from sitting in the foyer of the police station? They are probably better sitting there than anywhere else, and certainly safer.

As I said before, the closure of the sobering-up centre flowed on to an organisation in town called Cameliers Guesthouse, which was run by a Christian group called Fusion. The facility was established in 1984 and it was able to accept 32 residents. Generally, it served homeless people, unemployed people and, to a lesser extent, people struggling with alcohol and drug issues. It needed about $200 000 to keep going for another 12 months. Unfortunately, the people whom the police had been delivering to the sobering-up centre started to be taken to Cameliers, and its staff could not cope with them. The sobering-up centre, of course, had trained clinical staff. Cameliers had limited staffing and elderly volunteers. When the government said it could not afford to fund it, it pointed out other institutions, such as Short Term Accommodation For Youth, which is only for young people who cannot fit in at home, and Sun City Christian Centre, which gives families accommodation for three months so that they can get back on track and, hopefully, get into private rentals. They are not an alternative for the service that was provided by the sobering-up centre. When it replied to my letter, the government told me that it was developing a 10-year homelessness strategy. What we had before was managing. It was working. The combination of the sobering-up centre and Cameliers sort of worked and covered different people with different issues. But does this mean we wait for 10 years for the strategy to be approved?

The final issue that I will deal with is probably the one that the minister has been expecting, as we have had many exchanges on this issue; it is, of course, the Geraldton hospital. In 2017, before the election, the Barnett government promised to spend $138.5 million on the hospital to get on with it, basically, straightaway. The government's commitment was a bit over half that, but it is worth pointing out that it addresses the critical issues. However, so far nothing has happened. Geraldton is in a very different situation from almost every other regional city apart from Bunbury. Geraldton has the St John of God private hospital, which must stay in town. There is no point doubling the public hospital and St John closing, because that would put us back where we were before or maybe in a worse situation.

For years, St John of God has not been full, so the government has been able to buy beds off it. It has been a very good arrangement for both parties. The government gets beds at a reasonable cost and St John of God gets more turnover, which is what it needs to keep going. It is a pity that when the new government hospital was built back in 2003 to 2005, the decision was not made to co-locate it as the Court government co-located Bunbury's hospitals. Everyone tells me that that works very well. It was never explained why the decision was made not to co-locate. Every hospital has to have a lot of backup equipment. If one goes down, they have a piece of backup equipment. If we have co-located hospitals with two hospitals side by side, we do not need two pieces of backup equipment; we need only one. With the cost of medical technology and the fact that it has to be replaced regularly, that represents a significant saving. The problem for St John of God is this it has a value on the existing hospital that it sees as a salvage hospital. It has discussed all kinds of things that it could do with the existing hospital when it co-locates. One of the suggestions I have heard—it fits with the problem of the lack of dialysis chairs—is that part of the St John of God hospital could become a specialist dialysis centre for Geraldton and, if necessary, it could be contracted out. I know the government is not keen on contracting out.

[Member's time extended.]

Mr I.C. BLAYNEY: There is a potential there for a win–win situation to utilise St John of God and to get the hospital component of St John of God to co-locate onto the existing site of the hospital.

We are fortunate in Geraldton, unlike a lot of other parts of the regions, in that we are able to get good staff and retain them. We find it easier than a lot of other places find it. I recently spent a day at the WA Centre for Rural Health in Geraldton. It is a University of Western Australia institution. I think it is one of 17 in Australia. It had a twentieth anniversary symposium, and it was interesting to meet people there who are part of similar institutions in, for example, Mt Isa, Alice Springs and Shepparton in Victoria. I spent the first two years I was in Parliament on the Education and Health Standing Committee. For a new member coming to Parliament, since health takes up about 30 per cent of the state budget, it is probably the best committee to serve on if we could choose. I think we were lucky to have Janet Woollard as chair at the time, because for all her faults, she —

Mr R.H. Cook: Member, you should've seen the number of eyebrows that went up around the room.

Mr I.C. BLAYNEY: Janet Woollard knew a lot about the health system and she asked a lot of questions.

Mr R.H. Cook: She was very passionate.

Mr I.C. BLAYNEY: Passion is good. From listening to what people said at the symposium and what I saw when we spent 10 days up in the Kimberley looking at remote health problems, I think in some ways—I said this when I summed up the day—the hospital system we have in Geraldton has more in common with Perth than it does with places such as Balgo or Fitzroy. I think that maybe we need a third health system in Western Australia to address this specific issue of remote areas because I think that the problems and services that they require are so different from, as I said, my community of Geraldton. They probably have very little in common in many ways with Geraldton, but that is by the bye. I decided to shake a few trees and that was one of the issues I raised.

The Leader of the Nationals WA has touched on doctor training, which I do not think we do particularly well either. Whenever we talk about the way the military do something, some people recoil in horror, but a cousin of mine trained as an engineer for the Royal Australian Air Force. He had to attend a university but he had already signed up to the Air Force. The Air Force gave him $25 000 or $30 000 a year to live on and it paid for all his education costs. He then graduated and became part of the Air Force. The agreement was that he had to serve for the equal number of years that he had studied plus one. His degree went over four years so he had to serve in the Air Force for five years. He could buy his way out of the program if he wanted to, but for the full cost. We should indenture in a similar way young people who are prepared to work in remote or regional areas. We are probably going to have to accept slightly lower academic standards, but perhaps we just have to work a bit harder at educating them. I think that many people choose to do medicine purely because it is the hardest course to get into. We should sign up these people who have indicated right from the start that they are prepared to work in the regions. If they are not prepared to work there when they graduate: "That's fine by us. Here's a bill for half a million dollars, because that's what it has cost us to educate you, and we'll take you out of the program." If we want to train Australians to serve in those remote places—I say "serve" because it will probably be eight or 10 years of hardship working in those areas—that is what we should do. This is a serious business; there is no mucking around. I understand that the federal government has made some similar changes but people have only to make-up silly excuses and they get let off. We really have to put a bit of steel into these agreements.

As I mentioned earlier, a constituent of mine is stuck in Perth because he cannot get a seat in the dialysis unit at the local hospital in Geraldton. It is costing him $500 a week in rent. I had to find him the other day to get him to sign the confidentiality form so that the minister's office could look at his case. As I have suggested, a win–win solution may be possible. I understand that dialysis at Geraldton Health Campus has previously been looked at to make it into a service that is—I am wary of using the word "privatised"—contracted out to a private operator and put into the St John of God health system. That may be a more cost-effective way of providing the service rather than increasing the size of the existing service within the Geraldton hospital.

I will endorse what the Leader of the Nationals said about the Geraldton Universities Centre midwifery course. I will stay out of the argument between the doctors, the hospitals, the paediatricians and everyone else. The experience we have had at the Geraldton Universities Centre with training people as nurses and teachers is that they stay in the regions. We train them there and they stay there. In many cases, it is too difficult for them to go to Perth to study, but having courses available through this hybrid model at Geraldton Universities Centre where they study online but have access to tutors has proven to be a very good model. It has been adopted by the federal government as the model throughout regional Australia. I think that another eight centres are being set up at the moment.

When I was learning from Dr Woollard on the Education and Health Standing Committee, people made predictions about a tsunami of diabetes that would hit in about 15 years. We are getting closer to that time now, and the fact that we are out of chairs in the dialysis unit in Geraldton despite increasing them a number of times is the first indication of that.

Recent events in Geraldton have highlighted and brought home to all of us that mental health is an issue that we are not dealing with particularly well. I am not sure of the number of people evacuated from Geraldton at the moment for mental health treatment. I was told some years ago that about 90 people are evacuated from Geraldton every year for treatment in Perth. The trouble is that they come back to Geraldton and they are basically turned loose again. When the government builds a step up, step down mental health facility in Geraldton it will be a very good service for us to have. I will ask questions sometime down the track about the treatment that a particular person had when she was in prison and what services were available for her when she came back to our community. I think that has probably played a part in what tragically happened in Geraldton recently.

Finally, I would like to acknowledge the work of Geraldton Regional Aboriginal Medical Service. It does a very good job. It is a tough job, but its standard is probably as good as any other Aboriginal medical service in the state. Thank you very much.

MR R.S. LOVE (Moore) [5.05 pm]: I, too, would like to rise to make a contribution to this very fine motion moved by the Leader of the Nationals WA. It states —

> That this house condemns the McGowan government's ongoing failure to prioritise investment in regional health.

I will start, as some of my colleagues have, by outlining some of the issues that continue to plague health services in regional areas. The member for Geraldton just spoke a little about the patient assisted travel scheme. According to the brochure that is sent out by the patient assisted travel scheme, it is easy to apply for and involves a simple six-step process. Basically, a patient has to get an application form signed by their general practitioner. They then have to fill out their information on the form and send it off to PATS for approval. The PATS clerk then assesses the application against the policy, which is a quite substantial document of some 40 pages, if I am not mistaken. There are many pitfalls and reasons in that document outlining why a patient might not be able to receive PATS in the end. Once a patient has had their application assessed against the policy, they are offered an approval. They are then given a PATS certification form that they take to their specialist. If it is declined, PATS will inform the patient of the decision and the outcome and they are advised of the appeal process. Usually, the appeal process ends up in a phone call to the members for Central Wheatbelt, Geraldton, North West Central or Moore. I do not know whether they call any Labor members. I dare say that the member for Pilbara and other members would also get such requests. It then becomes quite evident that it is far from an easy process for people to understand and that often when people go to the local person in charge of the PATS process, that person is seen as the gatekeeper of the scarce amount of funds available. They guard that jealously and are very efficient at sending away anyone who does not quite meet by the slenderest of margins one of the criteria, even though those people are genuinely in need and have a situation that needs to be addressed.

I think that the member for Geraldton outlined some cases. I have also had similar cases in which people have come to me. One that is a bit interesting at the moment seeing as we did just hear from him, is the case of a constituent of mine who lives in a coastal community 250 kilometres north of Perth. She applied to have her hip replacement done in Perth because that is where her family who would care for her after the operation live. The surgeon insisted that she had to remain in Perth for up to six weeks after the operation. However, PATS insisted that the surgery should be carried out in Geraldton. Although that is slightly closer to home, there is no-one there to care for here. These are the types of cases that fall through the cracks. To the minister's credit, his office is quite receptive to people who come forward with issues such as that, but many other people may not take the time, or do not realise that they can get in touch with their local member and perhaps get a reversal of a negative decision.

In my own electorate—I think the member for Central Wheatbelt alluded to this, because she also sees this type of scenario—people live on the urban fringe, if you like, on the edge of the metropolitan area. Those people have very little health infrastructure and few health services available to them. They are quite heavy users of transport and accommodation that might be available to them in Perth. Oftentimes, they just fall through the cracks because of the distance criteria. They may not realise that people with cancer may well be eligible for PATS, because they have been knocked back in the past and they do not reapply. They have run up considerable bills before they realise that they would have, after all, been eligible. For many country people, the diagnosis of an illness requires them to travel to Perth. Unlike some other members, there are significant health facilities right throughout my electorate. There are some very fine places such as Moora Hospital, the Morawa Perenjori Health Service and a lot of others that all do a great job. However, a lot of my constituents also live in areas where they have very little infrastructure, so they need to go to Perth more often than perhaps people realise. For many of them, that will mean that they have to have a relative or carer drive them there. Then the relative or carer needs to find somewhere to stay overnight. I know of one constituent who had to drive backwards and forwards with her late husband to Joondalup from one of those towns on the central coast, when he was very ill. She was quite fearful that she would not get to Perth in time, with some of these episodes, to get him to the health centre. On occasions, when she might be waiting at the hospital, virtually overnight, she tried to grab some sleep on a couch or chair in the hospital and was asked to leave, and was sent out into the car park on a freezing night. That sort of thing is the reality for people in our electorates. It must be remembered that, when people are getting treatment, there is all the pre-surgery analysis, and the post-surgery care, and all the expense associated with negotiating their way through the Perth metropolitan area by taxi or, when they are ill, the burden of having to use public transport, which is not often set up in a way that they can easily understand and make use of.

We have just seen the passing, in this house, of the Voluntary Assisted Dying Bill 2019, and one of the matters raised in discussions about that bill was the need for proper palliative care. I know from experience, and I have highlighted this in that discussion and other discussions in this place in recent years, that palliative care is very difficult to access in many parts of my electorate. For instance, farmers who are dying of cancer have to be driven to and from Perth by their families. When they have come back home, and need someone to look after them, they might be trying to access palliative care through one nurse who might be looking after patients from the coast all the way across to eastern parts of the electorate of the member for Central Wheatbelt—one person, and no-one to call after hours. I do not think that approaches any sort of measure of what could be called an appropriate level of

palliative care, but that is the current position. It really needs to be addressed urgently. Recently, the family of an elderly palliative patient in a very distressed state in a regional town, where there is a hospital, checked to see whether he could be admitted. When they took him to the hospital, the hospital would not admit him because there was no doctor on duty. The family was told he would have to be transferred to a larger regional hospital in the central wheatbelt, at Northam, 200 kilometres away. The family refused to make their way down to Northam with the patient, and eventually the local hospital agreed to take the patient in. The confusion about whether the admission procedures were able to cater for this patient was distressing for his family. Those types of issues should not really happen, when we think about the consequences for that family of the refusal—a 200-kilometre trip in the back of an ambulance or in a car to another hospital, leaving behind a perfectly good hospital in their own town.

I want to also briefly touch upon the issue of general practitioner availability. I think the member for Central Wheatbelt had some very good examples of towns that have difficulty getting access to a GP, or if they do, it is only on a very part-time and insufficient basis. Many times, the communities have to put in a large amount of money to attract and hold doctors. If they do not put in a huge amount of money each year, often they may have to provide facilities for the doctor, such as housing or a surgery. I know of one situation where virtually all the costs were picked up for the surgery by the local government, even though the practice does not belong to the local government. That is a huge outlay for a small country local government—sometimes in the hundreds of thousands of dollars. Royalties for regions was used in the Southern Inland Health Initiative scheme to help address some of those issues by providing incentives, in some circumstances, for GPs, but obviously more has to be done to keep attracting GPs into the area. Not only that, we need a workforce that is willing to go out there. It should be the number one priority of anyone trying to design improvements to the health system in Western Australia to reinforce the workforce throughout the regions, including GPs and also allied health professionals.

In some of the towns in my electorate now, there may nominally be doctors, but often they are drive in, drive out doctors. They are available only during business hours, and only on the basis that patients never know whether they are going to see the same doctor twice, because regularly there is a revolving system of locums. Northampton, which has a hospital, faces to the north, and the next major centre is Carnarvon, hundreds of kilometres up the North West Coastal Highway, and the doctor at Northampton is available only a couple of days a week. That community has been in that situation for a number of years, despite the shire offering incentives to improve that situation. Last Monday, I was in Dongara, and a constituent dropped in because he could not get in to see the doctors in Dongara. There is a surgery there, but the doctors are part of a health firm that also has a practice in Geraldton, and the doctors drive up and down from Geraldton. Dongara is a pretty fair little community of 2 000 to 3 000 people. It is well serviced, and has very nice facilities and a lovely coastal location. If towns such as that struggle to get doctors, we can see the issues that might be facing Carnamah or Three Springs, if they lose their doctors and have to replace them. It is very difficult. The onus falls back on the local communities. As a former shire president, I remember a time when the doctors at Jurien Bay left town. Within three days the council chambers were being stormed by ratepayers, GWN was filming people on the main street, and it was clear that something had to happen. The shire locked itself into a long-term and very expensive program of subsidising GP services. I actually had to personally ring the head of a large firm in Sydney to make sure that the negotiations got back on track, and we were able to get somebody to the town very quickly. Even though local government councillors are not supposed to be involved in administration, sometimes we need to take over.

Ms M.J. Davies: Be pragmatic!

Mr R.S. LOVE: Yes—sometimes we have to be pragmatic. When the council chamber is completely taken over by people with a legitimate grievance that they cannot get their illnesses and their scripts reviewed, it is a very dire situation. The situation in my area is now so dire that I have taken to publicising the online service that is provided by Telstra. That service was initially funded by the Western Australian government. It is called CallADoc, and the telephone number is 1800 432 584. That is displayed in my office. I told the guy from Dongara who could not get to see a doctor for love or money that if he needed somebody, he should ring these people, because that was the best I could do for him at the moment. I told him that until there was a change of government, there is not much that we can do. We are pleading with the current government to do something about this situation. It is pretty pathetic that I have to advise people in a town like Dongara that the best way to get hold of a doctor is to ring the Telstra CallADoc service. I have heard that that is a pretty good service. It is doing a good job. I am not knocking it at all. I am recommending it. However, that is not because I want to do that. I would rather there was a doctor in the town. I would rather there was a doctor in Northampton, Gingin and throughout my electorate, and that I did not have to ask people to ring a telephone service.

I have outlined some of the issues. Other members have also outlined some of the issues. The question is: why condemn the state government about these issues? The reason that I am joining in on this discussion is that none of this is new. On 30 November 2017, when I was protesting the dropping of the Turquoise Coast Health Initiative, I brought a grievance to the Minister for Health that outlined many of the deficiencies that I have spoken about

today. I pointed out at that time that a number of discussions had taken place with the former Minister for Health, Dr Hames, and the WA Country Health Service. WACHS had done a lot of planning about building health services throughout that district. I remember a meeting that was held with the CEO of WACHS, at which an undertaking was given that it would do that planning.

[Member's time extended.]

Mr R.S. LOVE: At that time, work was done to put in place a business case to improve the health and aged-care services in the area for my constituents. That discussion was along the lines of the issues that I have outlined for the area between Dongara and Perth. That business case was developed and funded in January 2017. However, the current government made the decision to cut that funding. I remind the minister of his response to my grievance on 30 November 2017. I will quote only bits of this publication, because I do not have time to read the whole thing. I will read some of the more relevant sentences. The Minister for Health said —

> I respect the member for bringing these issues to this place, but one thing we have to do is to actually operate within our means.

That is fair enough. The minister continues —

> Obviously, the government had some priorities upon coming to government. Those were to commit to its election promises in the royalties for regions program … Unfortunately, the government identified that some of these projects had to be set aside until it had a better line of sight of the needs of the state … I do not for one moment say that these services are not needed … I make a commitment, as I did at budget time, that all these royalties for regions health projects are not forgotten. They will be borne in mind and the government will continue to look at them and see how it will be able to fund them in future budgets. I commit to work with the member to make sure that we get a proper analysis of the priorities to fund them in due course.

That was an undertaking.

Mr R.H. Cook: We have not got together, and we should.

Mr R.S. LOVE: Yes. The minister said also —

> I note that the member said that people in that area are struggling to access the patient assisted travel scheme. I am very keen to work with the member to understand the nature of that problem and to get to the bottom of it to see how we can continue to improve PATS to make sure that it serves the needs of people in those communities.
>
> I confirm that these projects, unfortunately, had to be reprioritised, but they are not forgotten. We will revisit them and I will personally visit those facilities early in the new year to get a better personal understanding of these matters.

I know that the minister has visited some of these projects, and I commend him for that. On the back of that grievance, I wrote to the minister and thanked him for the undertakings he had made. I also offered to work with the minister on the patient assisted travel scheme, and welcomed his commitment to revisit the health initiative that had been dropped. However, unfortunately, two years down the track, I have not seen any work to address the issues which I raised in 2017, which I raised with the previous government in 2015, and on which I had a business case developed by WACHS. That was a very good and comprehensive plan. These issues have not gone away.

In March this year, the Nationals raised a matter of public interest about health issues. Remarkably, that MPI covered some of the same ground that we have covered today. That is because these issues have still not been addressed. That is despite the fact that WACHS has a very good line of sight of the issues I have raised and has brought together a package to address them, despite the fact that I have raised these issues a number of times in this house, and despite the fact that the minister has listened and taken those issues on board. The lack of action brings me to the conclusion that this house needs to condemn the McGowan Labor government for its ongoing failure to prioritise investment in regional health care. I urge all members of the house to vote in support of this motion.

MR P.J. RUNDLE (Roe) [5.27 pm]: I rise to make a brief contribution to this motion to condemn the government, and I look forward to a positive response from the minister. I would like to talk about a few issues that are relevant to the electorate of Roe. Those issues are local governments and their commitment to the health system; the patient assisted travel system; St John Ambulance, which is very important; mental health; and rural clinical schools, which are a key part of our health system and potential future system.

The Leader of the Nationals WA talked about the local government contribution to GP recruitment. It is important to understand how much local governments contribute to regional health and to obtaining doctors for their town. That is often quite a burden for smaller local governments and smaller towns. Larger towns often have a greater

number of GPs and do not necessarily need to contribute. The non-monetary incentives that are provided by local governments include the supply of housing, cars, extra holidays and gardeners, and the provision of electricity, telephone and internet services, along with the likes of business premises, and, in some cases, a receptionist or similar person. Quite a large contribution is made by local governments. Some local governments also rely on a drive in, drive out service. For some of them, that is not necessarily satisfactory, but that is all they can get. Obviously in some of those towns we also have smaller hospitals, which to a large extent rely on telehealth. That was one of the great improvements of the previous Liberal–National government and the Southern Inland Health Initiative, which helped with the cost of telehealth and providing that throughout the regional network. Our leader mentioned nursing posts, and they are a very important facility. In my electorate, I think about places such as Tambellup, which was upgraded recently. That upgrade provides a great service to the community of Tambellup, and there is a doctor maybe 50 kilometres away in somewhere like Katanning. The provision of the nursing post cannot be underestimated.

I move on to the patient assisted travel scheme, about which other members have spoken. I will give a couple of examples. First, a highly disabled lady in Esperance needed maxillofacial surgery. She had to travel to Perth. She used PATS for one appointment, but was knocked back for the second appointment because PATS does not cover dental. We had to contact the hospital and get it to look into the case again and recognise that maxillofacial surgery was not dental but was actually surgery. Fortunately, the PATS application was then approved. There was a lack of understanding. As other members have pointed out, the first appointment seems to be okay, but for the second appointment there might be an issue with a regional airline, such as a delay, or something similar, and all of a sudden there is a problem. In another case, a patient in Narrogin needed an echocardiogram and a stress test. Both procedures had to be done in Narrogin with the cardiologist who travelled there once a month. Both tests could not be done on the same day, so the patient had to return to Narrogin for the second test. When she claimed for PATS, she was told that she could claim only the first test; however, the patient had no choice but to travel to Narrogin for the second test. Those are some of the issues my constituents have been up against recently.

I return to the local government scenario. One matter I wanted to bring to the minister's attention was the situation in Kojonup. Last December, I was at the recreation centre. As the Leader of the Nationals WA pointed out, sometimes the local government is the one that takes the brunt. In this case, 250 people at the rec centre were targeting the local government and the shire president and other councillors about why they were not providing a suitable medical centre. I am pleased that the community received a $500 000 donation from George Church, a prominent member of the Kojonup community who passed on. The community is in the throes of setting up an excellent community medical centre. The shire has come on board. Only this morning I spoke to Tim Shackleton from Rural Health West, who went to Kojonup yesterday and spoke to the community and to the group that is organising the medical centre about recruiting people to go into the medical centre once it is built—about how to recruit a practice manager and how to get doctors in there. In that respect, Rural Health West is doing a good job.

Our recent Katanning health forum reiterated to me how important St John Ambulance is and the huge impact the transfers are having on our local volunteer drivers. A large increase has occurred recently in hospital–patient transfers from Katanning to either Narrogin or Albany. As the minister knows, as I have pointed this out many times, on many occasions in the emergency department in Katanning it is a case of which direction do people want to go—is it north to Narrogin or south to Albany? This puts a huge load on the volunteers in St John Ambulance because it is depleting their volunteer pool, and it is having an impact on their hospital crew and transport availability when transfers are being taken away from the local service. Even in a Royal Flying Doctor Service scenario, there still needs to be an ambulance transfer to the local airport. I do not think the minister can underestimate the impact this is having on our volunteer services.

One of the other things I want to talk about is the mental health shortfall. Regional areas have an irregularity of available counsellors and a high turnover of staff. If a patient gets to see one counsellor, quite often on the next visit it is someone different and they have to start over again. Continuity is really important. We cannot underestimate what is happening out in society and the perceived pressures on all parts of our society, and certainly on our younger generation. When we think that things are getting easier in society, they seem to be becoming more difficult due to drugs, social media and other elements. Katanning does not have enough mental health staff. It is difficult to get in to see a general practitioner, let alone a psychologist. Narrogin has only one private psychologist and a visiting psych from Northam. Any patient admitted to hospital after hours must be assessed remotely from Northam. Staff shortages for mental health are critical and the recruitment processes take too long. Esperance has been without a consistent private psych service for quite a while now.

I rang one of my constituents last night who lives in a small rural town not far from Kojonup. Unfortunately, a young 20-year-old farm girl took her own life on the weekend. That gentleman is the local store owner and the locals are basically going in to talk to him, almost as their counsellor. He has been doing his best. It is a really

difficult situation for that small community. There are some fantastic families there. I recommended to him a couple of counsellors I knew with Anglicare and the like. Having those services close and handy is really important.

As the Minister for Health knows, my favourite subject is the Katanning update. A few new GPs are trickling into Katanning. None of them is permanent, but it is a short-term fix. Julie Armstrong from the minister's office has recently updated that after the Rural Health West meeting on 24 May, Rural Health West recruited a new doctor who did a block of work at Katanning. Another was recruited by WA Country Health Service, great southern, for some casual locum coverage. The WA Country Health Service is working closely with Rural Health West on this issue. Obviously a call has gone out to the Albany GP practices with capacity to assist, and currently four Albany doctors are undertaking further training to meet credentialing requirements at Katanning. We are certainly hoping to see improvements there. However drive in, drive out GPs are still covering shortfalls in the emergency department roster at Katanning Hospital and St John Ambulance volunteers are still under pressure. I can update the house that submissions for the new Katanning medical centre closed on 31 July 2019 and we are looking forward to hearing from the Shire of Katanning shortly on how that has all gone. However, I am disappointed that the Well-women's Clinic has not been reinstated, which serviced Lake Grace, Gnowangerup and surrounding towns. It was always fully booked and was being run by a female GP who was doing a great job. She was getting support from the WA Country Health Service in the provision of rooms et cetera, but the rug seems to have been pulled out from under that service. I would love to see it reinstated because it was such an important service for breast cancer sufferers and females in outlying towns.

I also want to talk about the ongoing maternity issues in Katanning. Geraldine Ennis from the WA Country Health Service said in May 2019 that there was no reason that low-risk births could not continue to happen at the Katanning Hospital, but there has been no progress, minister. I remember in late 2016, in the lead-up to the election, the appearance in Katanning of—I will not say the Messiah—the member for Kwinana. The member for Dawesville was there and we all heard the member for Kwinana say that he would fix maternity and other services in Katanning if he became minister.

Mr R.H. Cook: That's right.

Mr P.J. RUNDLE: I am looking forward to it. I have been here for three years and I am still waiting. He is now Minister for Health and the community of Katanning is still wondering where he is. He has not turned up, but we look forward to him showing up and fixing those maternity issues at the hospital. It is probably the biggest issue I have witnessed in health in the whole of the great southern. The community is dismayed about the lack of maternity services at that hospital. Three years have now passed and I look forward to the minister's solutions in this area.

Recently it was confirmed that the great southern is short by 15 GPs, including five in Katanning and one in Kojonup. The Nationals WA have had to pick up the baton and have written to the federal health minister to ask him to come across to WA. We look forward to running a health forum in regional WA with him—the state Minister for Health will also be invited.

Mr R.H. Cook: November—he will be in town in November.

Mr P.J. RUNDLE: Okay; the federal minister and the state minister can look forward to some communication from us.

There are certainly issues in this area, which I will talk about very briefly. There are issues with recruitment. The member for Geraldton said that we need to focus on training regional doctors, and that is why the Rural Clinical School of WA is a fantastic asset for regional WA. It is a great facility with about a dozen clinics around the state. Recently, I spoke to Rhonda Worthington, the senior team leader of the Rural Clinical School of WA in Kalgoorlie. She told me that Bridgetown and Manjimup will be added to the list next year. I am sure the member for Warren–Blackwood will be interested to know that another rural clinical school will hopefully be based in the Bridgetown–Manjimup area next year. During the year, the member for Central Wheatbelt, Hon Jacqui Boydell and I visited the Kalgoorlie Rural Clinical School.

[Member's time extended.]

Mr P.J. RUNDLE: That was a highlight of my year. We met 10 fantastic, young, positive people who are doing their training out there in Kalgoorlie—everything under the sun—and we need to keep them there. An issue we need to bring up with the federal health minister when he comes across in November is that some young students who have come into the system, sometimes with slightly lower marks, have been bonded to the system—not all students at the Rural Clinical School are bonded—but are getting out of the system. They buy their way out with the excuse that they need to get back to the metropolitan area because their mum is not very well or whatever the case may be. They are able to present an excuse and buy their way out of the system. This needs to be addressed, and I believe that the federal government will be clamping down on this. Many times I have pointed out that the

ratio of doctors in places like the member for Cottesloe's electorate is substantially higher than in regional WA, and that in Dunsborough, on the coast, there are 17 doctors, yet we struggle to get doctors into the regions. That is a weakness of the system. Rural clinical schools are fantastic, but we must make sure that students who are bonded spend four years in the regions and fulfil their bond obligation.

Finally, I mention code blacks, which have been a concern in regional hospitals. Kalgoorlie Health Campus has had 49, Geraldton Health Campus has had 38, Hedland Health Campus has had 17, and Bunbury Hospital at South West Health Campus has had 11. Obviously, there is a smaller number of presentations in smaller hospitals, but it is a real challenge for doctors at the coalface. The students at the Rural Clinical School in Kalgoorlie certainly see plenty of things that they should not have to.

In conclusion, on a positive note I look forward to joining the Minister for Health at the opening of the Narrogin Hospital in early October. That hospital, funded by royalties for regions, has been a work in progress for a good few years now. I look forward to joining the minister at its opening. I appreciate the updates I have received from the minister's staff, especially Julie Armstrong who does her best to keep us up to speed. I look forward to working with the minister and the federal health minister on rural clinical schools. I work with the likes of Tim Shackleton and Kelly Porter. They are important links in Rural Health West for rural GP recruitment and I cannot underestimate the value they add to the system. I also look forward to the full implementation of the sustainable health review, which will take advantage of telehealth et cetera. I think that it will help to improve parts of the regional health system.

MR Z.R.F. KIRKUP (Dawesville) [5.48 pm]: I, too, join with the Leader of the Nationals WA in condemning the McGowan Labor government's ongoing failure to prioritise investment in rural health. This is a very good motion and is reflective of a theme in this house over a number of weeks in which matters of public interest and private members' business motions have condemned the Minister for Health and his custody of the health portfolio. It has been very warranted. We have seen a number of failings in regional health by this government and the Minister for Health. I will talk at length in my 20-minute contribution about some of the concerns the opposition has about the minister's handling of regional health. In particular, I will discuss concerns about dialysis; expand upon some issues I raised during question time about regional health, sexually transmitted diseases, bloodborne viruses, elective surgery waitlists that continue to increase at a shocking rate in regional Western Australia, and maintenance funding gaps; and I will finish on the electoral impact this will all have if the minister and government continue to ignore rural Western Australia.

National Party members talked about a number of concerns that are raised across our community on a regular basis about how this government is continuing to treat the health system. The health system is in a parlous state. Obviously, doctors and nurses do a fantastic job, but in reality this government is not putting nearly as much investment into hospitals as is needed. Critical indicators across the board continue to deteriorate, which reflects a lack of leadership from this government in taking charge of our state's health system and investing where it should.

Picking up on the member for Roe's point, to give the government some credibility, I would like to talk about dialysis for a moment. Dialysis is an area of interest of mine, particularly in a regional and remote setting. It is one of the measures that needs to be put in place. Renal dialysis clinics need to be well funded, because those clinics prevent a deterioration in the condition particularly of Aboriginal people. There is a disproportionate level of demand for those services from the Aboriginal community, particularly in regional and remote Western Australia. The government has committed funding in the north of Western Australia. More recently, I saw the Kalgoorlie renal dialysis clinic. Undoubtedly, the minister has been out there, too. It is an amazing facility. It is very culturally appropriate. Walking through the clinic, it is a calming place. It was deliberately designed with local Aboriginal people in mind. There is a lot of local Aboriginal art. The lights are dimmed and things like that so that it is not particularly invasive. It is a very impressive facility. If only there were more of them. Unfortunately, the waitlists for dialysis treatment in places like Kununurra, Derby and Broome have blown out year on year.

Ms M.J. Davies: Is that the one with the pictures on the roof?

Mr Z.R.F. KIRKUP: Yes. The Leader of the Nationals WA has just highlighted some of the design features there. She is right—art is on the floor, walls and the ceiling so that people feel much more comfortable in an environment in which they are surrounded by art that they are familiar with. It helps calm them during what is a very invasive procedure. People have to be there for long lengths of time.

Mr R.H. Cook: Since they have introduced all that Aboriginal art at Kalgoorlie hospital, their DAMA rates—discharge against medical advice—have gone through the floor. I think they have gone down by about one-third. The feedback is that Aboriginal patients just feel so much more welcome there because of the iconography that is everywhere.

Mr Z.R.F. KIRKUP: I think it is a good reflection of a government facility that is clearly designed for the people who need it. A deliberate investment in this cultural design outcome has had a very real clinical outcome. If only there were other facilities around the state that could have such significant attention paid to their design.

It is worth pointing out that the waitlists for dialysis in Kununurra, Derby and Broome continue to be an issue. Leader of the Nationals WA, I think there are also concerns about the waitlist for dialysis treatment in the wheatbelt. I hope the government continues to invest in this. Attention needs to be paid to bringing about important investment in an active program to try to target people who need those dialysis chairs and to get them into the hospital. The discharge against medical advice rates that the minister spoke about have a very real impact. If people do not attend appointments on a regular basis, their life expectancy becomes very much under threat. It speaks to the growing gap in Western Australia, the worst state in the Federation. I believe proper investment is needed, particularly in Kununurra, Broome and Derby. That attention is paying off in Kalgoorlie. Under this government, the waitlist for dialysis in Kalgoorlie has gone down from about 500 days to days in the double digits. It has been a great result. It was reflected when I was in Kalgoorlie a number of months ago. The teams there do an amazing job and should be applauded for that.

On the topic of Aboriginal health, I raised in question time some issues that had been flagged as part of the quarterly update by the Department of Health in a report titled "Notifiable Sexually Transmissible Infections and Blood-borne Viruses in Western Australia" for the period ending 30 June 2019. I picked this issue up today. It may have been released more recently. It certainly has not been tabled in this place. It points to some disturbing trends in the rates of chlamydia, gonorrhoea and hepatitis C for the Aboriginal population. There has been a particular increase in the rates of STIs and bloodborne viruses in the regions. Unfortunately, this report highlights that, generally speaking, Aboriginal people, specifically those in regional Western Australia, are worse off. Over the past year, there has been significant growth in some of the figures that I will go through. They reflect well above the five-year mean. In Western Australia, there have been deteriorations in a number of areas.

I will go through that report to talk through some of my concerns. Of course this motion speaks about regional health, and in my case I think it is also important to highlight the Aboriginal population in the regional and remote parts of Western Australia. One of the issues highlighted in the report is the rate of chlamydia. In the 12-month reporting period to 30 June this year, there has been an increase in the rate of chlamydia amongst Aboriginal people, yet there has been a decrease in the rate of chlamydia amongst non-Aboriginal people. In the regions, there has been an increase in the rate of chlamydia notifications in the goldfields, the great southern, the Pilbara and the south west, yet there are relatively stable figures in the metropolitan area. There are reductions in some areas. In areas such as the Kimberley, the great southern, the goldfields and the Pilbara there are very real increases in the rate per 100 000 people who have been impacted by chlamydia. There have been increases in the rate of gonorrhoea infections in the goldfields and the Pilbara. The Pilbara continues to have issues. Undoubtedly, the member for Pilbara is interested in this. The Pilbara has continually seen deteriorations when it comes to sexually transmitted infections and bloodborne viruses. There is very little light in the Pilbara at the moment. Of course, it is happening in a range of different regions, and unfortunately to Aboriginal people.

The rate of syphilis infections is something that is obviously quite concerning to me because, as I have recently been made aware, it can cause significant mental health deterioration as well as shortening life expectancy, or it has an impact on that in some way, shape or form. The report points out that in the first quarter of 2019, an Aboriginal child in the Pilbara region—once again—was born with syphilis. That is an awful circumstance. It is very concerning to me. When I look at the crude rate of infectious syphilis notifications for Aboriginal people in Western Australia, the number has significantly increased. It has gone from a rate of 61.8 people per 100 000 up to 191.6 people per 100 000. The rate for non-Aboriginal people has increased only marginally. There has been an almost threefold increase amongst Aboriginal people when it comes to the rate of infectious syphilis and a 15 per cent increase in non-Aboriginal people. That is very, very concerning to me. Looking at the regional breakdown for that, there are increases in the goldfields, the Kimberley, the metropolitan region, the midwest, the Pilbara, the south west and the wheatbelt. The only area that has a stable figure is the great southern. Almost across the board, the Kimberley and the Pilbara regions are disproportionately represented. Infectious syphilis is occurring at an alarming rate in the regions, and at a very distressing rate when it comes to Aboriginal people. The rate of infectious syphilis has been continuing to rise for some time.

In responding to a question from me during question time, the minister said that this is part of the trend in northern Australia. The concern that I raised during question time is that as this has been known for some time, given since 2014 the rates of infectious syphilis have continued to grow, this is not a new issue. Indeed, between 2014 and 2019 something like 236 cases of infectious syphilis were reported. In the two years prior to that, there were no cases. This has been a growing trend, particularly in the Kimberley region. If the government knows about this, we would expect it to invest in Aboriginal health services to respond to this issue in particular. However, we have found that that has not occurred. Since this government has come to office, there has been no increase in funding

for sexually transmitted infection screening for Aboriginal people. I would have thought it was very important for the diagnosis and treatment of these concerning diseases that are impacting the Aboriginal population in Western Australia. There is no increase in funding there.

As I mentioned during question time, the, I think $737 000 that has been spent on the climate change inquiry—I appreciate what that might mean—is far more than the total spend by the Department of Health on Aboriginal adult regional health services, and sexual health in particular. I believe there is a lack of prioritisation by this government. If the argument put by the minister during his answer to my question today that, "This is something that has occurred for some time, we have known about this in northern Australia and this is simply the way it is", I would expect the government to respond accordingly and increase funding for STI testing, for example. That has not happened and I think it is to the detriment of this government that it has not been more aware of the health issues and priorities in regional Western Australia. More than that, I do not believe enough effort has been paid to investing in Aboriginal regional health services, particularly in sexual health. It is concerning to me that the primary response of the government is to invest in our state's health system but it spends more on an inquiry being conducted out of "Silver City" or somewhere like that, and less money on sexual health services for Aboriginal people in the regions when there is a clear concern about the rates of Aboriginal sexual health there, which have increased at a phenomenal rate and continue to do so.

We saw this when we raised the issue of the flu, for example, and again those rates have disproportionately affected the regions. Once again, the government has said that that is the way it is. We cannot accept business as usually from this government, especially on regional health and the health concerns of Aboriginal people in Western Australia, especially on something like sexual health. Far more education, far more prevention and far more response programs should be occurring in those circumstances, but they simply are not there.

The rate of hepatitis B has increased in the goldfields, the great southern and the Pilbara—once again, the member for Pilbara's district, the area he represents. I hope to hear more from him about the concerns of his constituency because the issues in his district continue to occur, unfortunately. Whereas the rate of hep B in the metropolitan region has declined. Again, the notifiable rate of hep C has increased among Aboriginal people in the regions: the goldfields; great southern; midwest; Pilbara—member for Pilbara—and the south west. Indeed, I think, among non-Aboriginal people, the rate of hepatitis C has gone down. We would expect that a government that had its priorities in order would invest in Aboriginal health in the regions in response to something like this, particularly sexual health. It is a matter of great concern to me and, undoubtedly, for all in this place and we would expect the government to do more about it. It is not only the right thing to do; it is responding to a critical trend that has occurred over a number of years, yet the government simply has not increased the investment in those services as it should have. I look forward to the minister's strident defence of the indefensible because he should have put more money into it. Far more should be spent in that area.

In the six minutes I have remaining, I will talk very briefly about the elective surgery waitlists, which are very interesting to look at year on year. The August 2018 waitlist for elective surgery compared with that in August 2019—the same time split of 12 months—at those hospitals has increased in nearly every area, in some circumstances by a significant amount. Undoubtedly, that will be of interest to the member for Roe, who I hope has Katanning in his electorate—I believe he does. The waitlist for elective surgery at the Katanning Hospital has seen a 50 per cent increase. The waitlist for elective surgery cases at Albany hospital has increased by 22 per cent. As the member for Kalgoorlie has raised with me a number of times, the waitlist at Kalgoorlie hospital has blown out by 25 per cent. The waitlist at Carnarvon hospital, member for North West Central, increased by 62.5 per cent, which is unacceptable. The waitlist at Karratha hospital, my friend the member for Pilbara—I am looking through electoral districts in my mind; it might be the member for Pilbara—has seen a 96 per cent increase. That is unacceptable. There has been a 25 per cent increase at Warren Hospital in Manjimup, member for Warren–Blackwood. Manjimup is a great area, which produces some great people. We would think it would have a great hospital invested in appropriately to fund elective surgery waitlists. The people there are undoubtedly doing a great job, but, unfortunately, right across regional Western Australia we see a significant increase in the elective surgery waitlist, which is unacceptable in some of those communities. The increases in elective surgery waitlist times are right across the board, not just at those hospitals but also at Broome hospital, Geraldton hospital, Hedland Health Campus, Busselton hospital, Derby Hospital, Kununurra Hospital, Narrogin Hospital and Northam hospital. It is completely unacceptable that communities in regional Western Australia continue to see the time in which those important health services provide treatment drift further and further away. It is not good that this government continues to beat its chest and say how great things are going and how much money is being put into things like the maintenance program while there is very real deterioration in the level of service provided in those communities.

In the remaining three minutes I have, I would like to talk about the minister's recently announced, much lauded, maintenance investment of $81 million. However, it did not get a whole lot of media coverage because there will not be a lot of media coverage for the government just doing what should be its job. I am sure we all welcome

money for our local hospitals. Certainly, there was not as much for Peel Health Campus as there should be. Unusually, a lot more goes to the marginal district of Murray–Wellington than to the Peel Health Campus, but we will get through that. It is interesting to me when we look at the breakdown of funding in particular for the maintenance program announced by this government, goldfields–Pilbara got, I think, $ 1.54 million. That was how it came out, and that is great, but when we broke that down, we found that the goldfields got only $30 000 and the Pilbara—who would have thought, member for Pilbara, billion dollar man, the marginal seat up there—got $ 1.51 million for that area. The *Kalgoorlie Miner*—I am making sure I know my regional papers—has been running red hot on this issue, and rightly so because that community has been dudded by this government. It seems to me that not only does this government want to be lauded for simply doing its job after it has significantly cut its maintenance program —

Mr R.H. Cook: That isn't true.

Mr Z.R.F. KIRKUP: It absolutely is true. The government cut it and restored a smaller amount.

Mr R.H. Cook: You're misleading Parliament.

Mr Z.R.F. KIRKUP: I absolutely am not misleading Parliament.

Mr R.H. Cook: You absolutely are.

Mr Z.R.F. KIRKUP: I look forward to the minister disabusing me of that notion with his own spin; however he wants to do that. The reality is out there, minister. He might say that is not the case, but I can promise him that in regional Western Australia, when I visit Kalgoorlie with the member for Kalgoorlie and hear the contributions from our good friends in the National Party representing regional Western Australia together with a number of Liberal regional members here, the communities of Western Australia and regional WA, in particular, are very concerned about the lack of attention paid by this government to its health system. We see the blowout in people needing dialysis, in hospital elective surgery waitlists and in notifiable diseases such as STIs and bloodborne viruses when the government should be paying far more attention to those areas and far less attention to things like auditing food vending machines, which I know the minister loves to do. It is about time he steps up to the plate, does his job and invests in those communities. Otherwise, he will find that these motions that have been moved over a number of weeks or so will continue to be moved condemning this government for its lack of investment in health and ignoring regional Western Australia—at its peril.

MR V.A. CATANIA (North West Central) [6.08 pm]: What really hurts is when the Premier makes his visit to the north west once every 12 months, goes into Carnarvon, meets with the locals and says, "We're building an aged-care facility. We have $16.8 million of which $6.8 million is for palliative care. In 2017, the former government had $16.9 million in the budget to build a 38-bed aged-care facility. However, as everyone knows, we lost government, which is why we are on this side of the house, but it will not be too long before we are on the other side of the house. The amount of $6.9 million was taken out of the budget because the government thought it could reduce the 38-bed facility to a 21-bed high-end aged-care facility. However, the government realised that that could not be done because $1.7 million had already been spent on the aged-care facility to the point of choosing where power points would go, the colour of the carpet and the curtains. It had gone out for community consultation, but it has been delayed for two years. This government announced the facility in this year's budget, rebadged as palliative care, and went to Carnarvon last week or the week before and said, "Wow! Aren't we good?" Do members know what? That really hurts us all as politicians, because the community knows exactly who took that money out—the mean Labor government. I know that the Minister for Health has done all he can to put that money back in, after he realised that the facility had not only 38 beds, but also a cyclone shelter. He could not change the detailed plans or the engineering drawings, because it had already been factored in because Carnarvon, believe it or not, in 2014 had a cyclone go through. We need cyclone shelters and the hospital is the right place to have a shelter. Like I said, what hurts us as politicians is when people such as the Premier try to rebadge the money that he took out and say that it is new money. Everyone in the community goes, "Bloody hell! Here's another politician lying through his teeth, because we all know that that money was taken out." I am glad it has been resolved and I am waiting for that contract to go out to tender. Unfortunately, a lot of seniors who have not got much time also have been waiting and, unfortunately, some have passed away since the announcement was made. It is very upsetting that those people did not get to see the works at least start. If it had have been built in the time frame that we had for the high-end aged care, they would have been in that facility. Unfortunately, they have missed out, families are upset and people are questioning whether this project will still go ahead. I have the confidence from the Minister for Health that he will deliver this project that the Liberal and National Parties had ready to go back in 2017 and, hopefully, we can see a brick put on the slab in January or February next year.

Mr P.J. Rundle: He has one more budget.

Mr V.A. CATANIA: He has one more budget, but I am confident that he will not want to take out that money. The North West Central electorate has been stripped of the most funds for hospitals by this mean-spirited Labor

government. We can talk about Karratha Health Campus and how fantastic it is. When the Premier opened it, he spouted how wonderful the new hospital is, but we all know and the people of Karratha know that the former Leader of the National Party, Hon Brendon Grylls, built this $207 million hospital. It started on the day that I left the Labor Party back in 2009, I think it was—10 years ago.

Mr R.H. Cook: Happy days.

Mr V.A. CATANIA: It feels like yesterday because it is groundhog day, going back to the way the Labor Party operates in health. We were able to get that money—originally, it was $150 million of royalties for regions funding—put into the hospital. The vision of making Karratha into a city, which it has become today, allowed the then member for Pilbara to relocate the hospital to the right spot in the centre of town. The Premier yet again spouted how wonderful the Pilbara is and he wants to bring the Council of Australian Governments meeting to Karratha to look at it. He is trying to showcase how wonderful the City of Karratha is because of the former Liberal–National government's investment. It means that it can cater for the growth and the booms that it is about to have yet again. Having a state-of-the-art hospital means that it can cater for the growth of the former Liberal–National government's Pilbara Cities vision that it delivered on. When we go to the areas that are still the wealth-generating areas of this state —

The DEPUTY SPEAKER: Excuse me, members. Minister for Commerce, can you speak a bit less loudly for Hansard? Thank you.

Mr V.A. CATANIA: I know some ministers do not like the truth. The engine room of the Western Australian and national economy is Tom Price and Paraburdoo. Money was allocated prior to 2007 to build a new hospital in Tom Price because that is where the engine room is. The government has taken the $50 million that was notionally in the budget for Tom Price Hospital and put it into 20 kilometres of the Karratha–Tom Price road. Yet again, the federal government has put $230 million into the road and the state government says, "How wonderful are we? We have $310 million to seal the Karratha–Tom Price road", but in reality it is the federal government. Thank you to the federal government and the federal Liberal Party for that money. The Premier is going, "How good am I? I've delivered." People get so upset with politicians who really can talk through their teeth. They talk about fake news—that is fake news. The reality is that the coalition federal government will deliver it, yet the Premier is trying to take the credit.

Earthquakes have been occurring in recent times and there are cracks at Tom Price Hospital. Someone could probably go to the toilet and not have to use the toilet because the gaps are so wide that they could make it go straight outside! That demonstrates the level of disrepair of Tom Price Hospital. It is not fit for purpose. It puts stress and strain on the staff there because the staff are at one end and the patients are at the other. They cannot monitor the patients and run the hospital at the same time. Until recently, the emergency room was open to the wards, so people could walk in as they pleased. I note that the Premier visited Tom Price Hospital, although he did not visit Tom Price Primary School that had a fire and major damage. He was in Tom Price and did not bother to look. He said that he had better things to do; that was to get a silver shovel, stick it in the ground, flick some sand and leave. He can tick that box. "I've been to regional WA. I've bought some Rossis, so I feel like I'm a country person." We can see how the Premier is reacting when he goes to regional Western Australia.

Paraburdoo is another powerhouse of the Pilbara, yet we have an ageing facility there that is downgraded; basically it is a hospital, but it is a nursing post. The most needy hospital out of all this, apart from Tom Price and Paraburdoo, is Meekatharra Hospital. I have brought it up in this place before. Meekatharra is absolutely disgraceful. There is some money in the budget for maintenance at Meekatharra Hospital. Anyone who knows Meekatharra Hospital, will know that we cannot maintain it. We cannot fix rotten wood. There is only so much paint we can use. I think that if we put too much paint on it, it will fall down because it would be too heavy. If someone is in a wheelchair at one end, they do not need someone to push them down to the other. I know the hospital has had some maintenance done to it to make it workable. Meekatharra has been a powerhouse for our economy over many years, through the gold rushes and so forth, so I think it deserves to have a hospital that caters for the needs of the state. It services not only Meekatharra but also Cue, Mt Magnet and the surrounding towns, and sometimes even Wiluna.

Meekatharra Hospital has ageing infrastructure. An amount of $5.6 million or thereabouts was allocated to the Mt Magnet nursing post. That was also taken out of the budget. I have said it in this place before. The building is a little bit better than Meekatharra Hospital, but they were built within 10 years of each other in the 1950s. In this day and age, to have modern equipment going to a hospital built in the 1950s is difficult, even if someone is a smart engineer with the best equipment. The equipment can still suffer in a building such as that.

I want to look at not only the infrastructure that is needed, but also the staffing levels. We see that there are still single nursing posts. At Coral Bay, the nurse has to live in a caravan because there is no accommodation. Do members know that? A nurse or any other government department employee who comes to Coral Bay has to live in a caravan in an area called "Little Kenya". How does anyone function when they are living in a caravan? It may

be all right for that nurse to live there, but in this day and age we should be able to provide decent accommodation in a place like Coral Bay. The single nursing posts in Cue, Mt Magnet and Yalgoo, and the Sandstone Health Centre that receives a weekly visitation, all really need a minimum of two nurses working there. We cannot expect one nurse to be able to work 24/7 and to service a town. Obviously, the Great Northern Highway is a busy highway where quite a few incidents occur. Those nurses are called out and have to deal with quite traumatic incidents, which puts pressure on the volunteers. The volunteers of the Murchison, and pretty much all round regional Western Australia, are moving patients from Cue, for example, and can lose half a day or a day taking a patient to Meekatharra. If Meekatharra Hospital is unable to take the patient, they get flown out by the Royal Flying Doctor Service. We are burning out volunteers when it comes to the St John Ambulance service. We are using RFDS to fly people to Perth because some of these basic services are not being provided in places such as Meekatharra. In the minds of many people, the RFDS is used for emergencies. It is there to help the community, but it is becoming a taxi service to move patients from regional Western Australia to bigger cities like Geraldton and Perth.

We have infrastructure and staff issues when it comes to nursing, and in the bigger hospitals such as the Carnarvon Multi Purpose Service there is no respite for people who care for the elderly or those with dementia. Often a person with dementia will stay in the Carnarvon hospital throughout the week, but when the weekend arrives their relatives are told, "Sorry, there is no-one at the hospital to look after them", and they get asked to pick up their mother, father, aunty or uncle. What a sad set of circumstances we find ourselves in when we cannot provide some of the basic services that people in Perth have. There would be an outcry if those services were not provided in Perth—basic stuff! The government should show some humanity and provide these basic services.

I now turn to the tourist destination of Denham. Hundreds of thousands of people visit that place each year. Anywhere between 5 000 and 8 000 people can be found in Denham on any one day during the height of the tourist season, yet it still does not have a permanent doctor. This town has 900 permanent residents but that can increase to about 8 000, yet it still has no permanent doctor. Yes, a nurse practitioner is there, but more nurses need to be based there during the tourist season, coupled up with a permanent doctor to provide continuity in the service, especially for the seniors who live there. They need to see the same doctor. Often the pharmacist becomes the de facto doctor because they look at everyone's prescriptions to make sure that a new prescription does not affect previous prescriptions. The doctors often change from week to week and the patient does not necessarily remember what a previous doctor has prescribed. In places such as Denham it is a recipe for disaster.

When a person requires treatment, they can use the patient assisted travel scheme. In our office we deal with a huge number of PATS issues throughout the week. Often people come to us because they cannot get paid and it seems like the foot has been put on the hose in terms of the providing the financial support for someone to fly to Perth and receive the medical treatment that they need. In one instance in Exmouth, a woman broke her arm and had to be flown on a commercial flight to Perth. Her husband was the carer, but he was told that he could not have PATS. I will write to the minister about this one, because a person who is unable to use their arm, is unable to carry bags and unable to go to the toilet, needs assistance. On this occasion, he was rejected for PATS. Unfortunately, that is quite common. People living in Meekatharra or Mt Magnet who want to go and see specialists are told they have to get in a car and drive 400 or 500 kilometres to Geraldton, when it is easier to jump on a plane and fly down to Perth to see a specialist, so they are not driving all that way. Often, a lot of people cannot drive, or they are elderly. Driving those roads is dangerous. It is long and hard, especially when a person is ill and is told that they have to go to Geraldton. I understand that the policy of PATS is to push people towards their nearest regional centre—such as people in Carnarvon going to Geraldton—but often it is not practical for people to jump in the car and drive for those long hours, especially when they are sick.

There are many issues with PATS, and with regional health. If I go back to our time in government, with royalties for regions we built the Karratha Health Campus, and the Onslow Hospital, which I think the Minister for Health opened in June. We put $20 million of royalties for regions funding into that. For Exmouth Multipurpose Service we put in $8 million; Carnarvon, $26 million; and for aged care in Carnarvon we allocated $16.9 million, which was taken out by the government and then reinstated and rebadged. Our investments extended to Kalgoorlie and Albany.

Mr R.S. Love: You aware of the situation in Mullewa? The health centre there has been promised, but nothing is progressing. The community has not been kept up to date, and does not know what is happening. Perhaps the minister might be able to explain that to us.

Mr V.A. CATANIA: That is a very good question, and I think that the minister has heard that.

Mr R.H. Cook: I was not listening to the interjection, so you'll have to repeat that.

Mr V.A. CATANIA: Mullewa Hospital, which has been promised for a long time but has not been delivered by your government.

I have not got much time left. All in all, the status of the north west health system is dire. Funds were put in, and funds have been taken out and rebadged. People know, and see right through this mean-spirited government and this mean Premier. Come 2021, I think they will let him know. The National Party delivered royalties for regions, and put it into health, and I look forward to doing that again in 2021, when we are back in government, to bring back royalties for regions, and bring back the money that is needed to bring our health system back up to scratch, because this government has severely hurt the people of regional Western Australia.

MR R.H. COOK (Kwinana — Minister for Health) [6.28 pm]: I thank members for their contributions today, and I will take some time to move through some of the issues. I will try to address some of the specific issues raised, and also speak in general terms about some of the points a number of members made, for instance, about general practitioners, PATS and so forth. I will take some time to go through those as well.

As members will be aware, yesterday the government made an announcement of a significant contribution towards infrastructure investment in the WA health system. It is an $81.5 million package that will go significantly towards continuing to make sure that people have opportunities to work within the Western Australian community, to make a contribution to their community and to the economy. One of the really pleasing aspects was that we were able to dedicate $37 million—almost half of that—to rural and regional community hospitals. This is a really important contribution, because we know that, with these mostly minor works, the vast majority of the work will go to small businesses operating locally. It is a component that I am very proud of. Within this $37 million package we have $8.62 million going towards wheatbelt health, $8.37 million to midwest health, $7.34 million to south west health, $6.85 million to Kimberley health, $4.58 million to great southern health and $1.54 million to Pilbara and goldfields health. I know that the member for Kalgoorlie, who is in the chamber, would be very keen to follow up on the issues canvassed in the *Kalgoorlie Miner*—that is, the claim that somehow Kalgoorlie was short-changed in that process. The fact of the matter is that Kalgoorlie has been funded significantly for a number of health-related projects, including the significant upgrades of the Kalgoorlie hospital. That essentially means that the schedule of outstanding repairs and maintenance work is not as great as it is for other areas. In addition to the work we are doing at Kalgoorlie hospital, we are also investing $6.3 million for an MRI machine at the Kalgoorlie Health Campus and $12.46 million to build a community mental health step-up, step-down centre. The reason that is important is that the tenders for that are going out at the moment. Building Management and Works is working very closely with the local community to make sure that package is carved up in a way to enable it to go to local communities. With the step-up, step-down facility that we developed in Bunbury, we saw that 87 per cent of that project went to local content—local builders, local companies, local workers—and we expect a similar outcome in Kalgoorlie. That will be a significant increase, and the member for Kalgoorlie should be very happy with it. There is $10.48 million to expand the capacity to provide dedicated mental health services at Kalgoorlie hospital, including an additional $3.8 million to expand existing inpatient mental health service capacity in the goldfields. The member for Kalgoorlie would also be familiar with our commitment for the new 64-slice CT scanner at Kalgoorlie hospital and also with the advanced construction works for the 19-bed Kalgoorlie renal hostel, which will open in 2020. I place that on the record because I heard the member for Dawesville making commentary about these issues on behalf of the member for Kalgoorlie and significantly misrepresenting the amount of investment going into Kalgoorlie health infrastructure. The member for Dawesville made the inaccurate and misleading comment that we are cutting repair and maintenance programs for the year, but we are already undertaking an estimated $147 million worth of repairs and maintenance investment in the WA Country Health Service. The money that we announced yesterday is in addition to the usual expenditure, which, as I said, was in excess of $147 million in 2018–19.

This is a significant investment. It means that our country hospitals continue to receive the investment they deserve. It comes off the back of a strong investment program leading to the opening of a range of new facilities around the WA Country Health Service. Governments of all persuasions have invested significantly. I remember the last Labor government made significant investments in every hospital north of Perth. It essentially rebuilt or redeveloped every hospital in the Kimberley region. Of course, the member for Kalgoorlie will remember that the last major investment at Geraldton hospital was from a Labor government.

Several members interjected.

Mr R.H. COOK: Sorry, the member for Geraldton. I had just been speaking about the member for Kalgoorlie and the riches that are being rained on his township.

Mr Z.R.F. Kirkup interjected.

Mr R.H. COOK: Unfortunately, the member for Dawesville was not in the room —

Mr Z.R.F. Kirkup: I heard your dulcet tones.

Mr R.H. COOK: — so he missed out on my award-winning performance in talking about the investment in the renal hostel, in the new step up, step down facilities, and the MRI machine. What else, member for Dawesville?

Mr Z.R.F. Kirkup: The slice machine, or whatever it is called.

Mr R.H. COOK: The slice machine? The CT machine. That is on top of the investment at Kalgoorlie hospital. The Geraldton hospital investment was also very significant. I am very pleased and proud to be part of a Labor government that is now coming back to do that investment.

Ms M.J. Davies interjected.

Mr R.H. COOK: At least it is in the budget, member for Central Wheatbelt. The former government had eight and a half years, and it did nothing there.

Mr W.J. Johnston: Shame!

Mr R.H. COOK: The former government did nothing for eight and a half years. That begs the question, member for Moore, of why this heartfelt commitment to the Turquoise Coast Health Initiative was not announced until 29 December 2016. It was never actually put in the budget.

Mr D.T. Redman: You've got more names on plaques across Western Australia than words in the dictionary!

Mr R.H. COOK: I would like to think that, member for Warren–Blackwood. The former member for Peel, Hon Norm Marlborough, who was the member for part of what is now my electorate, holds the record for that. The reason he holds that record is that he decided to go out and get as many plaques as he could. He represented every minister he could find to open up whatever facility he could find. That included community toilets and things like that. He was basically on a mission to make sure that he got the most plaques of any politician in history.

Mr I.C. Blayney: He opened the sewerage farm.

Mr R.H. COOK: That is one of the finest sewerage farms, which the member for Geraldton endorsed. That is a very important contribution.

I have to be honest with members. We erect these plaques to our great honour. I was touring a section of Royal Perth Hospital, which I will talk about in a jiffy in the context of the WA Country Health Service, and I saw in the corner a stack of metallic plates. It was at least this high; there must have been over 20 plates in the corner. I said to the person who was showing me around, "What's that over there?", and he said, "That's all the plaques with the names of politicians on them from things that have been opened in the past." Eventually, members, we just get recycled into some other brass plate in the future. Our time in this place is short, so let us make it count and get as many plaques as we can. I salute Hon Norm Marlborough and his great quest. I think he did rather well in that process.

I want to mention a specific hospital redevelopment, and that is Meekatharra Hospital. The member for North West Central is campaigning on that issue. He came in and made his speech, and he then left, so he is very committed to this debate.

Ms M.J. Davies: He's writing to everyone to let them know exactly what you are about to say.

Mr R.H. COOK: I am about to say that the former government never committed to the redevelopment of that hospital. It started a business case for the refurbishment or redevelopment of a primary care and community health clinic off to the side of the hospital. I know that the member for North West Central likes to characterise that as phase 1, but it is actually one of the newest buildings in the precinct. It is old, but it is one of those classic 1960s cream brick buildings, and it is perhaps more sound than the rest of the buildings on that hospital campus put together. That was the Nationals' commitment around that, so let us not get too excited. When I met with the Shire of Meekatharra, I was told that it could never work out why the previous government was just going to do this little bit of perhaps the newest building on the whole precinct. I have asked the WA Country Health Service to put together a business case for the redevelopment of the entire campus, because it does need redeveloping. I got the director general of Health and the chief executive of the WA Country Health Service to tour the facilities and have a look around. We have a vision for how we think Meekatharra Hospital should be redeveloped, particularly as the member for North West Central talked about providing a hub for the Cue, Mt Magnet and other nursing posts in the area so that we can make them more sustainable facilities. In that context, I am very pleased to say that $1.2 million of the $37 million has been set aside for Meekatharra Hospital to make sure that it gets valuable repairs and maintenance. It is a beautiful old building—it is one of those classic country hospitals—but it is sorely in need of attention.

Members have spoken about the patient assisted travel scheme and I want to quickly talk about some of those issues. In 2018–19, PATS subsidised 98 515 trips for country people living in regional and remote WA to access specialist medical services, with a total regional investment of over $38 million. The PATS investment has increased by $8.26 million since 2015–16, which is a significant financial commitment. I draw members' attention to the fact that a central piece of that work is around developing the PATS online portal, which was part of the

2019–20 budget. I think it was the member for Moore who talked about the rigmarole involved in filling out forms and having them endorsed by specialists and so forth. The difficulties patients have in making sure that the right forms are filled out continues to be problematic in terms of PATS. Getting that onto an online platform will be really important for making it work better. With regard to the inquiry by the Standing Committee on Public Administration into PATS in 2015, the WA Country Health Service is committed to revisiting a number of those recommendations. WACHS has tasked the PATS area office with preparing a business case proposing changes to be considered by government. This business case proposal is nearing completion.

It is an important element of what we do in health care, because as we know, we want patients to receive the best possible health care regardless of where they live. I know members have highlighted the importance of being able to get surgery within their communities, but members must also remember that this must be balanced against quality and safety. The international evidence on quality and safety is that if a surgeon is doing the same operation six times a day, five days a week, the quality of the outcomes for the patient is significantly improved. I know it is an inconvenience for patients to travel, but it is important to get them that quality service. We will continue to look at PATS to see how it can be improved. I would like to thank the member for Geraldton for acknowledging that our office is keen to work with members to make sure that if there are any individual failures in service provision, we can head them off and make sure we improve on them. As the proposals for improving PATS come together, I commit to working with members on them. The member for Moore quoted me from November 2017. I do think some of those hospitals in the turquoise coast region will ultimately need upgrades, but I commit to coming back to him to talk about PATS to make sure we get a better line of sight in terms of how it works in the interests of patients.

I want to talk a little about general practitioners. As members have observed, the provision of GPs is an incredibly difficult issue, but at the end of the day it is not the responsibility of the local government and it is not the responsibility of the state government; it is part of the federal government's primary health and care responsibilities. That is of little comfort to a councillor or a local government authority that has an angry community standing outside their door, saying "We want to have a GP in our community". I understand the efforts to which they have gone to attract GPs to their communities. Through what was initially the Southern Inland Health Initiative GP incentive program—which we continued to fund from July 2017 and is now part of our GP incentive program—we have been successful in attracting more GPs to practice in these communities, but it is difficult. A number of members acknowledged that GPs play an important role in local hospitals in ensuring that they can provide those services. But unless the federal government is going to do some of the heavy lifting around reimagining the system for remunerating GPs, we are going to continue to struggle.

I thought it was ironic that we had the member for Nedlands and the member for Cottesloe sitting in on this debate because, as they know, their electorates have the lion's share of GPs in Western Australia. It is, quite frankly, difficult. One of the solutions that we could look at is to make sure that the Medicare benefits schedule recognises telehealth services. That is a really important aspect. If the member for Roe gets the opportunity to meet with the federal health minister, I implore him to make some representations to him about these issues. We know that telehealth is the best way for people in these areas to get access to health care. Many members will be familiar with the success we have had with emergency telehealth, outpatient telehealth clinics and tele-mental health. Tonight on, I think, ABC news, we will be talking about the first rollout of tele-chemotherapy. That is an opportunity for people to receive chemotherapy in a regional hospital setting, for those patients who require fairly routine chemotherapy services. Our first patient is going through Karratha Health Campus now as part of the pilot. It is a really important incentive and a really important opportunity to see if we can continue to extend the service to country patients so that they do not have to come down to Perth hospitals to receive their chemotherapy. Obviously, it is for those patients whose chemotherapy regime is fairly straightforward, and it will be a fairly small cohort in the first instance, but that gives us a window into what we can do with telehealth. It is very exciting.

I am not sure if I have brought members' attention to this infographic in the past, around the success we have had in telehealth. With your indulgence, Deputy Speaker, I will table it.

[See paper 2817.]

Mr R.H. COOK: It shows how much work we have done in telehealth across the WA Country Health Service. This work has been undertaken by governments of all persuasions, but let us have a look at the size of what we are doing. In 2018 we had 21 415 outpatient appointments via telehealth, which is a 17 per cent increase on 2017, so it is going through the roof. Average outpatient consults per week via telehealth is now more than 400. That means fuel savings of $4.6 million and 5 200 fewer tonnes of carbon being emitted. That is the equivalent of planting 78 000 trees and has saved in patient kilometres travelled the equivalent of going to the moon and back 37 times.

Mr Z.R.F. Kirkup: What is that over the entire life span?

Mr R.H. COOK: That was just in 2018.

Mr Z.R.F. Kirkup: Wow!

Mr R.H. COOK: It is staggering stuff. It is really a sign of where we are going.

I want to talk about the investment we are about to make in the WA Country Health Service command centre, and I will make sure that members have an opportunity to tour it. This will make sure that within an area within Royal Perth Hospital where the aforementioned plaques are continuing to stack up and gather dust —

Mr Z.R.F. Kirkup: The plaque storage room!

Mr R.H. COOK: The plaque storage room! We will install a bank of screens that will enable us to have oversight of essentially any patient movements within the WA Country Health Service, but also to access telehealth for those patients to ensure that we get better service to them. This will make sure that we continue to take the WA Country Health Service to a new level. That is an opportunity for everyone to work within a strong clinical governance model so that we know what a patient is doing from ambulance call-out to emergency department presentation to surgery. We can track them and know what is going on throughout their entire patient journey. This will take the WA Country Health Service to a whole new level. It is an exciting development and has been spearheaded by the WA Country Health Service and Jeff Moffet, the chief executive. A lot of members have said, "We built that". Yes, but we will open it—I think I will get the opportunity to open it. I understand that I will not get the opportunity to open everything; that will be another health minister—maybe from the opposition's side; maybe from our side. That is the nature of health care. It requires everyone to keep investing in it and to make sure that we continue to grow our health services.

While the member for Dawesville is in the chamber, I will go back to an issue that he raised about sexually transmitted diseases and the flurry of thoughts he provided earlier on. We are facing an increase in the rates of sexually transmitted diseases and bloodborne diseases. This is a phenomenon. It is happening in not just northern Australia; it is happening around the world. I understand that we have to continue to work hard to make sure that we put downward pressure on those numbers. That is why we invested $700 000 this financial year, on top of our usual expenditure, in the work that we are doing with the WA syphilis outbreak response group, which was established to address infectious syphilis outbreaks in the Pilbara and Kimberley regions. My notes say that WA, unlike some other states, has been successful in stopping any new cases of congenital syphilis, which is transferred from mother to baby in utero.

Mr Z.R.F. Kirkup: That might be an old note now.

Mr R.H. COOK: The group implements and monitors the WA syphilis outbreak response action plan and supports regional response teams in managing outbreaks. The Department of Health has funded a new syphilis training website for health practitioners, registered nurses and Aboriginal health practitioners to give free treatment to patients with chlamydia, syphilis and gonorrhoea in the regions. We have published our "Talk Test Treat Trace" manual, which I remember launching, member for Central Wheatbelt. If she thinks she had problems getting her tongue around soft-shoe shuffle, the "Talk Test Treat Trace" manual is significantly difficult! As part of that, there are public campaigns that will help raise awareness of sexually transmitted infections. Consequently, in the uptake of preventive measures, we recently approved $700 000 in funding this financial year for STI public awareness campaigns that target a range of key areas, including the Aboriginal sexual health campaign, the Aboriginal bloodborne virus campaign, the youth STI campaign, the Get the Facts sexual health education campaign, and the syphilis and gonorrhoea and sexual health in women campaigns. It is an important effort, as the member for Dawesville highlighted, albeit in fairly strident tones, and it is one to which we are responding. We are making sure that young Aboriginal people in particular have access to information sessions, publishing a range of information material on social media to get out information and working with a number of our partners, particularly the Wirrpanda Foundation, through the Deadly Sista Girlz program, to raise awareness about STIs. The issue of sexually transmitted diseases is a notoriously difficult issue to deal with but one that we will continue to fund well.

The member for Dawesville raised renal dialysis services. There has been significant investment in this area. I have already spoken about the Kalgoorlie renal hostel. We recently opened two renal chairs at Onslow Hospital and are adding to the scope of works of the Newman Hospital to make sure the renal dialysis service there has two chairs. We are funding the Kimberley mobile dialysis unit and the Halls Creek dialysis service, which allows people who receive renal dialysis in Broome to get back onto country, particularly for important matters, as well as a range of renal dialysis programs particularly at the Northam Health Service, which has an outreach service.

Mr Z.R.F. Kirkup: That Northam one we opened, that didn't have patients for a long time. I can't remember what it is called.

Mr R.H. COOK: I will read my notes and perhaps that will help. A dialysis satellite outreach service will be available at the Northam Health Service in 2019. Capital funding of $1.75 million was provided through royalties for regions. This facility will provide four chairs for wheatbelt haemodialysis patients who require nurse-led care closer to home. It will be located within the Northam Health Service, and will be managed, staffed and operated by Fresenius Kidney Care, a private provider. The Geraldton Health Campus has a same-day, in-patient haemodialysis service with nine chairs. Chairs are currently rostered Monday to Saturday with two main shifts. Renal dialysis continues to be invested in significantly.

In the final minutes I have left I want to quickly touch on the issue of midwifery training. An issue about midwifery training, particularly in relation to those at the Geraldton Universities Centre, was raised. One problem is that there are simply not enough babies being born in Western Australia to feed our current cohort of midwifery students.

Dr D.J. Honey: I've done my bit, minister.

Mr R.H. COOK: You have, member for Cottesloe—an outstanding effort.

We will continue to work to make sure that there are opportunities for regional patients.

Members have acknowledged the work of the Rural Clinical School of WA. It is doing an outstanding job to make sure general practitioners get training in regional communities. At the moment about 112 rural GP trainees are practising under two organisations—Western Australian General Practice Education and Training, and the Remote Vocational Training Scheme. These are really important training schemes, because, as the member for Roe observed, if we can get people to train in the country, the chances are that they will get a taste for it and either return or stay within those rural clinical schools. I acknowledge that the member for Geraldton—it might have been the member for Roe—talked about incentives that the federal government offer young graduates to keep them in rural communities either through an incentive scheme or by waiving some portion of their HECS debts. That would ensure that they get an opportunity to enjoy some time in a rural setting and, after getting a taste for it, might stay there. Through the Nationals WA work in the Southern Inland Health Initiative scheme and our work in the General Practice Rural Incentives Program we are having some success with that, but it is an ongoing struggle.

Member for Roe, the Well-women's Clinic in Katanning is not funded by the WA Country Health Service. We provided clinical space for them, but they withdrew services in relation to that. One good thing we have now is the WA Primary Health Alliance, which is funded by the federal government to invest in good primary care initiatives. The Well-women's Clinic should benefit from that sort of funding, but it has not had a lack of funding from this government. The member will be very pleased to hear that Katanning residents have access to two female GPs at a choice of two local private GP practices in Katanning. That is a step up from where we were before, but we have to continue to do more hard work. I am sure I did not say that I would fix it, member, but I thank him for apportioning great feats and ambitions on me in opposition. The government is working hard with the WA Country Health Service, the primary care sector and with locum services to continue to augment the number of GPs who are available in that community. Ultimately we need to get more GP specialists, such as GP obstetricians and GP anaesthetists to operate in these areas. But, as the member for Roe observed, it is much easier to attract a GP to Dunsborough than to a place like Katanning. That is a very sad, because Katanning is a great community and I think that people would find it a very rewarding place to practise.

All the issues that have been raised are important and the government continues to invest heavily in them. I thank members for their contributions. In particular, I thank members of the Nationals WA who brought forward some well-considered views to the debate today.

Debate adjourned, pursuant to standing orders.

House adjourned at 7.00 pm