## REGIONAL HEALTH SERVICES

*Urgency Motion*

**The PRESIDENT**: The next item of non-official business is a proposed urgency motion in the name of Hon Wendy Duncan. Governed by standing order 72, as modified by the temporary standing orders, it is necessary for at least four members to indicate their support for the discussion.

[At least four members rose in their places.]

**The PRESIDENT:** That having been done, I invite Hon Wendy Duncan to move the motion.

**HON WENDY DUNCAN (Agricultural)** [10.58 am] — without notice: I move —

> That this house consider as a matter of urgency, the government's failure to address the neglect of regional health services, which have been described by the former chief executive officer of the WA Country Health Service, Christine O'Farrell, as "blatantly bloody unsafe" and suffering "ongoing relentless chronic neglect" due to "metro-centric attitudes".

I bring this matter to the house as a matter of urgency because the government has failed to respond adequately to the alarming public comments made by the former chief executive officer of WA Country Health Service, Christine O'Farrell, in *The West Australian* on Wednesday, 26 March 2008. Christine O'Farrell was chief executive officer of the WA Country Health Service for five years following a long and distinguished career in the health sector, particularly in country health. When a retired public servant of her experience and standing makes comments such as those recorded in *The West Australian* on 26 March of this year, those comments must be taken seriously.

For the benefit of the house, I will summarise some of the comments and observations made by Ms O'Farrell, which I hope will help members see the urgency of this matter, and the need for the government to investigate and act on her concerns immediately. In the article in *The West Australian*, Ms O'Farrell stated —

> "You still have to provide a responsive medical emergency system out there for country people and it's not just there all the time anymore," she said. "In some areas, it is becoming blatantly bloody unsafe."

Ms O'Farrell describes the whole system as "fragile", and blamed the country health system's inability to cope on the metro-centric attitudes of bureaucrats and politicians, and their focus on pouring funds into bricks and mortar. She talks of "ongoing, relentless, chronic neglect". She further states —

> At some stage you cannot get away with this sort of neglect."

I bring this matter to the attention of the house as a matter of urgency because my Nationals colleagues in the other place endeavoured to suspend standing orders so that the minister could respond to the comments made by Christine O'Farrell, and advise members of the action he intended to take to investigate those allegations and implement strategies to immediately address the crisis in country health services. Instead, the minister spoke with pride about the bricks and mortar provided to country health services without talking about the delivery of the services.

**THE PRESIDENT (Hon Nick Griffiths)**: Hon Wendy Duncan cannot allude to a debate in the other place.

**Hon WENDY DUNCAN**: There is not much point in having a new health facility if the services it provides are dysfunctional. There are plenty of examples in which the demand for bricks and mortar is dire. In the last election the minister promised Kalgoorlie a $14 million upgrade and Esperance a $13 million upgrade for their hospitals. These upgrades have not happened, and those hospitals continue to be dysfunctional and unsafe.

The government denied members in the other place the opportunity of debating this question by voting against the suspension of standing orders. Members have been silenced on this issue, just as the voices of regional communities have been silenced by the disbanding of country health boards, and treating the current health advisory committees like mushrooms. Ms O'Farrell said she was puzzled that country residents had not been more vocal about the neglect of their health care at a policy level. I can tell members why the voice of country people has not been heard: it is because our community representatives have been shut out from the coalface and denied the information they need to properly assess what is happening. Health service staff have been forced to sign draconian confidentiality agreements. They fear for their future employment prospects should they speak out. Health services have been plunged into a downward spiral by the standard response: we cannot get staff so we will reduce the service. Then the demand reduces, so the service is further reduced.

If one more health service bureaucrat tells me that it is impossible to get people to live in the regions, I will explode. It has been said to me, "Health professionals don't want to live in the regions—why would they?" Plenty of Australians want to live in the regions, and they are as deserving of health services as Australians

living in the metropolitan area. Health professionals would want to live in the regions if they had decent housing, access to good quality education, childcare and community facilities, and functioning medical and support services. In a wealthy state such as ours, there is no reason that these standards cannot be achieved if the government has the will. There is also no reason why Western Australia cannot sustain fully self-sufficient, modern and vibrant cities outside the Perth metropolitan area.

Ms O'Farrell stated that country people have not been vocal; I can assure members that my colleagues in the Nationals have heard the voice of country people. Our offices receive calls daily from constituents who have had to endure Third World conditions in the country health system. Only last week I was told of a woman in Kalgoorlie who has decided to return to Thailand because she would feel safer there should she fall ill. If someone breaks a limb in the regions, it is highly likely that it will not be able to be dealt with without the person coming to Perth. My colleagues who represent country electorates are continually raising health matters with the minister and the department. Even though individual cases may be investigated and dealt with, there is no will to deal with the systematic failure that produces these cases.

The stories are many; such as a gentleman from Coolgardie who drove himself to Perth eight times before he had his hernia operation. That is a five-and-a-half-hour drive. A woman had to twice drive 400 kilometres from Tom Price to Port Hedland before her internal bleeding abscess could be operated on. A young fellow broke his arm and his parents drove through the night for four and a half hours to Port Hedland because his local hospital could not deal with him. That is a hazardous drive, with the risk of collision with cattle, camels or kangaroos in the dark of the night, and it should not be expected of country people. Several incidents have occurred in Esperance District Hospital in which people with life-threatening emergencies have had to wait far too long for medical attention and action due to the shortage of doctors for after hours and weekend rosters. Advanced Incident Management System forms are being submitted reporting clinical incidents about which no apparent action has been taken or remedial work done. Patients have been flown to Perth or a major regional centre, and then discharged without the support of family or friends and left to find their way home. Disabled and ill people who fly to Perth for treatment have to find their way through the maze of transport, accommodation, bureaucracy and form filling on their own in unfamiliar territory, without family and friends and without any support mechanisms. Getting out of Perth airport alone is virtually impossible for somebody who is ill or disabled. A taxidriver cannot leave his car to help with the luggage and the patient cannot leave the luggage to go out and get help. It really is a very distressing situation for elderly and disabled people who come to Perth.

It is all very well having a hub-and-spoke model, but if no consideration is given to the transfer between the hub and the spoke and there is no glue to hold the model together, the wheels inevitably fall off. The transport crisis that has accompanied the demise of rural health services has been brought to the attention of Parliament regularly by my colleagues. The inadequacy and inefficiency of the patient assisted travel scheme, the huge increase in demand on the workload of the Royal Flying Doctor Service, and the demands being made on volunteer ambulance officers are all examples of a system in crisis. The Royal Flying Doctor Service has experienced a 60 per cent increase in its workload in the past decade. It now travels five million kilometres a year. Of those flights, 82 per cent are devoted to inter-hospital transfers—the work of the state government. The RFDS has now reached a point whereby it attains its benchmark of one hour and 15 minutes to attend a priority 1 callout zero per cent of the time. These standards have inevitable consequences for real people—real Western Australians with spouses, children and friends who are traumatised by the adverse outcomes, such as the tragic death of Dominic Epis at Edjudina station.

Christine O'Farrell is not the only experienced and credible health professional coming out publicly about the state of country health. The Australian Medical Association north west spokesman, Scott Teasdale, also warned in an article in *The West Australian* on 26 March —

> . . . longstanding shortfalls by successive governments in rural funding and the training of doctors, particularly GPs with the broad range of skills needed for country practice, had started to bite

He said that a system-wide failure to attract and retain staff had led to the rationalisation or amalgamation of services in many remote areas, forcing patients to travel longer distances to access first-stage primary health care, and to travel much further for specialist services. He said that as a result, serious medical conditions were often diagnosed later, when the chances for successful treatment were reduced. He said that the country has poorer access to health services and poorer outcomes.

On Tuesday night I attended an Oxfam function for the Close the Gap campaign, which calls on people to help close the 17-year life expectancy gap between Indigenous and non-Indigenous Australians. I call on the government to beware that the gap between regional and metropolitan health outcomes does not also go the way of Indigenous health. It is a very real risk unless immediate and positive action is taken by the government. This issue is of very grave concern to country people, who are apprehensive about the standard of health care in their

regions and who have had their confidence shaken by the comments made by Ms Christine O'Farrell. The only way to deal with this issue is to ask Ms O'Farrell to detail her concerns.

I have a motion on notice that calls on the government to form a select committee to give these issues the attention they deserve. I would like to find out this morning whether the Leader of the House and the Leader of the Opposition will support the establishment of this committee so that we can take pre-emptive action to avoid adverse outcomes such as those experienced in Queensland at the Bundaberg Base Hospital.

**HON SUE ELLERY (South Metropolitan — Minister for Child Protection)** [11.12 am]: I indicate that the government does not support the motion. However, I acknowledge that the provision of health services across a state as geographically large as Western Australia is a challenge, given the features of different areas in which live different populations with differing needs, such as those of urban regional centres and remote communities. All Western Australian governments have, over the years, faced these challenges. The WA Country Health Service operates within a total statewide health system and is highly integrated with metropolitan and statewide health services. I refer to a recent article that demonstrates ways in which such integration can and does work well. I will table the article. The article by Marnie McKimmie, health reporter with *The West Australian*, appeared in the health section of that paper on 26 March and describes the health care provided to two mums who gave birth to baby boys in King Edward Memorial Hospital in early March, and the way in which both babies received the same start in life. One family lives in Tuart Hill, which is 10 kilometres from King Edward Memorial Hospital, and the other family lives in the Billiluna community near Halls Creek, which is approximately 3 000 kilometres from Perth. The article looks at the way in which Perth's teaching hospitals are trying to tackle distance health care. It is pertinent to today's debate. The article states —

**KING EDWARD MEMORIAL HOSPITAL**

- Under Medical Specialist Outreach Assistance programs, midwives and obstetricians teach rural medical staff how to deal with a range of obstetric emergencies.
- WA Neonatal Transport Service transfers infants living in rural and remote areas.
- Accommodation is provided at Agnes Walsh Lodge for country women who need to be near the city-based hospital during pregnancy or after birth.
- Department of Psychological Medicine provides Statewide advice about the treatment of mental health disorders in the perinatal period.
- The Sexual Assault Resource Centre medical and forensic service provides 24-hour telephone support to regional health care workers, emergency departments and police.

**PRINCESS MARGARET HOSPITAL**

This is the hospital that, depending on the state of their health, each baby may well have to rely upon. The article continues —

- Provides 102 clinic visits to country centres each year, covering paediatrics, endocrinology and diabetes, cardiology and respiratory medicine.
- Runs an outreach Burns Telehealth Service.
- The Diabetes Department sends a nurse, dietician, social worker and doctor to seven regional centres to consult with families.
- A type 2 diabetes management program for remote Indigenous children has been set up.
- Family Pathways provides consultation, assessment, treatment planning and reviews to the rural sector via telepsychiatry in addition to intensive two to four-week admissions for children and families from rural areas for assessment, treatment planning and therapy.

**ROYAL PERTH HOSPITAL**

- Runs a statewide HIV program. RPH doctors and nurses visit remote areas and hold community information sessions and educate local GPs and nurses. Particular focus is on assisting pregnant women. Teleconferences are often conducted to advise on medication and doses. A similar program is run for hepatitis C.
- Burns experts also use teleconferencing to liaise with medical staff in remote areas.
- Renal consultants run clinics in the Kimberley and Goldfields.

**Hon Wendy Duncan**: I'm talking about regional towns, not remote areas.

**Hon SUE ELLERY**: I listened to the honourable member quietly and did not interrupt her. I ask her to pay me the same respect. The article continues —

- Takes part in the WA Health Department's Meet and Assist and liaison programs, which support and limit culture shock among remote-area Aboriginals coming to Perth for specialised treatment. The service, which is also open to the general public if needed, involves the patient being met at the airport and accompanied to the hospital or to their accommodation. Assistance is also provided with contacting family, discharge and after care.

The provision of sustainable and safe health services to country Western Australia has been and continues to be a key priority for the government. The government will continue to direct efforts and investment towards activities that deliver measurable improvements to the health of all Western Australians, including those living in country Western Australia. Since the last election, the government has effected a 31 per cent improvement to country health budgets, which represents an increase of $167 million. There is no doubt that the tight labour market resulting from Western Australia's booming economy is having an impact on our capacity to staff many different areas of the economy, including country health services. However, despite the tight labour market and workforce shortages, the government has increased the rural workforce by an additional 278 full-time equivalent positions over the past 12 months. These have been deployed into regions of significantly increased activity, including the Pilbara and the south west. A telehealth development group has been established to lead the integration of telehealth across health services in Western Australia. Western Australia is one of the jurisdictions in Australia carrying out this initiative—we have to, because of the geographical nature of Western Australia—to increase and improve access to clinical services in rural communities.

The WA Country Health Service undertakes accreditation programs on a regular basis to ensure that our health services meet national standards and that all adverse clinical incidents are fully assessed. The state government has implemented a program called Safety and Quality Investment for Reform. This is a clinical practice improvement program that began last year. The government allocated $2.38 million to the WA Country Health Service to develop regional clinical governance teams to implement a mandated clinical practice improvement program and to support clinical audits. The nature of health services is such that clinical incidents will occur from time to time, whether or not there is a workforce shortage—there is no question about that. When risks or safety concerns are identified, action is taken to immediately rectify the situation. For example, in the past we have gone to such lengths as temporarily suspending services, if necessary, if there are severe medical or nursing workforce shortages, and offering patients safe care alternatives, while actively recruiting staff to ensure that patient care is not jeopardised.

A major reform program of health service delivery is currently underway through the established clinical health networks. The major function of the health networks is to plan services based on community needs, stay at the forefront of developing innovative health care policy, and set targets and measure and monitor the outcomes. Rural health service planning and delivery is a core component of that work. Clinical service planning has been completed in each of the seven regions, which has involved wide consultation with clinicians and has focused on ensuring that we continue to expand safe and high-quality health care services to Western Australia.

I want to talk about bricks and mortar. I do not accept the proposition that our investment in bricks and mortar is somehow doing a disservice to country health. This government has committed more than $600 million to rebuilding country health services, and I will table the list that sets out in detail how that $600 million investment has been allocated.

**Hon Barbara Scott**: Has it been spent?

**Hon SUE ELLERY**: The member will see it in the document that I will table. It outlines the money that has been spent, the work that is underway, and the funds that have been allocated and the work that is about to commence. The document provides details across those three categories. This is not an insignificant investment. These things make a difference to the way in which health care is delivered in country and regional Western Australia. I do not accept the proposition that this government is not doing all that it can to ensure that we continue to deliver high-quality services to Western Australians, wherever they may live. The government opposes the motion. I table the two documents, the article from *The West Australian* that I referred to earlier and the list detailing the $600 million investment in rebuilding country health services.

[See paper 3901.]

**HON HELEN MORTON (East Metropolitan)** [11.22 am]: I totally support the motion moved by Hon Wendy Duncan. I will give members a bit of the background of my association with Chris O'Farrell so that they can understand the enormous shock I received when I saw her comments reported in the newspaper. Chris O'Farrell and I commenced work as regional directors in the country at about the same time. She was the regional director for the Kimberley and I was the regional director for the central wheatbelt area and, subsequently, the Gascoyne

area. In that time we worked diligently with people in the country to provide services. We were responsible for hospital services, mental health services, childcare services etc. That was the broad role of a regional director. Chris O'Farrell had worked as a registered nurse in one of the hospitals in the Kimberley—I think it was Fitzroy Crossing District Hospital—and had then gone to work at Derby. She was one of the most dedicated workers I could ever imagine. At the time that we became regional directors, the Department of Health formed the country regional directors group, and we used to get together every three months or so and work through country issues in the regional directors forum under the fantastic guidance of Dr Andrew Penman, who was the assistant commissioner for country operations at the time. My ongoing association with Chris was a fantastic working relationship. We also developed a personal friendship. When I went to work at the health department as the general manager for finance and resources, Chris was the general manager for operations, so once again we were working together at a central level. At the same time, Neale Fong was working as a general manager and was one of our colleagues. Both Chris and I wanted the job as the assistant commissioner for country operations. She was successful and I was not. I was very disappointed, but that is life. Chris was appointed because she was the better applicant; there is no doubt about that. She had better experience and clinical knowledge and she was a fantastic operator in that role. I will describe what a loyal servant to the government Chris O'Farrell was. When I left my role as the general manager at Armadale Health Service, I tried to make contact with Chris on a few occasions.

**Hon Ljiljanna Ravlich**: She probably didn't want to know you.

**Hon HELEN MORTON**: She did not; that is absolutely true. However, it was not because she did not want to know me; it had been indicated to her that my interest in politics would not make it a very good idea for her to continue our relationship. I respected that and made no further contact with her. Chris O'Farrell was an extremely loyal servant to this government. She resigned when she needed to resign. She has subsequently spoken to me and said that she was not pushed; she left willingly. She felt that she had come to the end of her tether of trying to make headway on country issues with the government.

**Hon George Cash**: She was very well respected.

**Hon HELEN MORTON**: She was extremely well respected. When I read her comments in the newspaper articles, I thought it must have been very bad for Chris O'Farrell to make those comments because she would never do that under any other circumstances. The issues that she raised and the language that she used were amazingly straightforward. There is no doubt that her comments were meant to shock people into some action. I do not want to raise all the issues that have been raised in the newspaper articles, but one of the issues was the council handing over between $200 000 and $600 000 annually just to keep the doctors and nurses there. Can members imagine what it would be like if that happened in the metropolitan area? Can they imagine what it would be like if their local council had to raise funds to keep enough doctors in their suburb to provide services to people?

I do not think that people have cottoned on to this matter, but Chris O'Farrell asked where the voice of the country was and why country people were not as vocal about these issues. When we were regional directors, we had no line authority to anybody who worked in those hospitals. They were employed by the independent country hospital boards. Those boards were the employers of the staff who worked at the hospitals. Any work that we needed to do on, say, the transfer of funding from one board to another had to be done wholly and solely through negotiation and by putting up a good argument and demonstrating the benefit of moving those funds. Invariably, we balanced budgets. I am absolutely proud to say that there was never a time in the country, even without line management, that I did not balance the budget for the regions that I was responsible for. The boards have been abandoned. This government got rid of hospital boards and inserted in their place an advisory committee that can give some advice to somebody about what it thinks is a good idea. The committee has no teeth. It has no authority. It has no ability to say directly to the minister, "This is what is happening in our local area and we need to do something about it." At the moment, the minister is the board and the employer of the staff. Members talk about why the staff feel intimidated. There is no doubt that they do feel intimidated about speaking up. Staff in the country regions feel too intimidated to voice their opinions and concerns until they resign from the department, and the local communities are in absolute fear of losing the services.

The country hospitals recognise, as the former hospital boards recognised, that the hospitals must be more than a typical hospital in the metropolitan area. Sometimes a regional hospital is the only service that provides a women's refuge or respite for the families of disabled or elderly people so that they can have a break. The hospital is sometimes the only place where homeless people can find support for their drug or alcohol dependency or that can provide acute medical care to an aged person who requires acute medical care but who lives at home. Country hospitals are more than just hospitals; they form part of the safety net of the community. They are more than just a health safety net. Invariably, however, over time those hospitals have been measured on their viability or cost effectiveness. Another thing that bothered me is that those types of admissions to the

hospitals were being referred to as social admissions and therefore the hospitals were told that those people should not be admitted. Those services are being stripped away from the hospitals rather than being considered as multipurpose services with a strong health emphasis. If we were to measure public obligation services in the metropolitan area on the basis of their viability, I do not think we would have either a Mandurah railway line or even a railway line to Armadale. Often I sit in my car and watch the train as it goes past and I can see that it is nowhere near full. Why can we not have a country hospital with a bed average that is less than what is expected to be a viable bed average in a metropolitan hospital? Why can a hospital in a country area not have to worry about what the bed average is on a particular day or month? I have said this before, and I will keep repeating it for as long as I stand in this place and see a socialist government opposite me: it is because socialist governments are based on the five "Cs" of socialism. The first "C" is centralisation. There is no way that a centralised government is able to provide, or even understand the importance of providing, services to the country in a way that ensures the people have a safety net. The second "C" is control, which includes the red tape that is required to provide services. When I was travelling around the Kimberley, I was told that the mental health services were losing staff who had applied and been accepted for a job. Acceptance for the job had to come from the Health Corporate Network in Perth and it took six weeks to process. By that time, the person who had been accepted for the job had found another job. The centralisation of and processing work from the metropolitan area is a huge disadvantage to people who live and work in the country. The third "C" of socialism is conformity. Conformity does not work well when trying to find creative solutions to specific issues that are unique to individual country regions. When the Department of Health requires everything to be the same and every service delivery model to fit a particular pattern or process, it works against the services that are needed in the country. The fourth and fifth "C" of socialism is the city-centric approach of this government. We have heard a lot about the city-centric approach of this government. Its delivery of health services is all about taking a city-centric approach to providing health services.

If the minister does not mind me saying so, it is ridiculous to say that this problem—I do not know whether the minister said it, but it is written in some articles that I have in front of me—is like a gold rush and that the government did not know about the boom or that it would need to provide all these services. The lack of planning seems to be a perennial problem of this government. These problems have been known about for years. The potential skills shortage issues have been talked about for at least 15 years. The predictions about what would happen have been known throughout the Department of Health. This has not happened suddenly. Chris O'Farrell and I went to regional country directors conferences and national rural health conferences and we listened to people tell us over and again about the problems facing us in the next five or 10 years. We were told about the things that government should be working on but we could not get the necessary response. It is pointless for anyone to talk about the lack of planning or knowledge or to say that the resources boom has brought on these matters in such a way that we cannot deal with them.

I have been focusing on mental health issues over the past three years. The government had had the business plan for the new mental health inpatient facility at Broome District Hospital for more than two years. Chris O'Farrell did not tell me that because she would not take my calls or meet me about any of those types of matters. The staff at the Broome facility told me about that and they were petrified that they were letting me know that the business case had been sitting there for two years. It was not until the day before the State Coroner's report was released that the Minister for Health suddenly announced that an inpatient facility would be built at Broome District Hospital. That was one of the recommendations in the coroner's report. That is an example of the poor, reactionary and ad hoc type of announcements that suit the needs of the minister.

I have previously raised issues concerning SouthWest 24, which is an emergency service in the south west of WA. The telephone calls divert to Sydney at 10.00 pm and do not revert to Western Australia until 8.00 am. The telephone operators in Sydney did not know where Manjimup was in relation to Bunbury because they lived in Sydney.

**Hon Barbara Scott**: What type of calls are they?

**Hon HELEN MORTON**: It is an emergency call centre for people who need psychiatric help in an emergency. Rural Link is another psychiatric emergency service for the rest of Western Australia. The two telephone emergency systems for rural people are not combined. Often the people who need the services move between those areas.

Fitzroy Crossing District Hospital does not have an obstetric service. When I was in Fitzroy Crossing either last year or the year before, a woman told me that she was prepared to risk having her baby delivered at Fitzroy Crossing District Hospital even though it does not provide an obstetric service. She preferred to do that rather than follow the policy that would require her to travel from Fitzroy Crossing to Derby three or four weeks before her baby was due because the housing offered to her in Derby would not accommodate her children. She was not prepared to leave her children at Fitzroy Crossing. She preferred to take the risk of having her baby delivered at

Fitzroy Crossing District Hospital so she did not have to leave her children in a situation in which she considered they would be at risk while she was away for three weeks. The simple and practical policy in that situation would have been to allow the children to go with their mother. However, that does not fit the planning model and the way things work at the moment. Similarly, I read a story recently about a woman who could not have her baby delivered at one of the hospitals in the Pilbara. I cannot remember if it was Port Hedland or Nickol Bay. There is a huge workforce up there, yet babies cannot be delivered at the local hospital. How many nurse practitioner roles have actually commenced in these country regions since the legislation for them was passed in this house? I have asked that question and have not received an answer yet. However, I expect that it is probably zero.

On the patient assisted travel scheme issue, a family in Esperance told me when I was there that a husband required air transport to Perth under the PAT scheme for quite a serious neurological problem. His wife was approved to go as his support person on the airplane. On the same day his 10-year-old daughter required treatment at Princess Margaret Hospital for Children but she had not been given approval to travel on the plane. She was required to get on a bus a few days before mum and dad would be getting on the plane because she did not fit the rules for travel at the same time. Some quick phone calls, and working with the member for Roe, Graham Jacobs, made it very clear that that was not acceptable, and it was changed very quickly. However, these are the sorts of stupid decisions that country people have to put up with that are bound up in rules and regulations that do not fit the commonsense need to provide those sorts of services in the country.

When I was working in the wheatbelt some issues impacted on me that have not gone away. There was one woman who had a severe hemiplegic condition. She had had a stroke and was paralysed on one side of her body. The services she needed were not available locally and she was required to go to Perth for rehabilitation. However, she made it absolutely clear that she preferred to put up with her residual paralysis and whatever condition that brought with it than disengage from her family and those people in the community who provided support for her. She preferred to live the rest of her life with that disability than go and live in the metropolitan area for the period that her rehabilitation required. Those are the sorts of cases that spur on people like Chris O'Farrell to ensure those services are provided locally.

**HON ANTHONY FELS (Agricultural)** [11.42 am]: I rise also to support the motion of Hon Wendy Duncan, and I thank her for raising the issue. Although the issue is urgent, it is certainly not a new issue and has been an urgent issue for many years.

I was a member of the Select Committee into Public Obstetric Services that was set up by this house two years ago to inquire into public obstetric services in Western Australia and the consultation process that the government undertook in making its decision to provide those services through the Department of Health of Western Australia. I had a particular interest in how that process was considered, particularly in rural and regional areas of Western Australia. Committee members saw a bit of everything to do with the provision of obstetric services in Western Australia. However, the worst case highlighted was that of Aboriginal women in Western Australia, which was highlighted again in the State Coroner's findings on suicides and deaths in the Kimberley region recently, and in the very poor provision of health services to Aboriginal women in particular and to Indigenous people generally. I guess that case highlighted the extreme conditions in remote regions of Western Australia. However, the same issues affect the provision of health services in the metropolitan region. There are ongoing delays for people being attended to in emergency departments, queues of ambulances waiting to get into emergency departments and ambulance officers having to treat patients in ambulances outside hospitals. Somewhere in between those problems and the problems in remote regions are the problems in rural and moderately populated smaller towns around the wheatbelt and other rural parts of Western Australia where there used to be small hospitals that made a big contribution to their local communities, both in the availability of services and in the employment of people. There may have been 100 kilometres between one hospital and the next, but to people in those towns that was considered quite close. A lot of those services around the state have closed, not only due to budgetary constraints, but also now because of the lack of practitioners to work in those regions.

Another issue that is paramount is attracting a general practitioner in private practice to work in those towns. Many local government authorities have to provide housing and incentives, including quite often free rental of a clinic, to attract a doctors to their towns to provide the most basic of services. There are a lot of issues that the government needs to consider to attract people to regional areas to provide those services. It should not come down to the cost and efficiency involved in the number of patients treated, because a lot of people in those areas get sick and need those services.

One recommendation from the select committee report into public obstetric services was that the government should in future give consideration to the flow-on effect to communities in the regions of a workforce associated with employment in hospitals. I have had experience with a number of hospitals throughout Western Australia

not only as a local member when I needed to attend one, but also when I had to take my son to Katanning District Hospital last year. He had an accident on a Sunday afternoon when the local hospital, Kojonup District Hospital, had only a skeleton staff and the local doctor was either not on call or unavailable. I took my son to Katanning and found the service there fantastic. It was a terrific hospital with terrific staff and very capable and competent doctors who really go beyond the call of duty in their work. This government is lucky to have those sorts of people in those professions who are prepared to work in those regions. The government should put more emphasis on attracting those sorts of people into the regions. There also needs to be more emphasis on training doctors through university. The University of Western Australia has increased its intake of graduates over recent years, but there are still large numbers of students who have the academic ability to become medical practitioners, nurses or whatever field it might be. The government really needs to consider training people in these courses when the basic infrastructure and academic staff are available to do so. It really would not cost much more to pump another 30 or 40 students through those courses. It would be of enormous benefit and would increase the availability of those professionals at the end their training. The government should really give some consideration to providing graduates with further incentives to work a couple of years in regional areas as part of their training and qualifications before they are admitted to practise on their own.

I want to address another issue. I noticed back in the late 1990s near my hometown of Esperance that Ravensthorpe District Hospital was a very basic hospital that had been set up many years before that. I think it might have had eight or nine beds in a very old building but it provided a very good service to the Ravensthorpe region. A decision was made back then by the Department of Health to provide a new hospital and I think it was planned in the late 1990s and completed early 2001 or 2002. It basically replaced the facility that was there before with a new building—a very nice building—but it was opened right at the time the Ravensthorpe nickel operation was about to commence. There has been a huge influx of population into that town that are employed by and service that mine, and we are all aware of the pressure that accommodation and the availability of services has put on towns such as Ravensthorpe and Hopetoun nearby. Better planning is needed in all government agencies. In this case the Department of Health should have recognised what was about to happen with the largest resources company in the world, BHP Billiton, building one of the largest nickel operations in the world, and talking about employing a couple of thousand people. The government knew that the operation was about to start and should have factored it into the equation when building the hospital.

It is not a question of only regional hospitals, but also the Department of Health generally. We have seen the problems in the metropolitan area and in remote regions with Aboriginal health. Those are the two extremes, but there are issues with regional and rural areas in between. The government needs to give health services greater priority.

**HON PAUL LLEWELLYN (South West)** [11.51 am]: It is fair to say that at many levels all is not well in regional and rural Western Australia. We need to look at the issue in a much broader sense than merely the question of health service delivery. There is a general decline in rural areas, not just in health but also in water, planning, power and so on. There is an increasing disconnection between urban and rural centres. When that connectivity is lost in a population, the viability is also lost of not only urban centres but also regional and rural centres. There is to some extent a failure in the delivery model of our health care services, but I believe it is in the context of a much broader failure in the way services are being delivered into regional areas.

If we are to resolve health care and service delivery issues, we also need to simultaneously resolve a whole series of other questions and ask ourselves what constitutes "healthy regional communities" and what constitutes a healthy population. I will come back to that question. I attended an urban planning conference in Bunbury recently. It was really apparent that it was not just in the area of health that we were basically doing crisis management; there was crisis management in water, power, planning and other services, and indeed educational service delivery. That crisis management related to the rate at which rural areas had been repopulated in some cases and, of course, the migration of older people into rural areas, particularly into the more equitable climatic zones, which is creating a health care service delivery nightmare. We must accept that this is a feature of some of our rural populations.

Turning to the disconnection and decline in rural areas, I go back to what constitutes healthy regional services, healthy regional communities and healthy people. What is required is meaningful and secure work. The trend towards fly in, fly out working services for the mining industry goes against the trend of providing meaningful work in decentralised communities; in fact, the delivery of those services tends to be centralised, which is exacerbated by putting in fly in, fly out arrangements. The Greens are very concerned about the continued use of fly in, fly out, for a whole range of environmental and health reasons.

If we want healthy communities and building capacity, we need meaningful work located in rural areas. We are stripping away meaningful work from regional areas. We need to pay attention to what kinds of enterprises get set up in regional areas, so that we can support schools, hospitals and so on. I would like to relate a recent

personal experience of my father going to hospital in Fremantle. He got absolutely remarkable service. My wife works in the Albany Regional Hospital mental health unit. She is an extraordinary practitioner. An enormous number of remarkable people are working in health care services in regional areas, and we must acknowledge that. What we do not want to do is burn such people out, whether they be in the city or country areas. We are burning our communities out. We are particularly burning people out in the health care area. I know that because I hear my wife talking about the number of people who have left. She has been in that service for three years. She has seen a remarkable turnover in staff because they cannot be held there. It is not a question of their difficult workload, but it is about ancillary services in those communities creating a meaningful community where people can choose to stay and live. That meaningful participation in communities is as much a part of the health care crisis as services, bricks and mortar, the disconnection, the centralisation and the layer of overregulation that seems to be pervasive in the delivery of health services and the number of forms that must be filled in. We know that we must monitor and keep track of developments, but the level of bureaucracy that lies over health service delivery seems to be burning people out because the amount of time spent with clients as opposed to the amount of time spent filling in forms has changed disproportionately.

My central thesis on the health care crisis and service delivery crisis is that it is pervasive and deeply rooted in the way we organise and deliver to our rural communities in general. The Greens would like to see more concerted decentralisation and relocalisation of delivery for a whole range of services as well as the relocalisation of control. The communities delivering the services on the ground are the best people to know how to reorganise the nuts and bolts. This kind of service delivery in which workers are given control is becoming commonplace. Even the motor industry and the most successful industries around the world are moving control down to the local level. Centralisation is the dysfunction that seems to be happening in health services.

An example of the disconnection between decision-making on service delivery, particularly health service delivery, has been made very stark to me. It was about the Busselton District Hospital. Some 70 per cent of the community said that they wanted to keep the hospital where it was. It is on a prime piece of real estate and the minister has chosen to relocate the hospital to a desolate housing estate built by a very salubrious housing developer, who has given four or five hectares of land—I cannot remember the exact figure. The minister intends to move the hospital from a 12-hectare site near the centre of Busselton. The claim is that it will improve service delivery. The argument used is that locating the hospital out of town will give better access because of better roads and transit access from Margaret River and other rural communities in the area. I believe that health services should be located close to population centres. A large number of community groups in the area around Busselton District Hospital are delivering meals on wheels and other very necessary ancillary health services. However, the government is saying that that counts for nothing; the new hospital should be located on the highway transit zone. The government is totally misconstruing what it means to deliver health services. Health services should be embedded in the community. The government needs to acknowledge the important role that voluntary and semi-voluntary community organisations are playing in the delivery of high-quality services to improve people's health and wellbeing. There is no doubt that as our society becomes more modern and as the incidence of modern diseases increases, we want our health services to become more medicalised. However, we also need population health services and community health services. We need to put healthy communities ahead of highly medicalised and highly technical service delivery. I am not arguing that we do not need high-quality and modern scientific and technical-based health service delivery. I am arguing that the dysfunction in the provision of health services in regional areas goes much further than the amount of money that is spent on buildings. It also goes much further than the number of doctors who are available. It goes to the heart of the organisation of our communities at the local level.

The motion moved by Hon Wendy Duncan states in part —

> That this house consider as a matter of urgency, the government's failure to address the neglect of regional health services, . . .

We need to be fair about the problem that has been created. The delivery of health services in regional communities is exacerbated by a range of issues that have caused failure in regional and rural communities, not the least of which is the spiral of despair that has been caused because regional communities are in decline for environmental reasons —

**Hon Wendy Duncan**: No, they are not.

**Hon PAUL LLEWELLYN**: I believe the health and wellbeing of our regional communities is certainly in decline. Some communities are doing extremely well. However, many communities are struggling. The evidence of that is very clear. We need go only into the outer wheatbelt areas and the north eastern wheatbelt areas to see communities that are struggling. Are the people in those communities capable? Yes. Are the people in those communities extraordinarily resilient? Yes. However, that is a different issue. Are the people in those

communities struggling because of environmental decline, rising oil prices and so on? Yes. I would not like to be in denial about that. We need to find a balance between measuring the successful delivery of health services by the number of dollars that we spend and the number of buildings that we put in place, and measuring the successful delivery of health services by the overall improvement in the health and wellbeing of the community. We need to re-think how people in regional areas can engage in meaningful work in their community, such as catchment restoration, renewable energy power generation, and the establishment of enterprises based on the delivery of environmental services, because those types of activities will revitalise regional communities, improve the health and wellbeing of the people in those communities and make those communities more sustainable in the long term. We will then be in a position to deliver health services in the long term, because it is the short-term thinking that is making people leave rural communities. The people who are delivering health services need to know that these declining communities have a viable future. We need to recognise what is happening in regional communities. We need to recognise that there is a problem. To engage in nostalgia and to go back to the way things were done in the past is not necessarily the right thing to do. The provision of health services should be localised, and we should establish autonomous health boards in regional areas and empower regional communities by giving them greater control over the delivery of health services in their area.

The service that was provided by Christine O'Farrell to regional health in Western Australia was extraordinary. I am aware of that as an observer from the sidelines. If the former chief executive of the WA Country Health Service is saying that regional health services are in crisis, we should take that very seriously. I acknowledge the extraordinary service of not only Christine O'Farrell, but also the many hundreds of people who are delivering health services in regional areas. The Greens certainly believe that this house should give urgent consideration to this issue. In saying that, I am not speaking on behalf of Hon Giz Watson, who is the person responsible for speaking about health issues on behalf of the Greens. I am speaking on this issue primarily as a regional member who has recognised that the delivery of health services is failing regional communities. It is failing the people who are delivering the services. It is failing the people who are receiving the services. It is failing the health and wellbeing of the people in regional areas,

**HON NIGEL HALLETT (South West)** [12.07 pm]: I want to speak briefly on the motion moved by Hon Wendy Duncan. I commend the member for her excellent motion. It is widely accepted that people in rural and regional Western Australia are being short-changed by this government when it comes to the health sector. We need look only at the under-investment in the health sector in rural and regional Western Australia. The funding for rural health has taken a real whack in this year's budget, because it has dropped from $61 million in the 2006-07 budget to only $27.2 million in the 2007-08 budget. I could be cynical and ask: where is this money going? Is it going to the city for the new Fiona Stanley Hospital? When we look at the recent blow-out in costs for that hospital, I think people are quite right to assume that that is where the money is going.

**Hon Ken Travers**: Are you opposing Fiona Stanley Hospital?

**Hon NIGEL HALLETT**: Nothing like that. I am not even suggesting that. It is good Hon Ken Travers is back in the chamber and listening to this debate. I commend the member.

**Hon Ken Travers**: I always come into the chamber to listen to you, Hon Nigel Hallett.

**Hon NIGEL HALLETT**: I know that because I always make Hon Ken Travers a wiser person at the end of it.

**Hon Ken Travers**: I wouldn't go that far!

**Hon Ed Dermer**: Is that where all that wisdom has been coming from?

**Hon Ken Travers**: No.

**Hon NIGEL HALLETT**: That is right. I would agree with Hon Ed Dermer. It is difficult, but we try.

I acknowledge the diminishing populations in the wheatbelt areas. However, we are talking about cuts in the south west at a time when the south west is acknowledged as one of the fastest growing regions in Australia. Many of the region's smaller hospitals, including Yarloop District Hospital, have been closed and the Pinjarra Murray District Hospital has been downgraded. Patients from these hospitals now go to Mandurah for their health services, taking these services to breaking point. As a result, many patients flow on to the city hospitals and put them under pressure. Areas such as Boyup Brook are under pressure and their hospitals have been downgraded. We have already heard from Hon Paul Llewellyn about what is happening in Busselton and we know that the hospital at Harvey has been downgraded.

Motion lapsed, pursuant to standing orders.