Division 21: WA Health —

Ms M.M. Quirk, Chair.

Ms A. Sanderson, Minister for Health.

Dr S. Bowen, Director General.

Ms A. Kelly, Deputy Director General.

Mr R. Anderson, Assistant Director General.

Dr P. Armstrong, Assistant Director General.

Ms J. South, Assistant Director General.

Dr L. Bennet, Chief Executive, East Metropolitan Health Service.

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

Mr J. Gurr, Chief Executive, North Metropolitan Health Service.

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

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

Dr N. Hadlow, Chief Executive, PathWest.

Ms V. Jovanovic, Chief Executive, Child and Adolescent Health Service.

Ms S. Hearn, Chief of Staff, Minister for Health.

[Witnesses introduced.]

The CHAIR: The estimates committees will be reported by Hansard and the daily proof will be available online as soon as possible within two business days. The chair will allow as many questions as possible. Questions and answers should be short and to the point. Consideration is restricted to items for which a vote of money is proposed in the consolidated account. Questions must relate to a page number, item or amount related to the current division, and members should preface their questions with those details. Some divisions are the responsibility of more than one minister. Ministers shall be examined only in relation to their portfolio responsibilities.

A minister may agree to provide supplementary information to the committee. I will ask the minister to clearly indicate what information they agree to provide and will then allocate a reference number. Supplementary information should be provided to the principal clerk by noon on Friday, 31 May 2024. If a minister suggests that a matter be put on notice, members should use the online questions on notice system to submit their questions.

I give the call to the member for Vasse.

Ms L. METTAM: I refer to page 1 of budget paper No 3, where the overview states —

- another record investment totalling $3.2 billion in health and mental health …

How much of this record investment relates to increased salaries?

Ms A. SANDERSON: The budget itself does not fund salaries as a line item. The breakdown of health service provider allocations for wages or workforce will be in the HSP annual reports, which are tabled each year. That information is provided in that way and not through the overall budget appropriation.

Ms L. METTAM: Is the minister able to outline how much of the $3.2 billion in record funding relates to meeting current demand in our hospitals?

Ms A. SANDERSON: All of the funding goes towards meeting demand for public health services. Whether it is clinical or non-clinical support, it all goes towards meeting the demand of the community. Obviously, there has been a significant increase in the salary component because we put on a huge number of staff between 2020 and 2023 in particular. That saw a large increase in FTE; it has gone up significantly. That increase included 4 000 FTE in nursing staff and 1800 FTE in medical staff. There was also a range of other workforce incentives, including the $12 000 HECS payment for regional nurses and midwives to work in the WA Country Health Service and other non-salary work components, such as flexible rostering and better support for graduates. A whole range of funding supports the workforce outside of salaries as well.

The CHAIR: We are having a bit of difficulty hearing. I know that it is not fashionable to ask people to raise their voices in the chamber, but if members would not mind doing that.

Ms L. METTAM: I have another question that relates to this line item. Can the minister provide a breakdown of the $3.2 billion between metro and regional areas?

Ms A. SANDERSON: That breakdown could be provided in answer to a question on notice. What I can say is that expenditure growth for wages and FTE was 21.4 per cent between 2020 and 2023. That was a huge increase. That accounted for staffing the additional 700 beds in the system, filling FTEs and increasing our staffing profile across the system.

Mr R.S. LOVE: Page 306 of volume 1 of budget paper No 2 contains a list of ongoing initiatives, including a listing of ambulance and patient transport services. The estimated actual is $6.6 million for 2023–24 and then $33.6 million has been allocated for the coming year. There will be $26.688 million next year and then $18 million and $21 million. That seems a large increase in what was a $6 million item in 2023–24. Can the minister explain that funding allocation and why it varies so much, between $6 million and $33 million, in each of the years?

Ms A. SANDERSON: That significant uplift forms part of our emergency access reform package, or the ramping taskforce, if the member likes. Moving patients around the system has an impact on bed flow and bed availability. If people need to move for treatment, particularly from a regional hospital to a metropolitan setting, that will free up the bed there. Obviously, every one of those hospitals is entirely interconnected, despite the fact that they are run by separate HSPs. As part of that, we identified that patient and ambulance transport are key components of ensuring that we have bed availability and improving emergency access. That increase is accounted for by additional funding to St John Ambulance in line with costs and activity growth as part of the new contract that was renegotiated by this government. The St John Ambulance extended care paramedic pilot, which will receive $1.4 million, will essentially provide skilled paramedics with additional advanced training and scope for them to treat non–critically ill patients at the scene, reducing the requirement to transport them to hospital.

It includes $21 million for mental health patient transport, which is for the continuation of the service to provide road-based patient transport, and the non-emergency planned patient transport service for metropolitan Perth and mental health, which addresses some of the cost pressures and increased numbers. The system is seeing more patients and, therefore, more movement is required. It also includes $14.6 million for the Kimberley ambulance service, which is a continuation of that service, and the Country Patient Health Support Service, formerly known as Country Connect, which supports patients who live in regional Western Australia, have come to metropolitan Perth for ongoing treatment, are unable to get back and are essentially sleeping rough or have really unfortunate circumstances. It essentially case manages and supports those patients to go back home. There will be a provisioned uplift for the Royal Flying Doctor Service, but that is under negotiation, so I cannot release that detail just yet.

[2.10 pm]

Mr R.S. LOVE: The minister has a list. Could she table it? It might be convenient for us all.

The CHAIR: We do not table in estimates. You can either ask a question on notice or request supplementary information.

Ms A. SANDERSON: I will not provide supplementary information. All this information has been detailed in government media releases.

Mr R.S. LOVE: The minister mentioned the contractual arrangement that the government is now undertaking, I take it, with St John Ambulance.

Ms A. SANDERSON: Correct.

Mr R.S. LOVE: What is the length of the current contract and what are the timeframes for the new considerations?

Ms A. SANDERSON: It is a five-year contract, with a review at three years.

Mr R.S. LOVE: How far are we into that contract now?

Ms A. SANDERSON: The former contract expired on 31 December 2022. We are just under two years in.

Mr R.S. LOVE: Under that contract, there were some penalty provisions that St John had to meet. Has it paid any penalties under the contract; and, if so, how much?

The CHAIR: That was two questions, by the way, member.

Ms A. SANDERSON: I can tell the Leader of the Opposition that, as of January 2024, the abatements component of the performance regime was fully operational, excluding any recently implemented clinical key performance indicators. What it has paid and whether it has paid I cannot disclose due to contractual arrangements.

Mr R.S. LOVE: In terms of consideration of the next contract, is it a matter of simply contracting with St John or is the government considering using other providers or other methods for sections of the work, if not the whole?

Ms A. SANDERSON: I can speak more generally about the contract with St John Ambulance. There have been two really important events in the last 18 months to two years, and one is a change of leadership at St John

Ambulance, both at a board level and in the organisation, and a new contract. I have to say that the new leadership and the new contract are working exceptionally well. St John Ambulance is working as a great partner with all the health service providers and the Department of Health. It is quite a shift change and we are working to integrate our functioning with the department and with St John Ambulance. The best example of that is the WA virtual emergency department sitting inside the St John Ambulance state operations centre, which is taking the 000 calls. Our vision is that the state operations centre moves to the State Health Operations Centre when that is up and running later this year. It is a great example of the two organisations, formerly very separate, working very well together. That is borne out in its KPIs and in its performance indicators. It is meeting far more of its P1 priority performance indicators. We are working with it to get ambulances back out on the road.

Under the former leadership, St John Ambulance was very, I would have to say, sluggish in its recruitment of paramedics. It was one of the government's frustrations. There were no levers in the contract to ensure recruitment of paramedics. Under the current leadership, it is doing everything it can to ensure that it is rapidly recruiting paramedics to meet demand. The contract and the new leadership are working very, very well. It is a requirement of the contract that, three years in, there is a review about whether the contract remains in house or continues to be contracted out. We are still early days into that contract, but the relationship is strong and the organisation is working well.

Mr R.S. LOVE: The minister mentioned that St John Ambulance is now reaching KPIs more consistently. Are there revised KPIs in the contract going forward? What does the minister see changing in the way that she would see as being a performance measure?

Ms A. SANDERSON: I think the KPI regime is appropriate. There are the publicly reported KPIs that St John reports itself and then there are the contractual KPIs that are working well.

Mr R.S. LOVE: Will the government not release those?

Ms A. SANDERSON: I am unable to release them because of contract requirements.

Mr R.S. LOVE: We had the parliamentary inquiry into ambulance services. Is the minister confident that the problems that were highlighted in that report have been addressed in the intervening period?

Ms A. SANDERSON: Overall, yes, I am confident. We have met a number of the recommendations; for example, we are well on our way with the establishment this year of the State Health Operations Centre and there is the renewed contract. A few need some more work. The St John Ambulance CEO recently met with the Aboriginal Health Council of Western Australia to improve its relationship with our First Nations people and what can be done to help families and that part of our community feel supported by and able to call St John Ambulance. That is a work in progress. Overall, the recommendations are tracking well and we have implemented a number of them. That is borne out in its performance.

[2.20 pm]

Mr R.S. LOVE: We have been referring to the line item "Ambulance and Patient Transport Services". A lot of towns in the area that I represent have volunteer ambulance officers, and a lot of them are becoming very stretched. With the provision of services becoming more concentrated in larger centres and Perth, there is more transport than before. What is being done to address this issue and ensure that country areas like north midlands have adequate patient transfer services? It is apparent from even stalwarts in St John Ambulance that they are finding it hard to cope.

Ms A. SANDERSON: In this budget, the government has approved $14.6 million for the Kimberley Aboriginal ambulance service, which is a continuation of funding. The member will recall that we have also invested over $30 million—it might be more; I will probably have to come back to the member on that—to increase the number of paid paramedics in regional Western Australia, including in Kalgoorlie, Esperance, Margaret River and a whole range of areas down in the south west. That list is public and has been well ventilated.

We work closely with St John Ambulance around demand and its local requirement. I think it is an ongoing and natural tension within St John Ambulance at some of those regional depots that primarily had volunteer paramedics and then got paid paramedics. Essentially, St John is mindful of managing that sensitively to support the volunteers so that they do not feel that they are no longer of use. Many of them have supported the community for decades and are incredibly important to the model in Western Australia. It is about managing that and ensuring that we are maintaining those volunteers as well. A state the size of Western Australia is always going to rely on a mix of volunteers and paid paramedics. However, as we see more acuity in the community and an increase in population, we are going to have to deploy paid paramedics in some of those regional centres. We have done that over the last three or four years.

Ms L. METTAM: I have a further question on the same line item about the contract with St John and a couple of matters that have been raised publicly. What progress is happening with the relationship between St John and the

Western Australia Police Force on the mental health cases that we have been made aware of in the community? There has been some frustration about the interaction between St John Ambulance, paramedics or volunteers, and WA police during those mental health call-outs.

The CHAIR: I am not sure whether this is the right division to ask that. I can probably get guidance from you, minister. Should that maybe be in the next division? We are dealing with health. Member for Moore, did you have a further question?

Mr R.S. LOVE: I think this was a question around the ambulance service, which is what we are discussing.

The CHAIR: Maybe the member for Moore could ask a question and the member for Vasse could rephrase that question so it is clearer.

Mr R.S. LOVE: Okay. I will ask a quick question and the member for Vasse can rephrase hers; how is that?

I go back to patient transport services. Will there be any funding increases for major centres such as Geraldton, Northam, Albany et cetera to ensure that they are less reliant on volunteers? I know there has been some provision. Is that going to ramp up; and, if so, could the minister give me some idea of the amounts?

Ms A. SANDERSON: It is always being watched and monitored by the WA Country Health Service and St John Ambulance. As the member has rightly noted, we have made significant provision for paid paramedics in major regional centres across Western Australia. We continue to monitor demand and the need for that.

Ms L. METTAM: Have any changes been made to the St John contract regarding matters related to the mental health call-outs and issues regarding the response, or lack thereof, from WA police?

Ms A. SANDERSON: There have been no changes made to the St John Ambulance contract about operational matters regarding the police. That is an operational matter for the WA Police Force.

Ms L. METTAM: Regarding the Minister for Health's role and the distress caused in the operations of St John, has she taken steps to intervene in these matters or to raise them with the Minister for Police?

Ms A. SANDERSON: I am trying to understand the member's question. It is very broad.

Ms L. METTAM: It is about mental health call-outs to which police have not responded. This has become very distressing for the people involved in these matters regarding the operation of St John, which is overseen by the Minister for Health. In light of these matters, has the minister taken steps to intervene to ensure that there is a good working relationship between the WA Police Force and St John in responding to these issues?

Ms A. SANDERSON: I can say that there is a good working relationship between St John Ambulance and the WA Police Force. Both are respectful and mindful of each other's resource allocations. They work together every single day and night to determine those priorities and how those resources are allocated. I am confident that they are working well together to do that.

As far as operational decisions for the police, that is a matter for the Minister for Police and the Commissioner of Police. I 100 per cent support St John Ambulance. It does a fantastic job. Our first responders—police, ambulance and the Department of Fire and Emergency Services—deal with some incredibly challenging and difficult circumstances and work well together.

Mr M. HUGHES: I refer the minister to paragraph 32.4 on page 311 of budget paper No 2. It refers to the Murdoch health and knowledge precinct and an allocation of $204 million. Can the minister please provide some detail on what this funding will be used for?

Ms A. SANDERSON: I thank the member for Kalamunda. The budget allocation of $204 million for the Murdoch health and knowledge precinct is for patient and staff parking at the Murdoch site to support the new women's and babies' hospital. As we know, the Queen Elizabeth II Medical Centre site carried an enormous amount of risk. There was a lack of reasonable solutions to increase the parking at QEII without essentially resigning the state to hundreds of millions of dollars of contract breach. This is an allocation for that parking. It will be delivered by the Department of Transport. It includes infrastructure for two car parks at Fiona Stanley Hospital as part of the new women's and babies' hospital. Hospital parking is an issue at every single hospital. I think that if we fixed the parking, people would think that the health system was working perfectly! It is an issue; it is about access. I understand why it is an issue and I understand why people get het-up about it. Fundamentally, it is about access to health care.

The new women's and newborns' hospital will deliver an additional two multi-deck car parks at Fiona Stanley Hospital. That money is provisioned in this budget. The expression of interest for that opened in February and we look forward to awarding the contract in the near future.

[2.30 pm]

Ms L. METTAM: In relation to the Murdoch health and knowledge precinct, where is the business case at for the new women's and babies' hospital?

Ms A. SANDERSON: The project definition plan is complete for the new women's and newborns' hospital, as was required for the expression of interest process. The PDP and business case are complete. That includes the Perth Children's Hospital component of the expanded neonatal cots and the Murdoch and Osborne Park sites. I can confirm that the scope reflects services intended to be included at the Queen Elizabeth II Medical Centre site. The expressions of interest are currently underway and the request for proposal is anticipated to be released in May this year, with the aim of engaging a managing contractor shortly after that. The scope will include an additional ambulatory care clinic, which is a health word for outpatients; additional consultation rooms for allied health, mental health services, breastfeeding and visiting midwifery services; maternal fetal medicine consultation rooms; increased inpatient support facilities for gynaecology and obstetrics; a dedicated perinatal loss room; a neonatal intensive care unit; a neonatology unit; a new family birthing centre at the FSH site; and an increase in perioperative capacity with additional theatres.

There are 1 500 births a year at Osborne Park Hospital and, with the proposed expansion, the site will be capable of supporting more than double that number of births, at more than 3 000. That will include the new standalone six-bed family birth centre; a new and expanded obstetric inpatient unit; further expansion of the neonatal intensive care unit; a dedicated eight-bed mother and baby unit, providing additional mental health support during the perinatal and postnatal period; dedicated obstetrics theatres; additional labour and birth suites and induction rooms; dedicated perinatal loss suites; a new gynaecology inpatient unit; and the establishment of a high-dependency unit for women who require higher acuity patient care that is not able to be provided in a standard ward or environment. Outpatient services will see a significant boost to capacity to support women's health services, such as obstetrics, including the midwifery group practice, and neonatal, gynaecology and allied health services. We will also have to upgrade a number of services, including pharmacy centres and pathology, sterilisation and catering. Broad community consultation and engagement will be undertaken in tandem with the development of the service to determine those delivery models.

As we know, the business case for QEII outlined overwhelming limitations and risks, and it would have been irresponsible to continue with that location, essentially providing unmanageable disruption to services currently on the site and unacceptable timeframes and cost escalations, with at least 32 patient services at Sir Charles Gairdner Hospital being impacted. Although the business case tried to mitigate the risks, none of them was sufficiently balanced to manage the control of those risks, including restricting access to the emergency department at Sir Charles Gairdner Hospital, the central energy plant being unable to support the redevelopment and being unable to ensure safe construction to minimise the impact and operation of helicopter flight paths, with the delivery timeframe of 2034.

Ms L. METTAM: Just to clarify, has the shortlist of preferred proponents been completed following the expressions of interest?

Ms A. SANDERSON: That is a confidential process done by the Department of Finance.

Ms L. METTAM: Is that currently being undertaken? Has that process started?

Ms A. SANDERSON: As I just outlined in my answer, yes, it is.

Ms L. METTAM: When will the tender be awarded?

Ms A. SANDERSON: It is anticipated that it will be awarded this year.

Ms L. METTAM: Is the minister confident that the $1.8 billion committed to the women's and babies' hospital will be within budget between Murdoch hospital, Perth Children's Hospital and Osborne Park Hospital?

Ms A. SANDERSON: The budget allocation reflects the PDP and the business case, so the costs are holding with construction across the two sites. I am as confident as I can be in the current construction environment that those costs will hold, but we have worked exceptionally hard to ensure that it is delivered in the same envelope.

Ms L. METTAM: How much of the $1.8 billion has been allocated to Osborne Park Hospital?

Ms A. SANDERSON: Obviously, the specific allocation is a cost estimate from the department and needs to be worked through the EOI process with the managing contractor, and that would be a commercial matter.

Mr R.S. LOVE: Paragraph 19 on page 309 under "Significant Issues Impacting the Agency" states —

> A sustainable and supported workforce is critical in the delivery of healthcare services. The Government is investing $4.6 million towards the national strategy to ease healthcare shortages by remediating barriers …

What specifically is the government seeking to achieve with that? Is it meant to recognise different levels of experience or professional qualifications from overseas, or is it a pathway to get people registered and through processes quicker? What exactly is that program?

Ms A. SANDERSON: This is Western Australia's share of the implementation cost around the Robyn Kruk review. I am not sure whether the Leader of the Opposition is aware of that review. Essentially, the commonwealth government instigated a review of the pathway for international medical graduates. Largely, it is complex, expensive and overly time-consuming. We are far behind other jurisdictions such as the National Health Service in the UK and Canada, and we do not have a competent pathway essentially for countries like India that export enormous numbers of high-quality health clinicians. This goes to every country where there are recognised competencies. Essentially, this is around implementing a range of reforms that were agreed by national health ministers and then adopted at national cabinet. Every state and territory is contributing to the implementation of those reforms. That is essentially it. It is the implementation of those recommendations, which is on track. The recommendations will ease the shortages of key health professionals, as well as overcome some of the barriers to migration for internationally qualified health practitioners. Those barriers are the complexity of the Australian visa system and requirements relating to professional registration with the Australian Health Practitioner Regulation Agency and the medical colleges.

[2.40 pm]

Mr R.S. LOVE: Is there a timeline for the development of that project, and where is it sitting at the moment?

Ms A. SANDERSON: It is a report published by the commonwealth government with implementation timeframes.

Ms L. METTAM: Going back to the question that was asked about the car park, I refer to page 311 and the line item relating to the $204 million allocation to the Murdoch health and knowledge precinct infrastructure. Is that $204 million part of the $1.8 billion allocated to the women's and babies' hospital?

Ms A. SANDERSON: No, it is not.

Ms L. METTAM: In relation to the proposed women's and babies' hospital, the minister also referred to the high-dependency unit at Osborne Park Hospital. Is that the same as the neonatal unit or is that an additional unit?

Ms A. SANDERSON: The high-dependency unit relates to women.

The CHAIR: The member for Moore with a further question.

Ms L. METTAM: A further question.

The CHAIR: The member for Vasse needs to be quicker because her colleagues are keen to ask questions. They are actively seeking the call. It is not a given that the member for Vasse will get the call. The member needs to be a bit more agile in seeking the call. Further question, member for Vasse.

Ms L. METTAM: Of the $1.8 billion, how much does the minister anticipate will be allocated to Perth Children's Hospital, and can the minister confirm that the satellite facility is still part of the plan?

Ms A. SANDERSON: For the first part of that question, I refer the member for Vasse to my previous answer, which is that those specific allocations will be subject to contract negotiations with the managing contractor. In answer to the second part of the question, the clinicians at Perth Children's Hospital and King Edward Memorial Hospital for Women proposed the satellite facility at Queen Elizabeth II Medical Centre, and that is under active consideration.

Ms M. BEARD: My question is in reference to paragraph 14 on page 309 and relates to regional communities facing unique challenges in accessing medical care. Can the minister advise whether there is a timeline for reinstating birthing services in Carnarvon? When can people expect that service to be in place?

Ms A. SANDERSON: Regional maternity care is a challenge around the nation, as the member knows. Recently, we saw the closure of maternity services at St John of God Bunbury Hospital. The challenge is not in any way unique to Western Australia and the public health system. In fact, the public health system works incredibly hard to maintain those services and keep them open, largely due to the work of the WA Country Health Service and the midwives and GP obstetricians on the ground. They work incredibly hard to support women in their community. It was a difficult decision to scale down birthing services at Carnarvon, but maternity services remain, and women are supported to birth safely in Perth or Geraldton, whatever the town of their choosing. I appreciate that this is not ideal and that they would much rather have the opportunity to birth locally. The primary focus for most women when they give birth is safety and making sure that they have a safe birth, and that is what we are providing them. We have undertaken a review of those services around regional Western Australia, and we are looking at some innovative workforce models, including discussions with the Australian Nursing Federation about a fly-in fly-out model to support some of those communities. Discussions with the ANF are ongoing. It is my ambition to reinstate those services. Can I give the member a timeframe for when that can be done safely? No, not at this time. The priority is to staff them safely.

Ms M. BEARD: Will the fly-in fly-out model be for post and pre-care, not actual births?

Ms A. SANDERSON: Not necessarily. We do pre and ante-care now with a workforce that is situated in Carnarvon. A fly-in fly-out roster model could potentially cover birthing.

Ms M. BEARD: My question is about nursing posts. Is there any provision in the budget for an upgrade of nursing posts—I refer to Yalgoo, Mt Magnet and those sort of posts—given that the Royal Flying Doctor Service report suggested that they are stretched?

Ms A. SANDERSON: There is no new capital provision, but those nursing supports are receiving a lot more support through the virtual command centre, which has access to specialists and specialist services.

Ms M. BEARD: Will nothing be spent on the posts in this budget?

Ms A. SANDERSON: Not in this budget.

Mr R.S. LOVE: Staffing numbers are laid out on pages 315 and 316. There are 22 813 FTEs in public hospital admitted services and 3 698 in public hospital emergency services throughout the state. Earlier we discussed the workforce shortage faced by the department. I note that the number of people who are working in the system during this period is very similar to the budgeted number of FTE for next year; there are 22 521 FTEs working in the hospital system at the moment and the budget for next year is for 22 813. My question is: is the budgeted number what the minister would consider the full workforce requirement for the hospital system or is it what is achievable? In other words, what is the target number of people the minister sees as being required if, for instance, the government is able to provide services in places like Carnarvon et cetera? My question ties into that. What does the minister see as the ideal number of people in the system?

The CHAIR: Minister, I think the basic question is: what is the optimal number of staff members?

Ms A. SANDERSON: That depends on the service. I will start from the last part of the question and work forward. There has been no budget cut or removal of the budget allocation to the Carnarvon service. What is budgeted for is the FTEs. Health service providers undertake a range of workforce planning to determine the appropriate clinical mix and service provided. The optimal mix will depend on any one service and its cohort of patients. Our public health system is enormous; it covers 2.5 million square kilometres and undertakes millions of episodes of care. I cannot give the member an overall optimal service mix because it is tailored to patients and the service. It has increased significantly between 2020 and 2023. We expect that increase to slow slightly because we are filling those roles and have now recruited for those extra beds and services. As I said, the number of nursing positions has increased by 33 per cent, which is a huge increase in nursing positions. The number of medical positions has increased by 41 per cent since 2017; that is nearly double the number of doctors. We are investing in the health workforce. Infrastructure is incredibly important, but it is the workforce that keeps the system going and delivers the care. Ultimately, the mix will change depending on the model of care. The model of care for mental health, for example, is changing; it is less clinical and more recovery based. We might have fewer psychiatric full-time equivalent positions and more social workers, occupational therapists and psychologists. Health is an ever-moving beast, and those models are constantly shifting. We have recruited to staff the extra 700 beds. There continue to be some vacancies, particularly in regional areas. We fill them with agency nursing and we continue to encourage and provide incentives for people to work in regional Western Australia.

[2.50 pm]

Ms L. METTAM: Given the minister is looking at, effectively, providing a fly-in fly-out midwifery service for areas such as Carnarvon, is she rethinking incentives for areas such as that? More needs to be done not only to allocate funds for positions that are not filled, but also to look more aggressively at trying to get the staff needed so that we are not relying on extensive flights to assist women in need.

Ms A. SANDERSON: I think I recall getting a question from the Leader of the Liberal Party, or certainly from the opposition, criticising our use of agency nursing, which essentially ensures continuation of service. We have regional incentives. When we talk to the workforce, we know that it is not only about money; it is about practice. Particularly for the midwifery workforce, it is about practising in the way that they are trained and registered to practise. That is why we are also very focused on providing models of care and maternity care that not only support women at the centre of that care, but also allow midwives to work to their full scope of practice, like in the endorsed midwifery model, for example. That attracts midwives into the system. It is, potentially, why St John of God Bunbury Hospital has struggled to find staff; it runs a model that is a little outdated and it is not the preferred model for women. Women want midwifery-led care and midwives who can work to their full scope of practice.

It is around a range of things. We continue to provide financial incentives, but many midwives would like the opportunity to work regionally for a number of weeks without having to relocate their entire family. Remember that this is a female workforce and 99.9 per cent of nurses who work in midwifery are women and often have children themselves. Many have expressed an interest in being able to spend a few weeks in regional Western Australia

and then come back and do more work in the metropolitan area, and that is what we are exploring with the Australian Nursing Federation.

Ms C.M. TONKIN: I refer to page 305 of budget paper No 2 and in particular to "Implementation of Nurse/Midwife-to-Patient Ratios". Can the minister provide the house with an update on the implementation of ratios, noting that Perth Children's Hospital ED has already been implementing the ratios since July 2023?

Ms A. SANDERSON: I thank the member for Churchlands for the question and I am very happy to provide an update and very proud to be the minister who has committed to overseeing the implementation of nurse-to-patient ratios. It is a historic reform and one for which nurses and midwives have been campaigning for more than 20 years.

This government has a track record of supporting nurses in their workplace. The last big investment in the nursing workforce and workforce management was under Hon Bob Kucera, a former minister, with the introduction of nursing hours per patient day ratios. The member is correct that ratios have been put in place in Perth Children's Hospital emergency department with the transition to the new staffing model in July last year. There are a lot of nurses at the Perth Children's Hospital emergency department and the principle is that there is a nurse allocated to several patients in the PCH ED. That means there is a ratio of one to three in the main emergency department and one to four in the emergency short-stay unit. The ratios do not apply to the shift coordinator, triage nurses and waiting room nurses or the supernumerary resuscitation team. That is because those roles do not provide direct patient care. The ratios are in place and all those roles are on top of that. Supernumerary resus or triage nurses are not included as part of the ratios.

EDs are complex and the number of beds and patients can change rapidly. That has made measuring those comparatively challenging, and it can change. These issues will be worked through with the rollout of the system-wide reporting mechanism. The Perth Children's Hospital ED is meeting the staffing profile for the whole ward, not just the ratioed areas, irrespective of the patients in the ward. It is an incredible achievement for the nursing staff at PCH ED and the management of PCH. I acknowledge the nursing staff who were part of the working group for rolling that out and the constructive role the Australian Nursing Federation played in the rollout. It could not have been successful if it was not for them, and the funding allocated last year provided for consultancy fees to undertake the planning works for the rollout.

Under the terms of the current Australian Nursing Federation agreement, a time-limited WA ratio model taskforce is being established, with the terms of reference for the taskforce under negotiation with the Australian Nursing Federation. Once those terms are settled, the taskforce will oversee the framework implementation in a staged approach.

Ms L. METTAM: Given there is no further funding in the out years, am I right in assuming that none of this funding is for additional nursing staff to meet additional rostering requirements?

Ms A. SANDERSON: There is funding in the out years for staffing. The taskforce will determine a model, which will determine the funding requirement.

Ms L. METTAM: Can the minister provide a breakdown of what the $1.128 million was for?

The CHAIR: Minister, do you want to take that question on notice?

Ms A. SANDERSON: No; I think that is okay, chair. It was for the audit, the consultancy support for the audit, the taskforce and the unit inside the department to support the rollout.

Ms L. METTAM: Is the minister able to provide the Deloitte report that, as I understand it, informed the nurse-to-patient ratios?

Ms A. SANDERSON: The report will be provided to the taskforce once it is established, as per the agreement.

Ms L. METTAM: Will that report be made public?

Ms A. SANDERSON: I am sure someone on the taskforce will attempt to make it public. I expect the member will have a copy in her hot little hand immediately after the meeting.

Mr R.S. LOVE: I would like to talk about the asset investment program on page 322, and there are a number of election commitments there. One of them is the Meekatharra Hospital upgrade—nearly $49 million in total, with $1.5 million this year, $12.8 million next year and $33.3 million the year after that. Can the minister give me an assurance that that hospital upgrade is underway and will be delivered in that timeframe?

Ms A. SANDERSON: We remain committed to delivering upgrades to Meekatharra Hospital. As the member knows, it is an incredibly heated construction environment and Meekatharra is a challenging location to build in, but we are currently evaluating the best ways to deliver that hospital and provide value for money for the taxpayer.

Mr R.S. LOVE: Can the minister explain where the government is in the process now and how far it is from sending out a tender?

Ms A. SANDERSON: I can tell the member that the submission for budget allocation will be progressed in the midyear review.

Ms M. BEARD: To clarify, if that budget submission is going through, does the minister have an expected time for the scope of works to be finalised?

Ms A. SANDERSON: The scope of works has been finalised. I just outlined the incredibly challenging construction environment in remote locations, and we are working out how to deliver that scope of works with the budget allocation. Should we require a further budget allocation, we will come back to the midyear review for that.

Ms M. BEARD: If the scope of works is done, will it go to tender with an end date once the budget allocation is finalised?

Ms A. SANDERSON: Correct.

[3.00 pm]

Ms L. METTAM: I refer to significant issue 2 on page 307 relating to additional nurses. How many additional nurses were added as a result of the minister's India mission to promote WA as a destination of choice for healthcare workers?

Ms A. SANDERSON: The member fundamentally misunderstands the purpose of international trade missions. The purpose was to establish links with Indian universities and training institutions to support the exchange of talent and staff between services. As the member well knows, a large portion of our healthcare workers are of Indian origin. In fact, 70 per cent of our neonatologists are of Indian origin. We could not run our neonatology services without them. The Australian Medical Association quite rightly pointed out in its remarks today or yesterday that there has never been a point at which we have not needed migration for healthcare purposes in Western Australia and Australia. There has never been a point at which we have not needed that. Australia needs to be best positioned in a way similar to how the United Kingdom and Canada are positioned in terms of smoothing and streamlining those processes. The mission was around establishing relationships with high-quality training institutions and understanding how those processes can be streamlined and smoothed so that the best graduates who want to come and work in Australia can do so. This is in line with the Cancer Research UK review that we just talked about with the Leader of the Opposition. It complements the work that the commonwealth is doing to streamline its national processes.

Ms L. METTAM: What are the tangible benefits of this trip? Are there any key performance indicators that the minister has attached in terms of real outcomes?

The CHAIR: I actually thought the minister had answered the question.

Ms A. SANDERSON: I have.

Ms L. METTAM: The minister was unable to answer how many additional nurses resulted from this trip at this point in time. What does she anticipate to be the uplift of health workers as a result of this visit?

Ms A. SANDERSON: I will give the member an example. It was a health skilling mission. It was not just around nurses. There are a couple of specialties in Western Australia—Australia, actually—that have a very limited pipeline coming through. People are not choosing to study the specialties; therefore, we are not producing them. Their training programs are long and we are simply not filling the training places. As an example, two specialties are paediatricians and psychiatrists. Essentially, we rely on international paediatricians and psychiatrists to provide services, to provide assessments for the Child Development Service and to work in our Perth Children's Hospital and our other tertiary hospitals that provide paediatrics. We require the psychiatrists to keep mental health beds open.

We are constantly recruiting internationally. Every health service provider recruits internationally now, rather than recruiting directly from the United Kingdom. What occurs is that they go from India to the United Kingdom, work there for seven to eight years and then go to New Zealand for another couple of years. They are then deemed to come from a competent authority. The aim is to establish a competency pathway between Western Australia and India, where a number of very highly specialised clinicians wish to come and work in our system. In fact, I went to neonatology units in India and met a number of paediatricians and neonatologists who worked and trained in Western Australia and returned there. There is a lot of mutual movement of skills, and it is an important relationship.

Ms L. METTAM: What agreements were signed as a result of the visit?

Ms A. SANDERSON: Part of the delegation was three of the universities in Edith Cowan University, Curtin University and the University of Notre Dame. We also took two large private providers in St John of God Health Care and Ramsay Health Care on the delegation. They are incredibly important and have their own workforce shortages and concerns. This is not just about doing it for public health; it is about ensuring that every part of the health system has the skills required. We also took the chief executive of the Australian Health Practitioner Regulation Agency, which was important from a regulatory point of view. We made a number of connections on behalf of those

organisations—universities, for example—which are entering into their own memorandums of understanding and agreements with other Indian state governments or universities. We are working through that from a WA Health perspective to target where and whom we might want to invite.

Ms L. METTAM: Does the minister anticipate signing any agreements as a result of that?

Ms A. SANDERSON: Yes, I do.

Ms M. BEARD: I refer to page 322 of the *Budget statements* and the election commitment for Tom Price Hospital that we have had lots of conversations about. From the $32 822 000 earmarked for Tom Price Hospital, I want to understand the amount of $77 000 earmarked for 2024–25. It seems particularly small given the scope and size of the project. Can the minister outline what that will be for?

Ms A. SANDERSON: A budget allocation for Tom Price Hospital of, I think, $32 million overall was made in 2021–22. This figure would probably be a small top-up to support continued planning and work on that hospital. As the member knows, we made the commitment at the last election, and then in partnership with Rio Tinto, to deliver new infrastructure in Tom Price. We have worked through the location and scope. We need to deliver a brand new hospital with the existing scope, and we have made that commitment. I am very disappointed with some of the rhetoric around it from the opposition, but particularly the Shire of Ashburton, attacking the services and the scope delivered by Tom Price. I think it is a very questionable use of ratepayers' money to launch a political campaign attacking the service and the scope of the hospital. At no point has the Shire of Ashburton ever raised the services run at Tom Price with me or the staff who run those services. At no point has the member ever raised the services or the scope with me. In fact, this clinical services plan was done in 2016 when the Liberal–National government was in power. It was done under the former government, and we run the same services now as it did then. It relates to the range of those services. The implication that the government can just get a bandaid there is distressing staff. I can assure the member it is distressing the staff, because they work incredibly hard. They run a 24-hour, seven-day-a-week emergency department. There is PathWest, inpatient radiology, child health, general visiting surgery, visiting specialists, dietetics, audiology, occupational therapy, speech pathology and physiotherapy. It is a misleading and political campaign essentially driven by politics. It is not driven by outcomes.

Ms M. BEARD: Further question.

The CHAIR: Can the member just wait until the end of the answer.

Ms A. SANDERSON: The $77 million allocation is nothing compared with the consultancy fees that the Shire of Ashburton has spent. I think around $9 million over the last couple of years has been spent on various consultancy fees. To be criticised for what is an incredibly challenging construction environment, while we continue to focus on delivery of this hospital, is pretty galling.

[3.10 pm]

Ms M. BEARD: The main thing I have raised with the minister is the building, not the services, because they are not something people regularly speak to me about. It is the new building they want. Having said that, there was discussion previously about the fact that Newman cost $61 million and it would potentially be double the cost of Tom Price Hospital in reality. Are there new costings for the Tom Price Hospital's scope of works, given the change in the building landscape?

Ms A. SANDERSON: We are committing to the scope of the existing services so there will be no reduction. Inevitably, yes, there will be a requirement for more funding, but it depends on the solution and we are working with our partners in industry on what that solution is. It may be modular. It may be staging. It may be a range of solutions. We are working with our partners and appropriate procurement processes to, firstly, get value for money for taxpayers and, secondly, ensure that it is done appropriately. However, we are not going to just start throwing money at it. We want to ensure that the infrastructure is upgraded, which is why we made the commitment and we are steadfast in that commitment.

Ms M. BEARD: So I am clear, the scope of works has been done, but has the costing for that scope of works not been done?

Ms A. SANDERSON: No; the costings are done.

Ms M. BEARD: If the costings have been done, are we saying there is still $32 million to do the rebuild?

Ms A. SANDERSON: There is $32 million allocated in the budget. Costings are subject to commercial negotiations, so I cannot release the costings until those negotiations are final.

Ms M. BEARD: The last question for me is: if that is the case, when will this go to tender?

Ms A. SANDERSON: Again, we are working with our industry partners around how we deliver that project.

Ms M. BEARD: So there is no timeline —

The CHAIR: When you said it was your final question, it was actually your penultimate question—right?

Ms M. BEARD: Sorry. Yes; I was just joking. Is there no end date when that might be?

Ms A. SANDERSON: We are very focused on delivering this hospital, which is why we made the commitment in 2021. We are in one of the most challenging construction environments we have ever been in. We continue to work with our industry partners to deliver this hospital—responsibly. We have to ensure that we are also getting the best value for taxpayers, and we want to do that without reducing the scope of the hospital. We are working through all the options around how we do that and do it in a responsible way through proper procurement processes.

Ms M. BEARD: This is my last question: is funding the issue? If the costings have been done, is it the funding that is a large issue?

Ms A. SANDERSON: Member, I have said numerous times that the construction market is the issue.

Ms L. METTAM: Can the minister understand the community's concern, given this was an election commitment? There are construction issues across the state, which we understand, but this is a community —

The CHAIR: Is there a question here, member?

Ms L. METTAM: Yes.

The CHAIR: Good.

Ms L. METTAM: What measures is the minister putting in place to illustrate the same urgency with this hospital project as we are seeing with other projects across the state?

Ms A. SANDERSON: I appreciate the acknowledgement that we are focused on hospital projects across the state, because we are.

Ms L. METTAM: I did not say hospital projects. I said other projects.

Ms A. SANDERSON: We appreciate the acknowledgement.

Ms L. METTAM: I said other projects.

Ms A. SANDERSON: We are absolutely focused on hospital projects across the state. I accept that the local community is frustrated. I am frustrated by the current market environment that we find ourselves in. I think the Minister for Housing is frustrated with the current construction market we find ourselves in. Many of these are a result of a supercharged post-COVID environment, a post-pandemic landscape we are working our way through. Although I accept that the shire is frustrated, I have not had any correspondence from community members. I accept that the shire is frustrated. I accept that there is possibly political ambition within the shire as well. Again, I question whether it is a questionable use of taxpayers' money to be launching a political campaign to build a hospital that we are already committed to building, and upsetting the staff. I know that Hon Peter Foster, MLC, who lives in Tom Price and knows these people, talks to them all the time. People largely understand the constraints and we are working with our partner, Rio Tinto, on delivering this hospital. I accept that the shire is frustrated, but it is also frustrated with the port of Onslow. It is also frustrated with a range of other government entities. We have to ask ourselves—why?

Mr R.S. LOVE: The minister's answer on Tom Price was very similar to the answer on Meekatharra, which will be very similar to the answer I am going to get on Mullewa. Why is it that the communities that are most distant and most in need of facility upgrades seem to be the ones that miss out, yet the minister is pushing ahead with projects in communities that are not at such a disadvantage? Why are these bush communities the ones being left to last?

The CHAIR: I think you have answered that, minister, but you can have another go.

Ms A. SANDERSON: I will, because the question was reasonable and intelligible. I think it is because they are incredibly remote. One of the things that I know the Minister for Finance is working through—this is probably a question for her representative in that session—is how we work innovatively around contracting and procurement of these very remote regional projects. I am limited in what I can talk about because of procurement guidelines, but I can assure those communities that the government is looking at all the ways we can use a more innovative procurement model, rather than procuring individual small hospital projects. On their own, they are probably not that appealing to a large builder. Building a hospital in Laverton is incredibly challenging, as is building a hospital in Mullewa or Tom Price, for example. We are working through innovative procurement models around how we can deliver those hospitals. I accept the view that they are frustrated, and I share their frustration. I, too, want to deliver these hospitals, and we are doing everything we can to ensure that we get value for money and deliver upgrades to those hospitals. In the meantime, we have focused on getting Bunbury and Geraldton up and off the ground. They

are up and running. We have managing contractors in place and they are going. They will have expanded services—a broader range of services—and they will be able to support a number of those communities.

Mr R.S. LOVE: The minister referred to innovative procurement techniques. Is the government considering packaging some of those projects with larger, more lucrative projects so that contractors are delivering something that is a bit more difficult along with one they may find more palatable?

Ms A. SANDERSON: In the interests of not breaching procurement guidelines, I can tell the member that everything is on the table.

Ms M. BEARD: In response to the minister's comment around not hearing from anyone from the Tom Price area, does the minister acknowledge that in those remote and regional communities, the first port of call is the Meekatharra or Tom Price shire? That is where people knock on the door and say, "This is bothering me." Does the minister acknowledge that is where the information is coming from?

Ms A. SANDERSON: I am not sure how that relates to budget estimates, member.

Ms M. BEARD: It was just a comment the minister made before.

Ms A. SANDERSON: It is not a line item in the budget.

The CHAIR: It is almost rhetorical, I think.

Ms A. SANDERSON: It is just silly.

Dr K. STRATTON: I refer to page 322 and to regional hospital development, in particular the Bunbury Regional Hospital redevelopment. Of course we are aware that St John of God made the decision to cease its maternity services in Bunbury. Can the minister please outline what work the state government is undertaking to support the women who have been affected by this cessation?

Ms A. SANDERSON: Thank you, member for Nedlands. Yes, I can provide an update. I can share with the chamber that I was very disappointed to learn that St John of God has confirmed it will be stopping its maternity services in Bunbury. I note that the member for Vasse has been largely silent on it, despite regularly —

Ms L. METTAM: No, I have not.

Ms A. SANDERSON: Maybe I have missed it.

Ms L. METTAM: Yes, you have.

[3.20 pm]

Ms A. SANDERSON: Certainly, it is really disappointing after many decades of supporting that community. I know and accept how important continuity of care is in maternity services. Having a baby is one of the most stressful and, equally, important moments of a woman's life, and having their birth plan disrupted can be incredibly challenging. It also follows the decision to cease maternity services at St John of God Mt Lawley Hospital, which really underscores how challenging it is to deliver safe maternity services globally at the moment with the workforce challenges we have. I am advised by the WA Country Health Service that women who have booked to have their babies at St John of God will be provided personalised information to support them to transition to the public system. That will also include transitioning to Bunbury Regional Hospital with existing obstetrician arrangements to provide continuity of care. As the member would appreciate, most staff work across both sites, so WACHS is working proactively with St John of God to ensure that there will not be any reduction in the service delivery levels and that Bunbury Regional Hospital is ready to transition those services. It is also working to lease 11 beds to ensure that it has the capacity to support women. There will be an overall increase in the public provision of maternity beds at Bunbury Regional Hospital, noting that many may choose to come to Perth and go to St John of God Subiaco Hospital. This will support the capacity of Bunbury Regional Hospital overall while the redevelopment continues, and that will include a doubling of maternity services. The WA Country Health Service will meet with the midwives to discuss what they would like to do in the future, and we would warmly welcome them into the public system. As the member would appreciate, most of them work across both sites, so they will be very familiar with the system.

Mr R.S. LOVE: I am still looking at the projects underway on page 322 of budget paper No 2. I refer to the primary health centres demonstration program, which is the funding stream that funded the Dongara Health Centre redevelopment and is purportedly funding the Mullewa Hospital upgrade. I note that there is $250 000 to be expended this year, $1 million next year and $3.13 million the year after that. Given the fact that there is no project proceeding in Mullewa, is this money being used for some other purpose or not?

Ms A. SANDERSON: I will ask the chief executive of WACHS, Jeff Moffet, to answer that.

Mr J. Moffet: Yes, I can confirm that the primary healthcare demonstration funds have provision for Mullewa and still do, but this expenditure in current years is for completion of minor defects and outstanding items for the previously completed projects in Pingelly, Dongara and Cunderdin. It is very small expenditure each year to complete minor parts of the projects.

Mr R.S. LOVE: All the existing funds under that program will be spent on those other earlier projects in some sort of upgrade or repair, so what does that mean for funding for Mullewa?

Ms A. SANDERSON: There is a budget allocation for Mullewa, but should there be a shortfall, we will go back to the budget for that.

Mr R.S. LOVE: The original budget was $6 million in 2017. There is less than $6 million left now—it looks like there is a bit over $4 million if that money is for Mullewa. How can the hospital possibly be developed in that timeframe? Has the government completely given up on the idea of a brand new centre, and is it looking to renovate the old existing hospital again?

The CHAIR: There are three questions there, but I am sure you can answer them, minister.

Ms A. SANDERSON: We have absolutely not given up on Mullewa Hospital, as the member stated. Should we require further funding, we will go back to the midyear review or budget for the funding.

Mr R.S. LOVE: Can the minister give me a timeframe for Mullewa?

Ms A. SANDERSON: I cannot.

Mr R.S. LOVE: If the minister cannot give me a timeframe for delivery, can she give me a timeframe for when the business case might be developed?

Ms A. SANDERSON: All of that work is being done and is near completed now. The work has continued on Mullewa and the small projects, as I referred to in my previous answer about innovative procurement solutions and procurement models for how we can deliver those smaller projects.

Mr R.S. LOVE: If the business case is being developed, how can the minister not know what the budget requirement will be?

The CHAIR: I am not sure I understand the question, minister.

Ms A. SANDERSON: The question does not make sense.

Mr R.S. LOVE: In the response, the minister said the business case had progressed. If the business case has progressed, how could she not have a figure of what the costs will be?

The CHAIR: I understand it is progressing and has not been finalised. Is that correct, minister?

Ms A. SANDERSON: We understand the costing and costing requirement. As I said, we are working through other procurement models, and when that is finalised, we will have a budget allocation.

Mr R.S. LOVE: The minister says that she has the costing requirements. Does she have the costs of the project now to build what has been planned for Mullewa or not?

Ms A. SANDERSON: There will be a shortfall, as there is with every single hospital and infrastructure development that requires significant cost upgrades. As we work through the contracting process, we will go back for further funding, just as we did with Bunbury, which is now nearly half a billion dollars. We continue to work with any potential contractor and work through the budget process for any additional funding that is required.

Ms L. METTAM: I refer to paragraph 32.8 under "Building World Class Infrastructure" at the bottom of page 311, which refers to $152 million for the redevelopment and expansion of Peel Health Campus. I understand that this commitment for the redevelopment is for next year. Can the minister explain why there has been a delay?

Ms A. SANDERSON: There are a number of things going on at Peel Health Campus that will support the redevelopment, including the transition back to public hands. That will be completed in August, and it will be a fully publicly run hospital. I think 95 per cent of staff have happily agreed to come back and work for the South Metropolitan Health Service and WA Health. The priority at this point has been to transition that hospital. There have been, and continue to be, a number of enabling works that will support the redevelopment, including critical infrastructure upgrades that will commence this year. As the member will understand, much of the site has become run-down, particularly under Health Solutions, and we are spending a significant amount of money to start some of those works, such as for fire safety and the sterilisation department. That work will begin this year with the current budget allocation. When we have finalised the tender process, we will know the final cost, and that will be crystallised in the budget papers for the broader redevelopment. We expect that work will commence this year on the upgrades to those sterilisation department and enabling works. There are also some critical power infrastructure requirements that need to commence, and we continue to work through the final redevelopment footprint. We have already

announced that it will include 63 additional inpatient beds; 20 mental health patient beds, including a 10-bed mental health emergency centre; 12 chemotherapy chairs; a new operating theatre; expanded outpatient facilities; palliative care beds; a reconfigured emergency department; a reconfigured and expanded day procedure unit; and the new build of medical imaging facilities. A complicating factor with the redevelopment is the decision of Ramsay Health Care to relocate offsite. Ramsay will not be part of the new redevelopment but, as it has previously announced, will seek to develop its own facility very, very close to the site.

[3.30 pm]

Ms L. METTAM: Has the business case for the upgrade been completed?

Ms A. SANDERSON: Yes, it has.

Ms L. METTAM: The minister talked about the workers who will transition over to the facility when it is public. Can the minister give an indication of the proportion of workers who will be able to be retained?

Ms A. SANDERSON: It will be 95 per cent.

Ms L. METTAM: How will the public facility interact with the private facility? What I mean by that is whether the private Ramsay Health Care facility will take up some services. More broadly, what will the relationship be like?

Ms A. SANDERSON: That is to be worked through with Ramsay. One important aspect of having the private facility there is that clinicians will be able to work across both private and public. There will be synergies and relationships there. They will not be onsite and integrated in the hospital as they are at Joondalup Health Campus or Midland Health Campus; it will be a standalone, separate facility. There will not be shared services, for example.

Ms L. METTAM: When does the minister anticipate the Peel Health Campus upgrades to be started and completed?

Ms A. SANDERSON: The enabling works for the upgrades will be started this year.

Ms M. BEARD: I refer to the asset investment program on page 321 of budget paper No 2 The line item for the Carnarvon aged and palliative care facility shows a budgeted amount of $100 000 for 2023–24 and then $1.448 million in 2024–25. Is the minister able to advise what those amounts represent or what they are for?

Ms A. SANDERSON: Was the member asking about the $100 000?

Ms M. BEARD: Yes.

Ms A. SANDERSON: I will let the chief executive of the WA Country Health Service answer that.

Mr J. Moffet: Similar to the question on primary healthcare demonstration sites, the $1.448 million is carryover funds from the project. The project was completed fairly recently and is not yet fully finalised and closed. The $100 000 for last year was, again, just for the completion of minor project items and issues in relation to the capital project, which was the construction of the facility itself and the commissioning of the facility.

Ms M. BEARD: When the facility was built, it was for 38 beds. There was scope in the second part for 22 beds, and a vacant block has been set aside for that. Is there provision in that $1.448 million for a business case or pre-works to be done in relation to the additional beds that will be needed?

Ms A. SANDERSON: That is not included in this line item.

Ms M. BEARD: Is work being done on the second stage of the Carnarvon aged-care facility?

Ms A. SANDERSON: We are currently working through delivering Tom Price, Meekatharra, Mullewa and Laverton hospitals and a range of other regional services. We have only just opened that aged-care facility. That fantastic facility has been delivered by this government. A number of communities would love to have that facility.

Ms M. BEARD: I just want clarification that nothing is proposed for that site in the near future—in the next couple of years.

Ms A. SANDERSON: That is not what I said. What I said is that we are prioritising our work, in an extremely challenging construction environment, on Tom Price, as the member has regularly advocated for; on Meekatharra, as the member has regularly advocated for; on Laverton; and on Mullewa.

The CHAIR: In the spirit of this portfolio, I will say that sitting is the new cancer. Please let me know when you want a comfort break, minister. If not, I give the call to the member for Nedlands.

Dr K. STRATTON: I refer to page 306 of budget paper No 2 and the $39 million investment in child development services, which provide free developmental assessments and interventions for kids in Western Australia. Can the minister outline how this government continues to improve the delivery of paediatric and child health services in WA?

Ms A. SANDERSON: I thank the member for Nedlands for her question. Child development services is unique to Western Australia; there is no service like it in the country. It is a service with a low barrier to entry and anyone

can refer. People can self-refer or they can get a GP or school referral. The service offers both assessment and intervention and looks after kids across 2.5 million square kilometres, from Kununurra to Albany. We are committed to addressing the challenges that the service faces, which include referrals to paediatricians going up by 123 per cent and to clinical psychology by 114 per cent; increasing patient complexity; social factors within families; and the requirement for multidisciplinary care to get the best outcomes. CDS is a priority for the government. We have been listening to the Child and Adolescent Health Service, parents and non-government organisations about the difficulties people face in accessing appointments. This investment will fund over 100 medical, nursing and allied health FTE across the metropolitan area and in the country. We will be onboarding the first tranche in July, which is very exciting. There has been some really good recruitment for this service. It will be over two years. The first tranche will be onboarded in July, so we expect to start seeing, from July, an impact on those waitlists and parents and families being able to be seen a little bit quicker than they have been.

The service continues to pilot innovative and more efficient ways of delivering care. It has established a medication clinic for those who continue to need medication management but whose paediatricians have closed their books or are no longer seeing families and children. That involves a clinical nurse specialist working to the top of their scope. We are also holding a combination of planning, assessment and service appointments. Normally, they would be separate appointments, but we are combining them. We are also creating more appointments on weekends, providing flexibility for children and families. On a recent visit to the Joondalup child health service, I met one of the speech therapists who said that Saturday appointments were fantastic because both parents can go, and they have never seen such engagement from dads. An unintended consequence of more flexible appointment arrangements is that parents can be more engaged with the supports that their children are getting. This is a great outcome.

Mr R.S. LOVE: I am looking at the completed works on page 323. One election commitment line item is for the renal dialysis centre in Halls Creek, with an estimated total cost of $920 000. What happened to the original promise, which was for a $24 million facility in Halls Creek, including a lodge? What have the people of Halls Creek been delivered, and will the $24 million renal centre still be delivered?

[3.40 pm]

Ms A. SANDERSON: Yes, it will. The scoping for the redevelopment is complete and we are committed to the project. Again, it is another challenging regional infrastructure project. We are looking at staging the project and working with local Aboriginal medical services to ensure that the model of care is appropriate. We certainly continue to maintain our commitment to that project and will go to the Expenditure Review Committee or midyear review for the funding for that project.

Mr R.S. LOVE: There is no allocation in the budget for that project at the moment?

Ms A. SANDERSON: Not at this moment, but there will be.

Mr R.S. LOVE: Has there ever been an allocation in the budget?

Ms A. SANDERSON: There is an allocation for planning money in the budget. That planning is now complete. We have finished that planning. We are working through the deliverability, working with the local Aboriginal medical service and Kimberley Aboriginal Medical Services as well as the Halls Creek-based Aboriginal medical service on the model of delivery. We will seek a further budget allocation for that.

Mr R.S. LOVE: Why do some projects that are a long way from being delivered have an allocation in the budget, yet an election commitment, which is very much underfunded so far, with $920 000 towards a $24 million commitment, is not shown in the budget?

Ms A. SANDERSON: It is probably a question for Treasury. The allocation of funding and its determination is a matter for Treasury.

Mr R.S. LOVE: The minister does not deny that there is an election commitment. There are headings in the budget for election commitments that are either completed or underway. Presumably, there was one for works that have yet to start. Why is it not mentioned?

Ms A. SANDERSON: A number of budget allocations have been made to election commitments. This is an important commitment and one that we remain committed to. We will seek further funding through the ERC process.

Mr R.S. LOVE: At what point will the minister consider she will be able to come forward with a project to take to the ERC to see whether it can get funding?

Ms A. SANDERSON: We are working to deliver those chairs and revising the project definition plan. Once that is finalised, we will seek the budget allocation so that we can deliver those chairs.

Mr R.S. LOVE: I understand that the four chairs that have been delivered are under the $920 000. That is a different facility and a different standard of dialysis from what the minister is planning to deliver in the future.

Ms A. SANDERSON: Correct. This is a standalone eight-chair facility.

Ms M. BEARD: I refer to page 306 and the patient assisted travel scheme. I see that it is increasing going forward. Will dental services, optical and audiology be included so that regional people can get their dental, audiology and optical treatment and claim for PATS?

Ms A. SANDERSON: The eligibility for PATS has not changed. It remains as it was under the Liberal–National government. The cost increase reflects the increased cost of flights and fuel, and volume of people requiring PATS.

Ms M. BEARD: I just want to confirm that the dental, optical and audiology will not be included at any point in time?

Ms A. SANDERSON: It is not included now and was not included under the Liberal–National government.

Ms M. BEARD: I just want confirmation that it will not be going forward.

The CHAIR: That is the third time you have asked the same question, member.

Ms A. SANDERSON: She is asking the same question over and over.

Ms M. BEARD: So, it will not.

Mr R.S. LOVE: The allocation has increased. Has there been any consideration of an increase to accommodation payments and the very low 16¢ per kilometre for fuel, which people are given if they are using their own car?

Ms A. SANDERSON: This government increased the allocation to accommodation from $60 a night to $100 a night. Under this government we have significantly increased the allocation to accommodation.

Mr R.S. LOVE: I was not asking for a history; I am asking whether the government is considering the allocation of funding to increase the accommodation allowance further and also do something about the 16¢ a kilometre, which it has been at for a very long time. It is probably well short of any meaningful contribution towards travel.

Ms A. SANDERSON: We are always looking at ways to support regional patients to access health care. The best way to support regional patients to access health care is through delivery of health care in their regional area or closer to their regional area. We have not only increased the accommodation allowance from $60 to $100, but also doubled the provision of cancer services in regional Western Australia that people can access. We have redeveloped Newman hospital, we are providing chairs in Karratha, we are providing a redeveloped Bunbury Regional Hospital and we have expanded and redeveloped Geraldton Health Campus. We continue to provide extended services to the community through the provision of care in their community.

Ms L. METTAM: I refer to the line item “Fiona Stanley Hospital—Bridge (Murdoch medihotel)” under “Completed Works” on page 323. This is the only reference to medi-hotels in the budget that I could see. Is this still a priority and when will it be completed?

Ms A. SANDERSON: Yes, it is still a priority and we expect it to be open in the new financial year.

Ms L. METTAM: What services will be provided from the 60 beds?

Ms A. SANDERSON: That is currently being determined through the South Metropolitan Health Service and will be determined through the commissioning.

Ms L. METTAM: Has there been reconsideration of the mix of the 60 beds in light of some of the concerns raised by the South Metropolitan Health Service about what the make-up of those beds will be in light of clinical demand?

Ms A. SANDERSON: The make-up of the beds will be determined by the clinical demand and we are working through the commissioning of that. The South Metropolitan Health Service and WA Health are working through what is required.

Ms L. METTAM: FOI documents indicate that the developer had directed what clinical demand would be as opposed to the South Metropolitan Health Service. Has there been a rethink?

Ms A. SANDERSON: I can assure the member that the health service will determine the clinical scope.

Ms L. METTAM: What will be the ongoing cost to the state of running the medi-hotel facility?

Ms A. SANDERSON: It is to be determined through negotiations.

Mr R.S. LOVE: A matter has been raised from a constituent’s email. Bear with me, I am trying to find when I can ask it. It is to do with continence support. On page 306 there is a heading for “Community Aids and Equipment Program and Continence Subsidy Scheme”. Maybe that might be a good one to do it in. It is to do with the WA Country Health Service. The director might be able to help the minister. I will quote from a letter sent to a person from WACHS. It said that due to a lack of capacity in WACHS, the continence service is no longer able to do assessment for NDIS and high-care packages. Further, it said that if NDIS clients are unable to get to Perth for assessment,

a private commission may be able to travel. Why has the WA Country Health Service withdrawn this service from the Narrogin area? Is it a temporary cessation or something that we will see continue into the future?

[3.50 pm]

Ms A. SANDERSON: I am going to ask the chief executive of WACHS, Jeff Moffet, to answer that.

Mr J. Moffet: The National Disability Insurance Scheme has largely transitioned to the commonwealth government. As a provider, we do not do a significant amount of NDIS work. I am not familiar with the issue. That issue has not come up with me—that specific matter in Narrogin. I am very happy to have a look at that separate to this process if it is referred through the usual channels.

Mr R.S. LOVE: I will give WACHS the email.

Ms M. BEARD: My question is around aged and continuing care services referred to on page 317. I agree with the minister on keeping people in their homes. I understand that the Silver Chain service in regional areas has moved into WACHS. Can the minister give me an overview of the service changes and the delivery?

Ms A. SANDERSON: It is the other way around.

Ms M. BEARD: It is the other way around; sorry.

Ms A. SANDERSON: Does the member mean the nursing posts?

Ms M. BEARD: It is the Silver Chain service's in-home care that gets delivered.

The CHAIR: What was the reference number, member?

Ms M. BEARD: It is on page 317 under "Aged and Continuing Care Services".

Ms A. SANDERSON: I think there are two different issues here. There is the nursing posts' transition to WACHS and then Silver Chain contractors deliver through the North Metropolitan Health Service more centrally for home care. What is the actual question?

Ms M. BEARD: Is there a shortage in the Silver Chain service that is delivered not in the nursing posts, but in towns like Carnarvon?

Ms A. SANDERSON: I think the member would have to ask Silver Chain.

Ms M. BEARD: Does WACHS not have any answer? There is confusion on the ground up there then.

Ms A. SANDERSON: We have not been advised of any particular shortage.

Ms M. BEARD: Has the service delivery improved since it has changed to the nursing posts?

Ms A. SANDERSON: Again, the member is confusing two completely different issues. There is home care and there are nursing posts.

Ms M. BEARD: Is that with Silver Chain, though?

Ms A. SANDERSON: The nursing posts are no longer run through Silver Chain. It has given them up.

Ms M. BEARD: Yes, but are people now getting the service that they were getting through Silver Chain through WACHS?

Ms A. SANDERSON: Correct.

Ms M. BEARD: Home care? Has that seen —

Ms A. SANDERSON: No. Nursing posts do not deliver home care, member.

Ms M. BEARD: All right. It is good to know and understand, because there is a lack of clarity, that is all. There are people who ask me about it.

Mr R.S. LOVE: We are talking about the Silver Chain transition. On page 306 under the line item "Rural and Remote Nursing Posts", the budget has a $3.9 million estimated actual. That is the money for Silver Chain to transition in those 11 centres across the state. There is a finite allocation of that money. Is there a guarantee that service delivery will be at the same level? Will that be carried on into the future? If so, should there not be another allocation into the future?

Ms A. SANDERSON: There is an uplift in funding to support some of the infrastructure and ICT upgrades that are required. They are running off very different systems. Yes, there is a commitment to maintaining that service and, in fact, to providing a better service delivered by the public health system. As the member is aware, Silver Chain ran a number of remote area nursing posts, which it requested to no longer run. They are in Leeman, Eneabba,

Mingenew, Shark Bay, Walpole, Eucla, Lancelin, Beacon, Bencubbin, Hyden and Brookton. They have been critical to those communities. We maintain our commitment to keeping them open.

Essentially, we have achieved that through the $11.5 million staffing allocation in this budget. Some of that has been to support the infrastructure upgrades and to ensure that it meets work health and safety requirements and that it has appropriate IT requirements that link with the WACHS system and the WACHS command centre. Overall, they will be incredibly well supported by the WACHS command centre and then the State Health Operations Centre when it opens later this year. It is another example of the public health system stepping in when the private and non-government organisation sectors could not provide the services.

Ms M. BEARD: That is exactly where I wanted to get to. Are the people in those 11 centres going to get a better level of service and will that include telehealth?

Ms A. SANDERSON: Correct.

Mr R.S. LOVE: I turn back to the projects on page 322. There is to be a $2.5 million spend this year on the Karratha step-up, step-down program, with the remainder spent in the next year. That is another project that has been very delayed and has been the subject of a fair bit of criticism that it has not been delivered. Can the minister update me on that project and its delivery? Will it be on the same land that was virtually gifted to the department, or is another project being considered?

Ms A. SANDERSON: I understand the community's frustrations. This project has taken a long time. As the member would be aware, a site was identified in 2019 by the Mental Health Commission. That site was subject to a campaign from local residents, which was sad and unfortunate because these are really well-run, good facilities that need to be in the community. Unfortunately, the local shire was influenced by that campaign and did not support the location of the site. It has taken too long to find an alternative site. It has certainly been my instruction to the new Mental Health Commissioner to get on with delivering the step-up, step-downs. I think the member will find that the new leadership at the Mental Health Commission will have a renewed focus on delivering these services that have been too long in the pipeline.

We have appointed a service provider for the Karratha step-up, step-down facility: Richmond Wellbeing. It is highly regarded in the area of subacute mental health supports. It undertook a round of community consultation, I think, two or three weeks ago with the deputy Mental Health Commissioner in both South Hedland and Karratha to determine the final site and model of care. Community consultation is ongoing now around what that model of care will look like. These step-up, step-down programs work well. As the member would be well aware, they were a big feature of the former government. A former Minister for Mental Health and Disability Services, Hon Helen Morton, was a big fan. They are complex to deliver and there must be good partnerships in the communities in order to make them work. To do that, we must establish a service that is absolutely appropriate for that community. That is what Richmond Wellbeing and the Mental Health Commission are doing. The community will see more action on the delivery of this step-up, step-down program in the coming months.

[4.00 pm]

Mr R.S. LOVE: Will the project proceed on the site that was, as I understand, sold to the government by the shire? To say that the shire was not supportive is a bit strange. Will it be on that site or will it be on another site?

Ms A. SANDERSON: They continue to consult on the site, given that the original site was campaigned against by local residents. We have got to get it right or it will be delayed even further by a campaign by local residents.

Ms L. METTAM: This has been a long time coming. The funding was allocated under the previous government; that is my understanding. Why are we still consulting on the site?

Ms A. SANDERSON: It is because it is highly contentious to the local communities, as per the campaign against the existing site. It is highly contentious; that is why. We have to get it right. We cannot just plonk it in someone's street. We saw the result of that. The residents did not support the campaign. I hope that when we find a site, the member will be out there barracking for the step-up, step-down program and not trying to score cheap political points.

Meeting suspended from 4.01 to 4.10 pm

[Mr S.J. Price took the chair.]

Ms L. METTAM: I refer to page 305 of budget paper No 2 under "Appropriations, Expenses and Cash Assets" and the total appropriations provided to deliver services. There is a six per cent, or $455.8 million, drop in the funding between 2024–25 and 2025–26. Is the minister able to provide a list or an explanation of what services will be cut or reduced to achieve this reduction?

Ms A. SANDERSON: I can confirm that there will be no reduction in services and no cutting of services. To provide some context for that budget allocation, over the past few years we have seen massive cost increases in delivering health care. We are seeing that in the private and public sectors. It is becoming more and more expensive to deliver health care. We are still yet to understand the post-pandemic landscape of the inflationary costs: What is COVID-19? What is the new landscape? What are the baked-in COVID costs, for example, and what is the new cohort of patients?

We are managing a range of inflationary pressures, and they have been funded in this budget. There are additional accreditation standards. Patients are more complex. They are of higher acuity. The length of stay is an additional 0.4 bed days compared with pre-COVID times. That is the same in every single state. We have an ageing population and face the cost of delivering regional healthcare services in the largest geographical region in the world. With COVID, there has been a huge inflation in the cost of delivering services. We are now coming off that peak. Rather than baking in all those additional costs for generations to come, we are working through exactly what are those baseline service costs and how they will need to keep pace with demand over the years, separating out those COVID costs.

The other important milestone this year is the finalisation of the national health reform agreement, which is currently underway. We are in negotiations with the commonwealth and that will be reflected once those negotiations are finalised. It is my view, and the view of every other state health minister, that the commonwealth needs to come to the party with more hospital funding, but also support the co-commissioning of services, such as subacute care for older patients who are too unwell for aged care but not unwell enough to be in hospital. We are working through a number of those issues with the commonwealth.

The other programs that are pushing up costs, if you like, or leading to that increase in funding are a number of time-limited programs we have in place that we are evaluating. The WA Virtual Emergency Department program, the State Health Operations Centre and a range of programs will be evaluated at various points in time. We do not just bake it into the budget. It has to be evaluated and if it is providing good patient outcomes and good value for the taxpayer, it will be continued. That explains it. There will be no reduction in services and there will be no cutting of services.

Ms L. METTAM: The Auditor General was quite critical last year of the lack of reporting around patients who stay a long time in hospital and the extended care of patients and highlighted the challenges of moving patients who perhaps should be in aged-care facilities. Has the modelling the Auditor General pointed to been undertaken?

[4.10 pm]

Ms A. SANDERSON: A range of modelling occurs for what we expect in clinical demand. The Western Australian government is at the forefront of a range of long-stay reforms and is ahead of any other state and territory. It is a shame that the Auditor General did not compare what Western Australia is doing with what is being done in other states. Western Australia is doing outstanding work in getting its older patients out of hospitals. We are investing $1 billion over 10 years in the transition care program. No other state is investing that amount of money. That money will support not only the aged-care sector, but also older patients. We support a strong number of respite beds for patients. The reality is that those patients should not be in hospital; it is not the best place for them. It is challenging for families to make the decision to put a relative in residential aged care. Often, they want their family member to stay in hospital while they make that decision, despite the fact that that is not always the best thing for their relative. We also have a regular forum with aged-care providers; their beds are full right now. We are also seeing a higher acuity of patients and higher numbers of dementia patients, who obviously need particular support in residential aged care. We continue to work with them to provide that, but there are limits to what the state can do if the beds are not available in residential aged care. One of the areas of reform that will be really important for our system moving forward is subacute aged care—supporting older adults who can be discharged from hospital but who need more nursing support than is provided in residential aged care. That area could be co-commissioned under the new funding reform agreement. It is an area that I am pushing very strongly with the commonwealth.

Ms L. METTAM: This also relates to a different line item on page 307, paragraph 8.1, under “Significant Issues Impacting the Agency”. An additional $10.2 million will enable transitional or temporary respite care in the community or aged care facilities. How many aged persons have been transferred under this program to date?

Ms A. SANDERSON: That is a question on notice because it is a question that requires data. I encourage the member to put it on notice and we will provide that data.

Ms L. METTAM: Can that information be provided by way of supplementary information if it is just for the last 12 months?

Ms A. SANDERSON: I will not be providing supplementary information, but in the interests of feeling generous, since June 2023, more than 240 people have been discharged through the residential respite pilot alone.

Ms L. METTAM: Is that since the beginning of the program—the first 12 months?

Ms A. SANDERSON: Since June 2023.

Ms L. METTAM: Is that an uplift in the number of patients?

Ms A. SANDERSON: We are seeing an overall uplift in the number of people who are being discharged through the residential pilot long-stay patient fund and the disability transition care pilot. There are three streams of funding for people with long-term disability who cannot get a National Disability Insurance Scheme plan. There are three facilities. One is run by Hall & Prior Aged Care in South Perth. There is one in Menora and there is one in Bunbury, which is run by Activ. It is largely for people with long-term psychosocial disability. It supports them while they get their National Disability Insurance Scheme funding. We have residential respite, which is a top-up. The commonwealth provides respite care, but it is not enough for it be viable for aged-care providers. We have worked with the commonwealth to enable the state to top it up and provide more funding and incentives for aged-care providers to take respite patients. The long-stay patient fund supports them into aged-care facilities. The numbers bounce around. They are largely going up with the patients being discharged into those pilot programs, but it will also depend on demand and staff availability in any one month.

[4.20 pm]

Ms L. METTAM: The minister is referring to it as a pilot program. When will it become a permanent program?

Ms A. SANDERSON: We continue to evaluate. We continue to evaluate both the disability transition care and the residential respite. It has a budget allocation. It is a well-supported program and it is very successful.

Ms L. METTAM: But it is still a pilot.

Ms A. SANDERSON: The funding is in the budget.

Ms L. METTAM: What is the rate of readmission to hospital for these patients or aged persons?

Ms A. SANDERSON: That is not data I can provide in this forum.

Ms L. METTAM: Is this measure a matter of shifting financial responsibility for these aged-care patients from the state to the commonwealth? Does that happen?

Ms A. SANDERSON: It is the other way around. This is the state taking up the commonwealth's responsibility.

Ms L. METTAM: But is the government not then shifting it to the commonwealth by shifting them —

Ms A. SANDERSON: No, because we pay for it. That is what the budget allocation is for. We are paying for it. The commonwealth is not paying for the beds. The state is paying for the beds when the commonwealth should be paying for the beds.

Ms L. METTAM: Once these individuals are in aged care, at what point does the commonwealth stump up?

Ms A. SANDERSON: Once they have their aged care assessment team assessment and an approved plan.

Ms L. METTAM: Further question.

The CHAIR: No. Member for Moore.

Mr R.S. LOVE: I am happy for the Leader of the Liberal Party to continue.

The CHAIR: Member for Vasse.

Ms L. METTAM: What proportion of those state patients who are shifted into commonwealth facilities are then transitioned to the ACAT?

Ms A. SANDERSON: Almost all of them.

Ms L. METTAM: So it is shifting the cost. I am not being critical of it. But those patients —

Ms A. SANDERSON: To the state.

Ms L. METTAM: The state and then ultimately to the commonwealth.

Ms A. SANDERSON: It is its jurisdiction. If someone has an approved ACAT assessment —

Ms L. METTAM: I am not disagreeing with the minister.

Ms A. SANDERSON: — the commonwealth should pay for it. What is the criticism here?

Ms L. METTAM: I am not criticising. The minister is getting upset about it. But quite clearly, this is a transition of patients from a state facility to a federal or commonwealth facility.

Ms A. SANDERSON: Because they are fit for discharge, they are discharged into more appropriate facilities, and it has freed up 13 000 bed days for other people to come into the system.

Ms L. METTAM: Sure. I am just underlining the fact that when they are in the new facility, when they are transferred, when they are discharged, the commonwealth will then take up and fund that place.

Ms A. SANDERSON: Correct. That is the way the funding —

Ms L. METTAM: Why did the minister disagree to start with?

Ms A. SANDERSON: Oh, my goodness; the level of questioning is insulting.

Mr R.S. LOVE: Once again at page 322, towards the top is the line item "Critical Staff Accommodation Upgrade Program" with an estimated total cost of $20 857 000 and just over $10 million to be spent this year. On page 309, the "Significant Issues Impacting the Agency" explanation says —

> $7.7 million to continue the WA Country Health Service Critical Staff Accommodation Program …

Is that a fresh allocation of $7.7 million? That is the first question.

Ms A. SANDERSON: Yes, it is.

Mr R.S. LOVE: Thank you. Will all that money be spent in the WA Country Health Service regions purview?

Ms A. SANDERSON: Correct.

Mr R.S. LOVE: How was the amount of $7.7 million calculated? What was the driver for that figure to be arrived at?

Ms A. SANDERSON: It was developed around what was deliverable to address immediate safety risks, deliver on committed programs, launch the marketing investment campaign and improve the processes and resources to manage and oversight staff accommodation. It will provide essential refurbishment upgrades and new housing assets to address some of the accommodation issues for regional and remote WA. WACHS continues to explore modular transportable options to upgrade accommodation stock and seeks to invest in regions with the most critical need, including the Kimberley, Pilbara and goldfields regions. It is a range of deliverables, including new buildings and refits.

Mr R.S. LOVE: Is it possible to have a breakdown by region of the program that is now going to be put forward?

Ms A. SANDERSON: I cannot give the member a financial allocation of the new builds. Some of those refurbishments will be prioritised over the next two years, but the key outcomes to date include the purchase of two-bedroom units in Kununurra, the purchase of a four-bedroom property in Gnowangerup—I apologise to the people of Gnowangerup for massacring the pronunciation. Please accept my apologies.

Mr R.S. LOVE: I did not even recognise the name of the town!

Ms A. SANDERSON: Gnowangerup—got it! There is also the refurbishment of three dwellings in Onslow, construction of two demountables in Laverton and the construction of six demountables in Halls Creek, which is completed, with services onsite installation due for completion in May.

Mr R.S. LOVE: Will any of that money be used to reopen the Collie nurses' quarters?

Ms A. SANDERSON: No.

Mr R.S. LOVE: I think it was allocated money in another program, but it does not seem to have happened.

Ms A. SANDERSON: No, that building is not fit for purpose. We are looking at what solutions are required for Collie. We are aware that it requires staff accommodation.

Mr R.S. LOVE: What is the current situation with WACHS staff who are being housed in short-stay accommodation and hotels and the like? Is that practice widespread throughout the regions, noting that I think in November last year we were told that 66 staff were staying in accommodation units for about $377 000 a month?

Ms A. SANDERSON: It occurs from time to time and across the regions as required. Providing accommodation for staff is essential to providing healthcare facilities. Obviously, we want to reduce our reliance on short-stay accommodation and the residential rental market because that takes up those residential homes for local community members. That is why we are investing in new builds and refurbs, to ensure that we get staff into more permanent accommodation.

Mr R.S. LOVE: Do we know whether any of the built units and houses in WACHS's current housing stock are vacant; and, if so, are they vacant for lack of maintenance or are they vacant because the government has been unable to find staff for a particular area?

Ms A. SANDERSON: It would vary from time to time. It would change over time. Largely, they would be vacant because they are prioritised for maintenance and WACHS would be, essentially, in the process of getting contractors to resolve the issues with that property.

Mr R.S. LOVE: Can the minister give me an understanding of what projects there might be in the Kimberley under this program? The minister mentioned the goldfields, I think, Pilbara, and one other, but I do not think the Kimberley was in there. Was there any allocation for the Kimberley; and, if so, how much?

[4.30 pm]

Ms A. SANDERSON: We have already opened two-bed units in Kununurra, and six demountable dwellings are due to open in Halls Creek this month. Those other refits and refurbishments will be prioritised as required.

Dr K. STRATTON: I return to page 311, paragraph 32.1, about the proposed women's and babies' hospital. Is the minister aware of any research or evidence that does not align with the views expressed in the paper penned by the Child and Adolescent Health Service's co-directors, which was developed in response to the decision by the WA government to change the location of the proposed women's and babies' hospital from the Queen Elizabeth II Medical Centre in Nedlands to the Murdoch site?

Ms A. SANDERSON: I thank the member for her question and support of the government's decision to relocate that hospital. I know that a number of local residents were very concerned about the disruption that ongoing construction would inflict on local streets. As we know, the QEII site carried a range of risks to patient, staff and visitor safety. There would have been parking constraints, an impact on clinical services, and disruption for many years. The new plan will provide better access for women and babies from regional Western Australia travelling by the Royal Flying Doctor Service, and more options for maternity care in the eastern suburbs. Issues raised by the Child and Adolescent Health Service's clinical staff association, and other staff across the sector, were of course carefully considered. Feedback from clinicians and staff is a key component of planning any major health project, and is vital to one as complex as the proposed women's and babies' hospital. I have said many times that no amount of consultation will change the decision, or the reality that if we cannot build the building, there will not be a service. We are constrained by infrastructure limitations. That said, it is critical that we deliver a major project that can provide excellent care, and with the proposed women's and babies' hospital, we will do that. The input of clinicians is critical to that.

However, not all clinicians have the same views. As the Minister for Health, I know that more than anyone. The Leader of the Liberal Party continues to claim that the CAHS clinician report is the government's own report, but it is not. I want to be clear about the status of that report so that the Leader of the Liberal Party and members of the opposition fully understand the status of that report. Although it has the CAHS branding, it is not an endorsed report of CAHS. It is not endorsed by the chief executive or the board, and it is not a consensus report of CAHS' executive leadership. There is no version control in the report and it lacks references to scientific literature. It has therefore never been adopted as CAHS' formal position. It is the view of those clinicians—I accept that it is their very strong view—but it did not go through the formal processes. Formal processes of a government or any organisation have to be endorsed for it to be the actual views. The views expressed in the document are their strong view, and I respect it, but there are a range of other views from other clinicians.

One of those views is from a senior clinical professor of neonatology, who is one of our leaders in neonatal research, and a senior neonatologist in Western Australia. He does not want his name used at this point, but may well do in the future. He undertook a comprehensive review of the evidence of the risk of death and disability if critically ill neonates needing urgent surgery are transferred. This was undertaken over a number of months using robust methodology and the Newborn Emergency Transport Service data. In his view, based on published expert research, best available evidence does not support an unacceptable risk. An overwhelming majority of studies do not report any significant relation between transport and increased risk of death in critically ill babies needing emergency surgery. That is based on 38 studies, including more than 42 000 neonates with various surgical conditions. I am happy to release the study in due course. I will table his overview of the studies with his name redacted, or I will provide it as supplementary information. I can also provide the committee with the specific studies that he refers to.

For example, I quote an article by Saritha Paul and Steven Resnick, titled "Long-distance transport of neonates with transposition of the great arteries for the arterial switch operation: A 26-year Western Australian experience". Published in 2015, it reviewed 80 critical babies with a complex heart defect called transposition of the great arteries. It states —

> … long-distance transport of neonates with TGA can be safely undertaken, with no evidence of increased transport mortality/major morbidity or high early surgical mortality.

I am happy to provide the member for Vasse with that study too. It was published in the *Journal of Paediatrics and Child Health* and I am happy to provide the citation. NETS WA has presented data at conferences demonstrating that infants with complex heart defects like hypoplastic aortic arch and transposition of the greater arteries are

safely transferred from Perth to Melbourne with near-zero patient mortality. We also must not forget that ambulances with critically ill patients do not sit on the freeway in peak hour traffic; we have an emergency lane. The transport is undertaken by the Newborn Emergency Transport Service, a mobile intensive care unit. To assert that NETS cannot transport neonates along a freeway is disrespectful to the work of this specialised team of doctors and nurses who are solely dedicated to providing neonatal intensive care during transportation, including over 2 500 kilometres.

Clinicians at Fiona Stanley Hospital, and some from King Edward Memorial Hospital for Women, are incredibly saddened by the rhetoric of unacceptable increased risk of death and disability over transport of surgical babies, and that it continues without any robust data. The evidence in its totality—I will happily provide this to the Leader of the Liberal Party—and the available expertise provides reassurance that transporting critically ill neonates from the proposed women's and babies' hospital to the Murdoch campus for urgent surgery is safe and unlikely to increase the risk of mortality.

The CHAIR: Just before the member asks a further question, the minister made the offer of providing some supplementary information. Is that something that the member for Vasse would like?

Ms L. METTAM: Yes.

The CHAIR: Was there a number of them or was it all the same thing being referred to?

Ms A. SANDERSON: It is one thing.

The CHAIR: What was that thing?

Ms A. SANDERSON: It is the overview of research of transporting neonates with critical surgical conditions to different hospital locations.

[*Supplementary Information No A4.*]

Ms L. METTAM: Can I confirm that one anonymous clinician has raised this counterview to the risks described by over 200 clinicians from CAHS and Perth Children's Hospital?

Ms A. SANDERSON: This person is highly regarded and well known in the sector, and has in fact taught a number of the clinicians who work in the sector now. No, it is not one individual. It includes Fiona Stanley clinicians and other clinicians at King Edward Memorial Hospital who hold significant concerns about those claims continuing to be made without any robust data behind them. I also make the point that I am not sure where the Leader of the Liberal Party gets the figure of 200 clinicians from. There were eight clinicians who authored the report, which had almost no scientific references and was not a formal CAHS report. It was eight clinicians.

Ms L. METTAM: Did this anonymous clinician inform the minister's decision to change the location, or was that decision made behind closed doors?

Ms A. SANDERSON: The decision was made and it was very transparent, because we published the business case. I have outlined the reasons for that decision. It is the disruption of 32 services existing at Sir Charles Gairdner Hospital. It is the relocation of those services, the sensitive equipment, access to the emergency department at Sir Charles Gairdner Hospital, and the continuation of elective surgery at that hospital. It is the continuation of access to the emergency department at Perth Children's Hospital. It is the continuation of access to outpatient appointments at Perth Children's Hospital. It is consideration of the 14 000 people who come in and out of that campus every single day. It is consideration of the staff who would have to use a shuttle bus for 10 years to get to their parking. It is consideration of the local residents. It is consideration of the women of Western Australia who cannot wait 20 years for a new hospital. It is consideration of the women with gynaecological and oncological requirements. It is consideration of the midwives and the staff who deserve a brand new hospital.

[4.40 pm]

Ms L. METTAM: Does the minister not acknowledge in her own business case that the women's and babies' hospital would be constructed within 10 years, not the 20 years she is claiming?

Ms A. SANDERSON: The Infrastructure Western Australia report outlined that 10 years was highly ambitious. The other construction requirements to support the hospital, such as the car park and the road network around it, could cause disruption for up to 20 years.

Ms L. METTAM: As is well understood, there are considerable transport issues and restraints at the Fiona Stanley Hospital site as well.

Ms A. SANDERSON: There is absolutely no comparison of the two sites in terms of deliverability. I might ask the director general to say a few words on this, as Dr Bowen was the chief executive of the North Metropolitan Health Service and head of the women's and newborns' service. She was part of making this decision.

Dr S. Bowen: Thank you. As members know, I was previously the north metro chief executive. As the business case work became evident to us, we realised that we would be significantly disrupting Sir Charles Gairdner Hospital. As the minister has already mentioned, there was significant risk to the delivery of critical services, in particular the theatre block and the intensive care unit, which would both be significantly disrupted by this build. The respiratory department, which had a number of immunosuppressed patients, would be exposed to a building site for a very long time. Access to the emergency departments would be limited for both Sir Charles Gairdner Hospital and Perth Children's Hospital. We recognised that from a patient, service and business continuity perspective, the vibration, disruption and dust—all those things—represented a really critical risk for Sir Charles Gairdner Hospital for a long time. As an executive team, we all pondered how we would be able to manage that service during that period. We delivered the message to the minister that, should it continue to be built in its current form, we had deep concerns about how we would deliver those services to the people who need Sir Charles Gairdner. That was in addition to concerns for our staff and the disruption in accessibility and parking and the daily disruption to their work. Having lived through a couple of hospital redevelopments, with the vibration and noise and very significant disruption to daily workflow, I recognised that our nurses probably would have voted with their feet. They would have been unable to tolerate that for the years to come. That is why it is very different from building on a greenfield site. Every day, people would not be exposed to noise and disruption all around them all the time. Of course, the patients would have been exposed to the same disruptions as well. Those two big reasons were of concern. The third part was time. I know many members have already been to the King Edward Memorial Hospital for Women site. It is now such an old site. It is not a place where we can easily deliver contemporary care. It cannot go on for too much longer in terms of its critical infrastructure and fire safety, which we constantly attempt to remedy, and the many other things we cannot service there. We were looking to deliver a building over a 15-year timeframe; it is 10 to 20 years, but 15 years on average. We needed something we could deliver within seven to eight years to mitigate the risk for King Edward's. So, yes, I was part of that decision.

Ms L. METTAM: Through the minister, as the head of the relevant health service provider at that time, was a recommendation made by the department for that decision? Was it aware?

Ms A. SANDERSON: There was enormous alarm and concern from the executive. To have the chief executive of the largest HSP and the board chair, who was intimately involved with the development of this business case, say there would be unmitigated risks to both the staff and the patients at this hospital with this build, that cannot be ignored. The department worked closely with the North Metropolitan Health Service and then made a recommendation around an alternative site.

Ms L. METTAM: Can the minister confirm the age of the report she is tabling?

Ms A. SANDERSON: The report was sent to the Child and Adolescent Health Service chief executive and the now director general in November last year.

Ms L. METTAM: I mean the research report.

Ms A. SANDERSON: Yes, in November last year. It is contemporary and in response to the CAHS report.

Mr R.S. LOVE: I refer to the Geraldton radiation oncology unit listed under new works on page 324. I see that $9 million sits in the budget, way out in the out years, with perhaps with no plan really to deliver the Geraldton radiation oncology unit. Could the minister give me an idea of the status of that project and its funding arrangements?

Ms A. SANDERSON: The former federal coalition government—I think Liberal member Melissa Price—made half a commitment to an oncology unit at Geraldton. That represents the $9 million. It did not provide funding for the full cost of the oncology unit and it remains half a commitment from the commonwealth. We continue to work with the commonwealth to enable it to make a full commitment so it can be accommodated in the redeveloped Geraldton Health Campus.

Mr R.S. LOVE: Is there no intention from the state government to contribute its own funds towards providing the people of the midwest with this radiation oncology unit?

Ms A. SANDERSON: The state government provides an enormous amount of regionally based oncology units and radiation oncology units. I would not say there is no intent, but the commonwealth needs to make an appropriate commitment.

Mr R.S. LOVE: Referring to the completed works, the Albany radiation oncology unit was completed with what funding from the commonwealth?

Ms A. SANDERSON: Sorry, I missed the last part.

Mr R.S. LOVE: What was the federal–state funding commitment for that project? It is in the budget papers as well.

Ms A. SANDERSON: I do not have that information to hand.

Mr R.S. LOVE: Does the minister not know for sure whether the Albany radiation oncology unit was fully funded by the federal government?

Ms A. SANDERSON: It was a state allocation. It was not fully funded by the commonwealth government.

Mr R.S. LOVE: I have a further question.

Ms A. SANDERSON: I am not sure it had any commitment from the commonwealth government.

Mr R.S. LOVE: I have a further question.

Ms A. SANDERSON: I know where the member is going. The point is that Geraldton Health Campus is under redevelopment and there is still the option that there will be a radiation oncology unit. I am not saying that in the future that will not be an option, but for the commonwealth to make half a commitment was a pretty poor commitment to the people of Geraldton. If Melissa Price was genuine in her commitment to the people of Geraldton, she would have provided the funding for the entire service. Instead it was for half a service.

Mr R.S. LOVE: Why does the state government feel it is appropriate for the people of Albany to have a state government–funded oncology unit but not for the people of the midwest to have a contribution from the state government towards their oncology unit?

Ms A. SANDERSON: I am not going to engage in the member's divisive politics and pit one community against another. This government is committing significant capital to redeveloping Geraldton Health Campus, which will provide an enormously expanded health campus, including an ICU, a mental health unit and expanded emergency departments. I am certainly not going to engage in the member pitting one community against another.

Mr R.S. LOVE: The minister mentioned the Geraldton hospital redevelopment, which is the most delayed project within the purview of the many projects that the Auditor General examined. We know it has been a terribly long time coming. Will the radiation oncology unit be included in the redeveloped Geraldton hospital?

[4.50 pm]

Ms A. SANDERSON: It is a live option and we continue to negotiate with the commonwealth.

Mr R.S. LOVE: Therefore, the state government is not willing to include radiation oncology in the upgrade of the Geraldton hospital at this stage, using that $9 million as part of the funds for that development; is that what I am hearing?

Ms A. SANDERSON: No. What the member is hearing is that the inclusion of radiation oncology is a live option in the redevelopment and we continue to negotiate with the commonwealth.

Mr R.S. LOVE: Why is it necessary for the commonwealth to fund the oncology unit in Geraldton but not the one in Albany when this government has a considerable budget surplus?

Ms A. SANDERSON: The state government has allocated $166 million to Geraldton Health Campus.

Mr R.S. LOVE: And no radiation oncology unit.

Ms A. SANDERSON: We have allocated $166 million. I think that Geraldton and Western Australia should get a fair share from the commonwealth government, and I will fight to make sure they do get a fair share. It is this government that is redeveloping that health campus, and we are providing $166 million to do so.

Mr R.S. LOVE: And no radiation oncology unit. I have no further questions.

Ms A. SANDERSON: I will take that as a statement.

Ms L. METTAM: I refer to paragraph 32.1 on page 311 of the *Budget statements*, and the $1.8 billion for the establishment of the new women's and babies' hospital. I note the minister's comments about the number of clinicians who have raised concerns. The letter from the Australian Medical Association was signed by about 150 clinicians, and in the same week that the Child and Adolescent Health Service draft report was released, a letter was received from clinicians at King Edward Memorial Hospital for Women. Why is the minister playing down the level of concern about the risk associated with this move from some of our most specialist clinicians in this state?

The CHAIR: Minister, that is not really a budget-related question.

Ms L. METTAM: I am sure she can answer it.

The CHAIR: Minister, you can respond how you see fit.

Ms A. SANDERSON: The member needs to refer to the report as it is and stop referring to it as a state government report because it is not. It was a draft report that was leaked to the media.

Ms L. METTAM: Of government clinicians.

Ms A. SANDERSON: That is what that was. It is the government's, the executive's and the minister's role to take into consideration all the views of clinicians. Some clinicians at the Nedlands site have a strong view; the clinicians at Fiona Stanley Hospital also have a strong view that is different from their view. The clinicians at Joondalup, Midland and those who work across the state have different views. I am not playing down anyone's views; I am considering all the views. That is what the consultation process did. The consultation was undertaken by Joel Gurr, who is here today as acting chief executive of North Metropolitan Health Service. The consultation process took into consideration everybody's views. I do not play down or dismiss anyone's views. Everyone is entitled to their view, and whatever their view, I accept that they are advocates for their patients, and that is where their advocacy comes from. Their advocacy is important, and that is what makes them amazing doctors. But there are certainly different views amongst clinicians in this group, and it is our responsibility to understand everyone's views, not just those of one group of clinicians.

Ms L. METTAM: I refer to paragraph 12.1 on page 308 of the *Budget statements*, which states —

> the delivery of an estimated 838,000 inpatient episodes of care, 1.13 million ED attendances and 3 million outpatient service events in the 2024–25 financial year;

Does this investment in additional episodes of care simply meet the current levels of demand?

Ms A. SANDERSON: I am confused about the question. The paragraph refers to delivery but the question was about investment.

The CHAIR: Maybe repeat the question, member for Vasse.

Ms L. METTAM: Is the investment in the budget associated with this paragraph just about meeting current levels of demand?

Ms A. SANDERSON: It is our responsibility to meet levels of demand, and that is what this does.

Ms L. METTAM: I know what the government's responsibility is; I am just asking the question.

Ms A. SANDERSON: Try to make it make sense.

Ms L. METTAM: Is this just about meeting the current levels of demand?

Ms A. SANDERSON: This is about meeting the requirements of the public health system for this year to deliver those episodes of care. That is an incredible number of episodes of care.

Ms L. METTAM: Does it include any scope for future growth over the forward estimates or does it simply maintain the status quo?

Ms A. SANDERSON: It is a significant uplift in core services. The member is talking about one year, she is not talking about out years.

Ms L. METTAM: Is it an uplift from the current levels of demand?

Ms A. SANDERSON: Yes, there is uplift.

Ms L. METTAM: So it is more than meeting the current levels of demand?

Ms A. SANDERSON: Demand increases every year.

Ms L. METTAM: My original question was: Is this about meeting the current levels of demand? Is the minister now saying that this is meeting the current levels of demand plus an uplift?

Ms A. SANDERSON: As demand increases, the funding increases to meet the demand.

Ms L. METTAM: I go back to our original question about the appropriations for service delivery. There has been a drop of about $448 million.

Ms A. SANDERSON: What is the line item?

The CHAIR: Member for Vasse, while you look for that, it is —

Ms L. METTAM: The line item is on page 305.

The CHAIR: No, member for Vasse, that is not a further question, that is a new question, so I will put you on the list and go to the member for Moore, who was before you for the next question.

Mr R.S. LOVE: I want to ask a question on the rapid antigen test sustainable disposable strategy, which is mentioned at the very bottom of that long table on page 306 of the *Budget statements*. It has a program cost of nearly $3 million this year for the sustainable disposal of our RATs. What is the total number of tests that will be disposed of under the program?

Ms A. SANDERSON: There are currently around 19 million expired RATs stored, and Health Support Services is evaluating offers in an open public tender process for the sustainable disposal of these RATs, and the outcome of negotiations and the tenders will be known sometime this month.

Mr R.S. LOVE: What constitutes "sustainable disposal"?

Ms A. SANDERSON: It is the ability to recycle parts of the tests. They have to be dismantled, though, in order to do so.

Mr R.S. LOVE: How many expired RATs have been disposed of in total?

Ms A. SANDERSON: I could not give that number. It is hard to know because people may have just thrown them out. We gave out millions and millions of RATs so I cannot tell the member how many have been disposed of.

Mr R.S. LOVE: How many RATs have been disposed of by the state?

Ms A. SANDERSON: I do not have the information, but I can tell the member that we are in negotiations to form a sustainable outcome for 19 million.

Mr R.S. LOVE: Do we know the total value of the RATs that will be disposed of?

[5.00 pm]

Ms A. SANDERSON: I do not think any that are in storage have been disposed of by Health Support Services. Obviously, we cannot tell the member what households have disposed of them and how. That is why we are in the tender negotiations. I think it is around $3 million worth of RATs.

Mr R.S. LOVE: Is it 19 million RATs?

Ms A. SANDERSON: Yes.

Mr R.S. LOVE: Is that the level that is held in storage?

Ms A. SANDERSON: That is the information that I have.

Mr R.S. LOVE: Are those the ones that have expired?

Ms A. SANDERSON: Correct.

Ms L. METTAM: I refer to paragraph 14 under the significant issues impacting the agency on page 309 of budget paper No 2, which states —

> Regional communities face unique challenges in accessing medical care and such inequity can contribute to poorer health outcomes of rural Western Australians.

I note that we have already covered the question about the reinstatement of maternity services at Carnarvon. When will reduced services be reinstated at Narrogin, Wyndham, Bridgetown and Manjimup?

Ms A. SANDERSON: The WA Country Health Service is constantly working to maintain and reinstate services. Staff shortages are not unusual from time to time, despite the fact that WACHS works to make sure that agency nurses are available to support those services. It happened under the member's government and it happens under this government. Regional services can be challenging to staff, but this government is committed to doing so.

Ms L. METTAM: Are there any plans to further reduce health services at any other regional hospitals?

Ms A. SANDERSON: We never have plans to reduce services. Our plan is always to improve and increase services. In fact, if the member looks at this government's record on major regional health campuses, he will see that we will be expanding services in regional Western Australia.

Ms L. METTAM: Although the government might not have plans, does the minister anticipate a further reduction in health services at any regional hospital?

Ms A. SANDERSON: Everything is done to maintain service delivery.

Ms L. METTAM: The minister referred to fly-in fly-out as being an option for Carnarvon. How seriously is the minister looking at that?

Ms A. SANDERSON: There are discussions with the Australian Nursing Federation. We are looking at not just FIFO but also a range of other innovative ways. We also have the critical site payment, which provides significant financial incentives to fill those roles. We are looking at a range of programs to support the staffing of those sites. We are always looking at ways to do it. I know that there are active discussions with the ANF around what the agreement currently enables.

Ms L. METTAM: Is the minister aware of the potential closure of any other services at any of the hospital sites in regional WA?

Ms A. SANDERSON: That is a long bow for the budget and I am not going to hypothesise into the future.

Ms L. METTAM: I have a new question that also relates to page 309. I refer to paragraph 15 under the significant issues impacting the agency, which is about staff. How many staff is WACHS currently short across the regions in terms of both the approved number and the actual number of staff?

Ms A. SANDERSON: The question was vague so I will give an appropriately vague answer. Essentially, staffing mixes change from time to time. There might be vacant FTE, but they are filled with casual staff and agency staff. Overall, staffing is pretty stable in WACHS, but vacancies are often filled with casual and agency staff.

Ms L. METTAM: Can the minister provide a breakdown, by hospital, of the approved number of FTE staff and the actual number of staff as at today's date?

Ms A. SANDERSON: I invite the member to put that question on notice.

Ms L. METTAM: Can the minister provide that by supplementary information?

Ms A. SANDERSON: No, I cannot.

Ms L. METTAM: How many nurses or midwives have signed up to the country nursing and midwifery incentive program since its inception?

Ms A. SANDERSON: The CNMI payment has been received by 2 462 individual nursing and midwifery staff.

Ms L. METTAM: How many midwives who signed up have since left, ceased employment or moved to metropolitan hospitals?

Ms A. SANDERSON: I do not have that information on me.

Ms L. METTAM: Does the minister have any other breakdown of those figures?

Ms A. SANDERSON: Anything at all?

Ms L. METTAM: The minister has a page of notes. Is there any other breakdown that she can provide on what the trend in take-up has been?

Ms A. SANDERSON: The way it works is that they get payments over time; they do not get it all up-front. The payments are made over time and depend on how long they have stayed. It encourages people to stay in the system, if that is what the member is asking.

Ms L. METTAM: Well, yes, as well as whether any have since left, ceased employment or moved to metropolitan hospitals.

Ms A. SANDERSON: I think that was a comment and not a question.

Mr R.S. LOVE: My question is almost on the same field but not quite. I refer to paragraph 15 on page 309 of budget paper No 2, which refers to the government investing to support staff et cetera in regional areas. One program that has been running until now that I am aware of is the regional graduate incentive scheme, which was a HECS-HELP scheme. Money was allocated in the last budget and for this year and the next year, but it does not seem to appear in this budget document. Can the minister advise whether that HECS-HELP scheme—the regional graduate incentive scheme—is still running; and, if so, where it would be parked in the budget?

Ms A. SANDERSON: It is fully subscribed, with 350 graduates last year. That is the cap on graduates and it is fully subscribed.

Mr R.S. LOVE: Is no consideration being given to a fresh program of funding into the future?

Ms A. SANDERSON: It was funded for three years with three lots of intake. There is a cap on the number of graduates that can be taken into any system, particularly in regional WA, as I am sure the member will appreciate. Supports, such as experienced nursing staff, are required around those grads to help them in that grad program. We cannot just put 700 graduates into the system. It is not safe for them, it is not safe for patients and it is not fair on existing staff. A 350 graduate intake a year is the amount that the WA Country Health Service has determined is a safe number. That is the number that is funded over three years.

[5.10 pm]

Mr R.S. LOVE: They were funded for two years, but there is nothing in the further years for future graduates.

Ms A. SANDERSON: It is important that we always evaluate these programs. We will get to that evaluation point. If it is highly subscribed and those grads are staying—I think they are required to stay for three years—or take on a contract with WA Health, and they are receiving that payment and it is working to keep people in regional Western Australia, I will go back and seek more funding to continue it.

Mr R.S. LOVE: At what point in time would the minister consider that that decision will need to be made?

Ms A. SANDERSON: It will be well and truly before the expiry of the three years.

The appropriation was recommended.