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Health Services Bill 2016

Wednesday, 23 March 2016

LEGISLATION COMMITTEE ON THE HEALTH SERVICES BILL 2016

The Acting Speaker (Ms J.M. Freeman) in the chair; Dr K.D. Hames (Minister for Health) in charge of the bill.

Advisers: Ms Rebecca Brown, deputy director general, Department of Health; Ms Robyn Daniels, senior solicitor, Department of Health; Ms Kirsten Seneviratne, solicitor, Department of Health; Ms Lee Harvey, Deputy Parliamentary Counsel, Parliamentary Counsel's Office; and Ms Michelle Gadellaa, legislation officer, Department of Health.

The meeting commenced at 1.40 pm.

Consideration in Detail

Resumed from 22 March.

Clause 26: Department CEO may issue policy frameworks —

Debate was adjourned after the clause had been partly considered.

Mr R.H. COOK: What is the relationship between the policy framework and the clinical services framework?

Ms Brown: It is envisaged that the policy framework will be set that sets out the clinical services plan for the system, and that will encapsulate the clinical services framework and will both guide the development of service agreements but also then provide a binding planning document for the system going forward.

Mr R.H. COOK: In that context, the clinical services framework is the long-term framework setting out what services will be run from which hospitals over a long period. If you come across something like the Bentley Hospital situation, where you wanted to close down the maternity services there, the clinical services framework paints a clear picture, but you might, for one reason or another—budgetary or whatever—be required to change it. How does that fit in with what the policy framework might say and what the service agreements might say?

Dr K.D. HAMES: The clinical services framework is just a guide. It is something that is developed by the Department of Health to give an indication as to what might be required at certain times in the future. It is a very useful document, but it is certainly not laid down in law because it is subject to changes in policy, changes in funding availability and a whole range of different things. In the case of Bentley, just suppose that instead of being in the East Metropolitan Health Service , it was in the South Metropolitan Health Service—the clinical services framework would reflect Bentley closing and its services going to Fiona Stanley, but a ministerial–government decision to keep it would mean a variation of contract in terms of activity-based funding to allow for the continuation; in fact, not even that, because it would continue as it is. The activity-based funding is already at Bentley. The proposal was that we would have had to transfer it; we would have just had a change in direction. Now, as it turns out, Bentley will be in east metropolitan, so that will have to link in its finances now with Royal Perth, Armadale and Swan Districts hospitals.

As I said, the clinical services framework is not binding. We do have frameworks around delivery of services, but those are subject to the influence of government.

Ms J.M. FREEMAN: Clause 26(1)(a)(i) refers to the engagement of contracted health professionals. Will they be contracts for service or contracts of service?

Dr K.D. HAMES: Ms Daniels understands the "ofs" and the "fors"—nobody else does.

Ms R. Daniels: Member for Mirrabooka, I did not check up on my "ofs" and my "fors" overnight. It is the persons who are contracted for the delivery of services.

Ms J.M. FREEMAN: So salaried staff. If it is the engagement of contracted health professionals and they are for those contractors, they will be under the definition of "staff" and not —

Ms R. Daniels: Correct, not employees.

Ms J.M. FREEMAN: In this clause, "matters that support the provision of health services, including the engagement of contracted health professionals", will be under the definition of "staff", which is employees and contracts for service.

Ms R. Daniels: Correct.

Ms J.M. FREEMAN: This does not go to those who have contracts of service—contracts of companies and others—that "matters that support the provision of health services" include.

Dr K.D. HAMES: Well picked.

Ms R. Daniels: It is an attempt to ensure that persons who come in under a contract for service are covered in certain circumstances under the policy frameworks. If they were seen as "this is a contract" —

Ms J.M. FREEMAN: Of service.

Ms R. Daniels: — they may not be included, but it is including those people in some of the frameworks.

Ms J.M. FREEMAN: In "staff", okay. At a public hearing today of the health and education policy committee, one of the people who had authorised beyond their authorisation levels for the alteration of the contracts was someone who was on contract. I was not at the hearing at that point. Would that person have come under this area and, therefore, been under the provisions of the health services policy frameworks? Was that person under a contract for service or were they under a contract of service?

Dr K.D. HAMES: Ms Brown, I think the key word was "of" service. I presume you are talking about Mr Piper. Is that the person you are referring to?

Ms J.M. FREEMAN: We did not get any name. I was not there when the name was mentioned.

Ms R. Brown: Mr Piper was employee C.

Dr K.D. HAMES: So none of those three.

Ms J.M. FREEMAN: They were contracts for service?

Dr K.D. HAMES: For service.

Ms R. Brown: This individual was employed. WA Health had a contract with an entity, of which this person was an employee.

Ms J.M. FREEMAN: A contract of service.

Ms R. Daniels: If that is the circumstance, in the bill, that person, depending on what the policy framework was and whether it referred to staff member or employee—I was going to say they could be covered, but that is not going to help you. If the policy framework mentioned staff members, it would be captured within that process.

Dr K.D. HAMES: I think this is different. Do you know the people involved?

Ms R. Daniels: No, not at all.

Dr K.D. HAMES: I think it is much better to move from —

Ms J.M. FREEMAN: This person, from what you were telling me, was working —

Ms R. Daniels: Of service.

Ms J.M. FREEMAN: Yes, of service, so they were working for a contractor. They were "contracted to" under the staff. They were working for a contractor. My concern is that what you have here is the engagement of a contracted health professional. My view is that that should capture both someone who is a contract for service and someone who is a contract of service. Basically, you want to make sure that they are complying with your policy frameworks around financial management of health service providers. But you have a definition of "staff" that only takes in a contract for service and not a contract of service, so you have this group of people who are going to come into your organisations who are not going to be encapsulated by policy framework issues. When you do that contract of service, I assume that part of that contract of service will say, "You are bound by the policy frameworks," but then you have the problem of whether that person was aware of the contract provisions and all of those sorts of things. I suppose I just want the assurance that anyone who is engaged to basically spend taxpayers' money on health is going to be bound by the policy frameworks.

Dr K.D. HAMES: Ms Daniels, if you do not know the answer and you need to look at the circumstances of the three individuals, it is better if we put it off, bring it back and get a definitive answer where you have talked through the issue.

Further consideration of clause postponed, on motion by Dr K.D. Hames (Minister for Health).

Clause 27: Policy framework is binding —

Mr R.H. COOK: This clause deals with the policy framework being binding on a health service provider and the staff who work for the health service provider. Does that include a privately contracted entity?

Ms J.M. FREEMAN: No, it only includes a contract for service.

Ms L.L. BAKER: Not of, so it is the same as referral, really.

Dr K.D. HAMES: No, because this is different. This one is covered. If we need to change it, we need to change it in clause 26, not in clause 27. Or do you think they need to be together?

Ms J.M. FREEMAN: Subclause (2) states —

> A policy framework that applies to a staff member of a health service provider is binding on the staff member and the health service provider.

You have a definition of "staff", which is employees and those under a contract for service, not for a contract of service. You are just binding —

Further consideration of clause postponed, on motion by Dr K.D. Hames (Minister for Health).

Clause 28: Department CEO may issue directions —

Ms J.M. FREEMAN: This clause relates to directions that a CEO may issue. If a minister gives a direction to a department, that has to be a written direction. If the minister gives a direction, I assume then that the CEO gives the direction, or does it jump and just become a ministerial direction over the top of the CEO direction?

Mr R.H. COOK: They can both give a direction.

Dr K.D. HAMES: As far as I know, though, if I give a direction—and I have never done one yet in all these years—I have to do it in writing and I have to table it in Parliament. I think each CEO is in a different position. There are no rules around tabling. He can direct compliance issues—for example, for our rule or whatever. So it might be something the government wishes to achieve. It might be a government policy, but in order to get the health department or the different organisations to comply, he might have to direct them.

Ms J.M. FREEMAN: Sorry, it is answered in clause 29(2)(c)—it does not override a direction of the minister under section 60. Sorry, I was not very clear. Is it answered anywhere else in terms of what form it will be? Will the direction be in written form?

Ms L. Harvey: I do not think we have specified. A direction usually would be in writing so that there is a record of it, but we have not specified.

Dr K.D. HAMES: This happens now. The chief executive gives directions now. They are operational directives—we discussed them yesterday, remember. He gives operational directives. He does that in writing and there is a requirement to comply.

Ms J.M. FREEMAN: There is a requirement to comply, but there is no requirement that the department CEO do it in writing.

Dr K.D. HAMES: No, not that we have seen. Do you think there is?

Ms R. Brown: No, it is just a requirement that the CEO must give that direction.

Dr K.D. HAMES: Under clause 31.

Ms R. Brown: Yes, under clause 31. It does not require it to be written, but it does require it to be provided so that the entities that must comply with that direction receive it. It is not that prescriptive —

Dr K.D. HAMES: They are quite clever; they do it in writing so that there is a clear record of that direction and a clear understanding of what it is that is directed. If you do it verbally, it would be hard to have any proof around it or any certainty around what it was that you did.

Mr R.H. COOK: It is like having the Nationals in your cabinet, really!

Dr K.D. HAMES: That is what the alliance is—they walk out. They are not in cabinet for those decisions.

The ACTING SPEAKER (Mr N.W. Morton): Members, let us keep this clear and concise for Hansard. Please, let us stay focused.

Ms J.M. FREEMAN: One of the issues that came up in the Auditor General's report on the ICT was that there was a lack of reportable documentation with respect to what people undertook and did and in terms of where direction had come from to make the decisions.

Dr K.D. HAMES: Yes, I think that is a fair call.

Ms J.M. FREEMAN: You have now put on record that you anticipate and expect that these things would be in writing. Another thing that came out of the Auditor General's report and during today's hearing was that meeting the financial requirements of those directions is self-monitored. How do you monitor that the directions have been followed? Is that going to be a self-monitoring thing where they will just say, "Yes, we've followed the directions", or are you going to audit that they are actually following the directions?

Dr K.D. HAMES: Do you have a specific answer?

Ms R. Brown: To the extent that a direction or a requirement has financial implications, that will be issued by the department CEO through a service agreement, and the service agreement will be monitored by the department in terms of the performance against that service agreement, and then subsequently through the tabling of the annual report. So, where there are financial implications, that will be far more clear through service agreements, and that includes that entity—the shared services entity.

For compliance with a direction or a policy framework, the department, through the department CEO, will have a responsibility for overall performance of the system and providing an assurance of the system, whether it be compliance with policy frameworks or other legislative responsibilities, bearing in mind that in setting up the separate statutory authorities, they will have their own audit assurance. As separate statutory authorities with boards and governance, they will be required to meet audit requirements under Treasurer's Instructions and they will be required to have risk and audit committees to oversee. There will also be board assurance in place to ensure that boards operate effectively.

Sitting suspended from 1.58 to 3.02 pm

The DEPUTY SPEAKER: Minister, you asked whether we could go back to the deferred clauses once we finished clause 28. According to the standing orders, there is a set order in which we deal with clauses, and deferred clauses must be dealt with last.

Ms J.M. FREEMAN: I can ask a question in clause 28. In that question that I will ask in clause 28, you may want to tell me how clause 26 would be looked at.

Dr K.D. HAMES: We could, but it will not help us in considering the clauses. We will still have to do the clauses at the end. We will do it while the knowledge is fresh.

The DEPUTY SPEAKER: Let us get to the formalities; that is, we are up to clause 28.

Ms J.M. FREEMAN: I do have a different question. In terms of the CEO and issuing directions and ensuring that the policy framework applies, would those directions go to clarifying the provision of health services, including staff who are contract for service and those who are contract of service?

Ms R. Brown: On clause 28 and the issuing of directions applying to staff, the definition of "staff member" is on page 7 of the bill. Under paragraph (a), an employee in the health service provider is a contract of service, so for many of our employees, they are contract of service. Paragraph (b) states —

> a person engaged under a contract for services by the health service provider;

That extends from our general workforce to those who are employed for service. This would include employees such as VMPs. A policy framework and an issuing of a direction would apply to both of those categories—"of" and "for".

Ms J.M. FREEMAN: In terms of issuing directions, say, for example, the CEO wants the health services to do sustainability policies—something around reducing energy consumption and looking at how they can change their light bulbs, basically. It can be as simple as that in terms of energy consumption now with LED technology as it is; it can save energy. I think some of them use something like 60 per cent less energy than the light bulbs that are currently being used. If they issued a direction around that sort of aspect of policy framework for sustainability, how would that be audited in terms of that direction?

Dr K.D. HAMES: I am not sure how it would be audited. What would happen is that having formed that decision, either from the minister or from the DG themselves, they would send out a written directive to the five organisations—the five boards looking after each of their regions. We would then be telling them to look at those sustainability issues within the area of their management. Any funds, obviously, that were generated from that would then be used by each individual board to manage internally. In terms of auditing that, I do not know that he would necessarily specifically audit it, but there are opportunities for him to do so. He could direct that they each report back to him on how they went and what the outcomes were. But remember there are still overall meetings. We have a thing called SHEF now, which is where all the CEOs of each of the areas meet regularly with the DG to discuss issues that are system-wide issues. They will still be having those meetings but linking in the board chairs as well. So he could raise it directly with the boards and ask them to put that. That is my understanding. Have you got any better understanding than that, Ms Brown?

Ms R. Brown: Probably what I would add to that is that the boards will have statutory responsibilities and, as part of those statutory responsibilities, they will put in place risk and audit committees to oversee all of their statutory responsibilities. They may, as part of that process, have regular audits of their health service to ensure they comply with department CEO directions, policy frameworks or other legislative responsibilities. If the department was concerned that there were compliance issues or any aspect across the system, the bill allows for the department CEO to investigate, inspect or audit a health service provider; so if they had a concern they could do that. The other point to note is that the Auditor General obviously has a responsibility in this space, particularly as they have certain statutory authorities. It may be part of their ongoing performance examination or investigation of the government agencies or particular areas, and they will look to compliance issues around the statutory authority complying with a range of requirements—legislative, policy, and department CEO directions.

Ms J.M. FREEMAN: Will the directions that are issued by the CEO be public, or will how many directions have been issued at least be available in the annual report?

Ms R. Brown: Under the current legislation, the department, or the director general, issues instruments called operational directives. At the moment we have in excess of 500 of those. They are publicly available, so the health service is required to understand the environment in which they operate. A department CEO direction would also need to be made public to enable the entity or the individual to be aware of what they must comply with. But we would be anticipating, by having the policy frameworks cover key areas, that there will be less of a requirement to issue department CEO directions over time.

Ms J.M. FREEMAN: When you say "public", do you mean public in term of it can go outside of employees or staff? If there is a CEO directive that, for example, if a worker takes industrial action, their pay would get docked, is that "public" just within the health department, and if a health department worker gives it outside of that, would they be breaching any sort of confidentiality in terms of directives?

Ms R. Brown: I think the question about whether they are public or not is around being made available. Often they are released now through the Health intranet site. Department CEO directions under the bill are actual instruments, as are operational directives now. Because they are binding, they need to be communicated in a way that the responsible entity is aware of them. I think the issue about whether or not they are public is whether they are listed on the website and whether they are circulated. They have to be made available. They have to be known. I think it is more erring on the side of they cannot be made confidential to the extent that the entity that will be held to account is unaware of them.

Ms R. Daniels: Clause 30 says "department CEO direction is binding", and clause 31 says "department CEO direction must be given". So, to the extent of being made public, it is given to the chief executive and to the board. But the bill does not address the broader public.

Ms L.L. BAKER: I have been waiting to ask this question and now seems as good a time as any to do so. It relates to all of the bill, really, but this seems like an appropriate time because we are talking about the CEO and directions. I am assuming that this is going to bring with it a whole different regime within the health department, or that at least aspects of it will have to change, about how the administration of health is done centrally. I am really keen to know what those changes are likely to be. It seems to me that you are making more of a funder–purchaser–provider split and creating clearer lines around that, which will have obvious ramifications for how you manage the services that you are contracting and how you manage the boards and all that kind of stuff. So I am just really interested in whether there has been any thinking into what will have to change within the health department when this comes into action. What will the new health department look like? What will the new divisions and sections look like? What kind of big strategic thinking has been put into how this will impact on the administration of health as it currently exists? Along with that, are there any resource implications? I am assuming no, because there is no money, but you never know.

Dr K.D. HAMES: There is lots of money. There is $8.2 billion.

There has been a lot of thought, and I will get Ms Brown to handle this mostly because she has been on the committee managing all of this—which has had Professor Bryant Stokes previously and now Dr Russell-Weisz, Michael Barnes, the Under Treasurer, Department of Treasury, and Ms Brown. They have been to other states to look at the structures they had and have come back and recommended that those structures be put in place to have a much more hands-on, close-to-the-service management.

As we said in the second reading, the department itself will become much more of a service provider and will downsize; whereas the boards will have oversight over each of the regions. They will have collective groups of hospitals within them. The east metropolitan region—where you are—for example, might have Royal Perth as the hub and it will encompass a wedge going outwards. So you would have Bentley, Armadale, the new Midland Hospital and Kalamunda. Those hospitals will not so much feed in, because patients are not necessarily directed to the hospital that is at the hub. We are aware that patients from Armadale may still go to Fiona Stanley and patients from Midland may still go to Sir Charles Gairdner Hospital.

It is about responsibility and management of the budget they get. They have a service provision model, as you say. They have a list of services that they have to provide and for which they have responsibility. The experience in other states is that that much closer to home, hands-on model has much better oversight over the day-to-day running of the services—things that I might not hear about for ages as minister; things I largely hear through Roger, the member for Kwinana, when things go wrong. They have direct feedback, but they are directly answerable, too. So they have a responsibility. So you will probably see less of me coming out when people complain about what is going on in the hospitals. The board chair is likely to come out and have to explain what they are doing, why they are doing it and how they are managing it. In the end, the minister still has responsibility and cops the flak in here if things do go wrong, but it gives more responsibility to the team who are looking after each area. I am sure Ms Brown can add much more to that. It was a broad question, because it really covers the whole bill.

Ms R. Brown: I suppose the only bit I would add is that the bill seeks to clarify the relationship between the department and establishing the health services. Certainly the clear intent is that the health services do exactly

that: they provide the services out in the community. So, to the extent that there is any provision of services now in the department—which there is very little—that will all move out into the community and be managed by boards. It is very much about the intent of having local oversight, local networks and accountability.

In terms of the department, probably the key change will be that the department has a dual role between supporting the director general and minister and supporting the director general as board of the metropolitan health service boards and WACHS as delegated by the minister. There are many things that happen in the department now that are supporting those boards. Those functions will be transitioned out to the health services. Largely, they are focused on a small number of functions that we do in the department to support the board, and we are working through quite a meticulous planning process to do that carefully.

I think the department will then become much more focused on providing strategic planning and leadership to the system over the medium to longer term. That includes things like workforce planning, clinical services planning and clinical leadership. So the department can still perform an important clinical leadership role. The department still has a role in managing and monitoring the overall performance of the system, particularly through the issuing of service agreements. The department also plays a critical role in communicating the rules of the system and the policy frameworks and having that audit assurance in place in the system.

Ms L.L. BAKER: I have a couple of questions having heard that information. Firstly, there will still, assumingly, be a clinical services framework document produced of some sort —

Ms R. Brown: Yes.

Ms L.L. BAKER: — which will still serve the same or slightly modified role that it does at the moment. Will you lose any FTEs—will you get rid of any of the FTEs—in shrinking the department to bring on this model? What will be the change in the staffing levels within the department, minister?

Dr K.D. HAMES: There is a minor increase in staff required for the management of the boards but those staff will be sourced from existing staff.

Ms L.L. BAKER: So no change?

Dr K.D. HAMES: Those positions will be filled not necessarily from existing staff but mostly by existing staff. There may be public advertising for senior positions, such as the chief executives of each region, that may end up in someone from somewhere else coming, as we have had in the past. South metropolitan had Nicole Feely, for example, who was from the eastern states. Those positions will be filled, and that is an increased cost that has been documented through the process.

Ms L.L. BAKER: They are new positions.

Dr K.D. HAMES: But there will be a subsequent reduction in FTEs at head office, if you like. Some of those will move out into the regions, but not everyone will want to move. Some will want to stay, and so we will have management processes in place for those who do not want to move to the new board management system.

Ms L.L. BAKER: Interpreting from what you are saying, existing staff will be given a priority in the placements into the new positions. Is that correct? So, before you go out, you treat them as redeployees or something within your organisation?

Dr K.D. HAMES: It depends on what level you are talking to. If you are talking to someone working as an administration officer in head office now, they are public servants. So they are entitled to employment and there will be an opportunity for redeployment if they want it. If they are getting to a part in their career where they do not want to do that, as you know we have redundancy packages that have been available that allow them to do that.

However, if you are talking about a senior level, a chief executive level, there are some who are in acting positions at the moment, including, for example, Robyn in south met. She will need to apply for that position as chief executive of south met. She is not being guaranteed that position, nor is someone who might currently be doing a similar role in east met or north met. Those senior positions are normally advertised and the best person wins them. Those people are usually under contract, are they not? Are they on contract or are they public servants?

Ms R. Brown: Yes, they will be staff, and other public servants.

Dr K.D. HAMES: Can I just check that that is the correct answer that I have given?

Ms R. Brown: Certainly the intent is that functions will move from the department that previously supported the boards that go out to the health services, and we are working through how those resources would transition out into services. But, clearly, where we have people capably performing those roles now, we will be working through how they would transition out to the health services.

Ms L.L. BAKER: I have one final question. Do you at the moment have information on the numbers and/or the positions? Do you have any information on the number of staff changes that will happen, the number of losses that you are expecting and the positions that might be affected? I totally understand that there will be new job titles and new positions created to support this and that people will be transitioned into them. I get that. I am just wondering whether you have had a chance yet to look at your organisation and say, "Well, actually, there will be 30 positions, or 12 or 110 positions that will be abolished and we will be creating an extra 15 and these are the job titles."

Ms R. Brown: Although we have been going through a detailed process, we are not at that stage. We have been very much focused on the functions and the accountability within the bill that are created and working through this, even with the new board chairs and their chief executives. It has been quite a detailed process that we have been going through and we have not got to the stage of how many people we would need to move or what resource capability or volume would be required.

Mr R.H. COOK: Can you tell us if there is going to be a change in head-count?

Dr K.D. HAMES: That is not an easy question. We have a target, as you know, of reducing FTEs across the system. In amongst that whole adjustment, the changes that these will generate are miniscule. I expect that there will be some changes, but whether that is up or down—or in which direction—is difficult to tell. There will be administration roles through the board itself that will require additional FTEs. There will be less of that required at head office. In making the submission to get approval for this —

Mr R.H. COOK: I was going to ask what Mr Barnes had to say about it.

Dr K.D. HAMES: There were costs listed but they were not significant. Can you detail what those were, Ms Brown?

Ms R. Brown: Certainly in our discussions with Treasury all aspects of the reform and the changes being made have been funded in the budget. We estimate—given that the establishment of the board is in 2015–16—approximately $2 million and that includes the salaries of the board.

Dr K.D. HAMES: Do you know how many FTEs that is roughly?

Ms R. Brown: I am not sure of an FTE count.

Dr K.D. HAMES: One of those is a senior person. So $2 million does not equate to a lot of people.

Ms R. Brown: Bearing in mind that the system was incurring remuneration for local government councils of approximately $1.4 million. Working within the budget has been quite important. As certain functions move out to the health services or there is some rationalisation of duplication, there is also a requirement to reboot some capability in the system and in the department.

Mr R.H. COOK: Just on that point, one assumes that these overheads or fixed costs or administrative costs will now be transferred to the activity-based funding costs associated with the functioning of the hospitals in those areas? Is that correct, or is it still going to be budgeted under a head office line item, for want of a better description?

Ms R. Brown: The administration of the boards and any other functions that they take on comes within their budget and their ABF allocation. We have to work through that with them very carefully, particularly as they have existing corporate services that they are trying to reskill or reallocate to new functions. As I think the minister said, the support for boards and the creation of boards is already being resourced within existing resources, albeit fairly limited at this stage. Then there are obviously functions within the department to support, which is being funded from internal resources.

Dr K.D. HAMES: If you take south metropolitan as an example, we already have a director of south metropolitan services, so that CEO position will remain, and the board will require some secretariat support, but not much outside that, whereas east metropolitan does not have anybody of its own yet, so that will require a new person to be put in that place, and the service requirements for the board, which are largely secretarial and administration in sending out minutes, taking minutes, recording decisions and so on.

Mr R.H. COOK: So what we are essentially saying is that, under the restructure, we have a $2 million cost which is being transferred from the head office to the activity-based funding sources, which is essentially saying that this is a $2 million shift from clinical services to administrative.

Dr K.D. HAMES: And I thought that the money you are going to be saving in head office would be used to fund these services in the five regions so that it did not have to come further out of an activity-based fund. Ms Brown, there are two questions.

Ms R. Brown: The first answer is that they have already factored into their budgets the remuneration for local government and councils and the support that was already in place. So that has been maintained. That is already in their budgets. The transference of any additional resource to support statutory functions or building capability,

the department is working through with them. My reference to activity-based funding was that we need to understand how that moves. Certainly there will be a requirement on the department in building any capability for new functions to work through that with the health services and, more likely, include that cost from other savings. But they have an element of savings within their budgets from the previous budget of the councils.

Dr K.D. HAMES: It is worth recognising that most of the other states have boards already. Their activity-based funding is not additional funding. Based on the fact that they have boards, they get funding for the service that they provide. So the funding for a hip is the funding for a hip, and recognised within that is a component for overheads. Victoria, as you know, has a lot more boards than we do, yet they do not get additional funding for those boards. It is calculated as activity-based funding.

Mr R.H. COOK: It is not necessarily a bad thing, but it is good to understand that what we are essentially doing is shifting these administrative staff—who, at the moment, are costed to a head office function—from one cost centre to another cost centre, which is essentially funds that would otherwise be activity-based funding. We are realigning the cost centres for those particular staff. Even though, in the global scheme of things, it is still part of the $8.2 billion, we are shifting them out of an administrative cost centre into a clinical cost centre. So I just wanted to clear on that. I am not necessarily saying that is a good or a bad thing. It is what we are describing here, is it not?

Dr K.D. HAMES: To a degree. Remember, that cost is across five regions, and it is more for some than others. If you look at south metropolitan, they already a chief executive, they already have an administrative function there, they already have people working in those roles, but they will then take on the responsibility of managing a board. So the chances are that the requirement for additional staff there will in administration. Met is a bit different; starting off again will require more funding. Remember, the activity-based funding will be going to those that have provided—we get a certain amount of money as a whole and some of that goes to running head office and some goes to activity-based funding, and that activity based-funding continues. But you are right in the sense that some of those will have a small increase on what they would have had. Remember, in the total context of what their budgets are, which is over a billion dollars each, there should be capacity to manage that. Remember, they all have got in excess of FTEs elsewhere that need to be managed as part of that system.

Ms J.M. FREEMAN: You are saying that a lot of that is in existing services. Do they all have audit and financial capacity already, given that part of the new structure will have them auditing and doing the financial propriety of their plans?

Ms R. Brown: The health services themselves obviously have existing corporate services. They have finance areas and there may be a requirement to build further capability within those existing areas. Over a period of time, because of the aggregation of the system, they have not had accountability but they certainly have those finance areas in place. Through the detailed work that we have been doing, we have an understanding of who does what now and what resources are in place.

With regard to audit functions, my understanding is that each of the health services does not have what they call "audit committees" but they have monitoring of audit requirements already in place. Going forward, they may wish to have further access to internal audit resources that can actually undertake the internal audit. Certainly under the local governing councils, they have been putting in place similar structures around safety and quality committees, audit risk committees and finance committees. They have been working towards that. They certainly have significant resources in those places. It is more about whether they have the capability that comes with that accountability that will follow.

Dr K.D. HAMES: Again, can I point out that they did have governing councils. They had some admin component in running governing councils that will continue. Remember, the 8.2 figure is a global figure that gets to health. If less needs to go to head office, that does not get chucked away; that funding is there and available to support other areas and probably will go into more health related services.

Ms J.M. FREEMAN: In terms of the admin capabilities, does that mean they will have a board secretary, given that they are a body corporate?

Dr K.D. HAMES: I presume so, yes.

Clause put and passed.

Clause 29: Relationship between Department CEO direction and other instruments and directions —

Mr R.H. COOK: This is a general and, hopefully, a brief question. In trying to build a list of the various decision-making functions that the CEO has, so far I have direction, operational directive, variation to framework and variation to service agreement, and one assumes, also, variation to contract, if the CEO is associated with a contract. Are there any other instruments that a CEO would use in terms of decisions in that role?

Ms R. Brown: Firstly, operational directives exist now under the current framework. They will not exist going forward.

Mr R.H. COOK: That is right; so they will be under framework.

Ms R. Brown: They will be under policy frameworks.

Mr R.H. COOK: Excellent.

Ms R. Brown: Secondly, by having policy frameworks and covering those key areas, the use of department CEO directions will be infrequent and used more for unforeseen events or for communicating a government policy direction. Service agreements are about establishing, on an annual basis, service requirements, budget allocations and performance requirements. The bill provides for variations and there can be agreement between those. The bill alludes to the head agreement between the department CEO and the Mental Health Commissioner, and provides a joint planning–purchasing framework across WA Health for public mental services. I do not recall that there are any others. I think they are the main ones other than the ability to undertake investigations, audits and inquiries. I will just check whether there are any requirements around communication of those. There is just the report for the inquiry. The only other one then is in regard to the operation of the step-in powers, which are the minister's.

Ms R. Daniels: The other power that the CEO has is that if the policy framework does not work, a direction does not work or a service agreement does not, he or she can speak with the minister about the recalcitrant health service provider.

Clause put and passed.

Clauses 30 and 31 put and passed.

Clause 32: Establishment of health service provider —

Mr R.H. COOK: Under clause 32, I want to take the opportunity to talk about the minister's foreshadowed intent to create the east metropolitan health service. A lot of the debate around that anticipated move has been about whether the health service is actually up to having a new service and whether the north and south actually fulfil the need for the moment. Generally speaking, it is seen as being a positive move. Some people are saying that perhaps we are still not big enough to justify three metropolitan health services in addition to child and adolescent at this particular point in time. I wonder whether the minister could outline for us the thinking behind the creation of these metropolitan health services. Specifically, I am interested in knowing whether that will see the replication of some clinical services, which otherwise would be done only north and south.

Dr K.D. HAMES: I will definitely answer the question, because I am not sure I trust the department to give the same answer that I might give!

Mr R.H. COOK: It is not a question of trust, I am sure.

Dr K.D. HAMES: The concept of an east metropolitan came out of discussions I had with the Australian Medical Association back in 2000, interestingly enough. It was a concept that we agreed was a good one and one that I have supported ever since. So I have had in my mind to do this for a long time, for the reason that I find it distasteful, even, that south metropolitan includes Royal Perth. In effect, it affiliated Fremantle Hospital and Royal Perth, so there was almost a disconnect between the nearest hospital, which was Sir Charles Gairdner, and Royal Perth. So everything was happening around that. It placed a huge burden on south metropolitan for the future with a board having two tertiary hospitals within its boundaries and such a wide diversity of services.

I do not think it recognises that there is an east metropolitan. If you place the City of Perth as the centre, we have the ocean to the west and clearly we have a northern suburban area, we clearly have a southern suburban area, and we clearly have an eastern suburban area that is quite distinct and different. It is not the same out in Midland as it is in Kwinana or north in Scarborough. It is a different type of community into the ranges and sitting below the ranges. I felt that the eastern suburban area deserved to have its own area. It made sense having a tertiary hospital at the centre of that that could work outwards.

What we did not want—and remember the discussions we had—was the boards that had been in place; there was a Royal Perth Hospital board that had nothing to do with Swan District Hospital and its management, and it acted as though Swan District Hospital did not exist. It was very much a solo operation. So we did not want that to happen; we wanted to have an inclusive arrangement. Creating those boards over a service area did that. Each of the three regions had a central tertiary hospital. It also had smaller hospitals within each region that had sufficient numbers to balance out, roughly, the three different areas. Having a board overall that can help coordinate the provision of those services within that area I think will be a big boon for those who live in the eastern suburbs—rather than having to rely on a southern metropolitan group to look after their interests. It reminds me a bit of what has happened in Mandurah and the Peel. We are classed as part of south metropolitan, but we are almost the forgotten ones down the end there. Even in south metropolitan as it exists, that will give south metropolitan a chance to focus more on the total area that is under its control. As well, north metropolitan is a discrete area and has always operated well as a body. I think that provides a good example of how it should work. South metropolitan has always been a bit big, a bit bulky and a bit difficult to manage.

Mr R.H. COOK: The second part of my question is: will there be services that you anticipate that east metro will have now which it does not have under its current south metropolitan service?

Dr K.D. HAMES: We do not think so—fairly confident, not. I have to say that was anticipated by all the doctors at Royal Perth who suddenly thought, "Fantastic, now we'll go back up to 550 beds." That is not the case. We have distribution of patients and we have activity-based funding. It will be funded according to the best location of the service. What you might find a little different is the issue of ophthalmology services that you have been asking us about. The proposal was for them to come out of Royal Perth as well and come across to Fremantle. I said no to that because it did not seem logical. It forgot the fact there was a whole lot of people coming from the eastern suburbs who feed directly into Royal Perth for that service. So you might find that some services where there otherwise might be consideration of some sort of amalgamation of service into a single location might not happen because there was more focus on each of the regions. I think that is a good thing, not a bad thing.

Clause put and passed.

Clause 33: Status of health service provider —

Mr R.H. COOK: On behalf of the member for Maylands, what does the clause mean, that "A health service provider is an agent of the State and has the status, immunities and privileges of the State"? I am also interested to know whether that includes a contracted private entity providing health services on behalf of a provider.

Ms R. Daniels: The answer to your second question is no because your health service provider is defined earlier as a board. Could you repeat your first question?

Mr R.H. COOK: What does "status, immunities and privileges of the State" mean?

Ms R. Daniels: It is my understanding that, as part of the state, you have a certain set of immunities and privileges, which you would not have if you were a private organisation.

Mr R.H. COOK: So it cannot be sued?

Ms R. Daniels: It can be sued, yes.

Mr R.H. COOK: I would have thought so. I undertook to ask the question and it has been asked.

Ms R. Daniels: The health department gets sued regularly.

Clause put and passed.

Clause 34: Functions —

Ms J.M. FREEMAN: By way of interjection, did you say prior to this they used to sue you?

Dr K.D. HAMES: I do not know that I said that, but I do frequently get sued. I am being sued for something at the moment.

Ms J.M. FREEMAN: You get sued because you are the board?

Dr K.D. HAMES: Well, I guess.

Ms J.M. FREEMAN: They do not sue you; they sue you because you are the board.

Dr K.D. HAMES: I am sued as the Minister for Health but, I presume, the Minister for Health as the board.

Mr R.H. COOK: And you have an outstanding video library fine, so he is being sued for that as well!

Ms J.M. FREEMAN: That is right; I have been up to the Parliamentary Library, I know about him!

At division 2, "Functions and Powers", clause 34(2) states, "A health service provider also has the following functions" and at paragraph (e)(iii) it states —

> to promote consultation with health consumers and community members about the provision of health services by the health service provider;

Does this include a complaints process?

Ms R. Daniels: A complaints process exists at the moment. This is more about actively consulting with your health consumers and community members.

Ms J.M. FREEMAN: Under clause 34, "Functions", a health service provider's main function is to provide the health services; teaching, training and research; and any other services agreed. The health service provider does not have any main function for consumers until clause 34(2), which has the term "the following functions". I understand that is the broader one, but where in the following functions is there a capacity to include a complaints process for consumers? I ask this because most of the constituents in Mirrabooka go up to Joondalup. Despite the fact that Royal Perth is probably their intake hospital, they tend to go up to Joondalup,

where there is quite an effective complaints process. If they do have trouble with different staff or a different process, or if something happens, there is a quite effective complaints process. At the end of that process, they feel it is quite resolved; compared to Royal Perth Hospital, where the complaints process is clunky and difficult for people to deal with.

Dr K.D. HAMES: I have not received any complaints about the complaints process.

Ms J.M. FREEMAN: I know how to deal with complaints processes and annoying public servants; it is part of my job! The question, I suppose, is: Where is that a function of the health service provider? Given that the health service provider will be a board that will oversee Joondalup and another board that will oversee Royal Perth Hospital, where is that included?

Ms R. Brown: Under clause 34(2)(g) and (h), which is to monitor and improve the quality of the health service provider and to develop and implement corporate and clinical governance arrangements for the service provider. It is probably likely that the ability to —

Ms J.M. FREEMAN: Probably likely?

Ms R. Brown: As health service providers are required to perform these functions, a board will look at those and ask, "How do we perform those functions?" Having an adequate complaints process in place, whether it is defined by the statutory board operations framework or their interpretation of the legislation, is not explicit, bearing in mind that the public health system operates under other complaints mechanisms, including through HADSCO. It is not explicit in there as a function other than to monitor and improve the quality of health services, as a requirement, I understand.

Dr K.D. HAMES: But all our health services have a complaints process, whether it is good, bad or indifferent. Is there no requirement in the existing legislation that those hospitals should have a complaints process?

Ms R. Daniels: It is not specifically in there. I suggested earlier, as has Rebecca, that it would be part of monitoring and improving the quality of health services if you have many complaints.

Ms J.M. FREEMAN: I have two questions. I get that this is about setting up an administration process for Health, but it could actually include some of the aspects of consumers' issues in the functions and powers rather than not having it specifically there and implying it in "monitoring and improving the quality of health services". Doctors could say that they are monitoring and improving the quality of the health service by virtue of the fact that they get an additional qualification around some sort of specialty area. On the record, I am happy that we have implied it in that clause, but it does seem to be a bit of a worry that it is not there. That aside, my second question is around whether it is in the existing legislation. I am just interested to know if Ms Daniels can tell me whether there is a requirement for the hospital board's functions in the existing legislation.

Ms R. Daniels: It is not in the bill. It is part of practice and it is accepted that we have a patient code of conduct in relation to the regular meetings with the Health Consumers' Council to ascertain complaints and consumer views. In essence, it is not in the present bill.

Ms J.M. FREEMAN: The minister will recall when we dealt with the Public Health Bill that codes of conduct were specifically talked about as a function in the bill. By specifying it in the legislation, you give it a legitimate legislative —

Dr K.D. HAMES: I agree with you. We should have a clause here that says it. The suggestion is to insert "to consider and deal with complaints about the provision of health services by the health services provider". Do you reckon that covers it? I was thinking something along the lines that the requirement of services is to have a process that deals with complaints regarding the service provider.

Ms J.M. FREEMAN: Yes, but I am not suggesting that dealing with complaints about the provision of health services and the health services provider would be done by the health department, but similar things to this have been done before. Burswood Casino has a line like this for people who gamble there when they complain about it. But all they have to do is say, "Yes, we have received it. Thanks very much. It is being considered and dealt with."

Dr K.D. HAMES: You need something that says "establish a process for dealing with patient —

Ms J.M. FREEMAN: Yes—establish something that is efficient and effective. Part of it is efficiency —

Dr K.D. HAMES: It is not always patient complaints, is it?

Ms J.M. FREEMAN: No.

Dr K.D. HAMES: It might be the family complaining.

Ms J.M. FREEMAN: Yes, it is often the family complaining about —

Dr K.D. HAMES: Let us try again.

Ms J.M. FREEMAN: Yes. I want to ask another question that the minister will be able to answer. Under the functions and powers of the health service provider, clause 34(2)(i) states —

> to maintain land, buildings and other assets controlled and managed by the health service provider;

The minister will know that for the last 50-odd years, there has been that health land that has been sitting in Mirrabooka. Part of the difficulty in maintaining that land is that it was left derelict. I have stood on my feet in the Parliament and said, "If this was in Nedlands or Peppermint Grove, it would not have been allowed to become the dust bowl that it has become." I did the same with the Department of Housing. I pointed out that people were camping on it, and they then came and took away every live tree on the plain and put yellow sand there. It made it look worse so that no-one would want to camp there any longer. As part of maintaining, I would like to know what the minister understands to be the maintenance of land that is owned but is vacant and is being sat on so it sits on the books as an asset. What would your expectations of a health service provider be around that land? This is a policy question.

Dr K.D. HAMES: I expect them to maintain that land according to the requirements of the Local Government Act, which deals with the maintenance of any land within a council area—that is, making sure that there are firebreaks and there is no refuse and that people are not camped on it. Remember, though, that the history of that land is that it was not our land at the start. It took a long time and a lot of work before that became Department of Health land. We owned different land and then we had to do a swap with the Department of Housing to get that land back. Then they argued further about the value of the land.

Ms J.M. FREEMAN: Minister, do you want me to put on the record that I am forever grateful that your department is the only one that has done anything? Actually, the Department of Housing has done something because it wants its own building on the land. Anyway, that is another thing. I am grateful.

Dr K.D. HAMES: I move —

> Page 28, after line 30 — To insert —
>
> (ea) to establish an efficient and effective procedure for dealing with complaints about the provision of health service by the health service provider;

Amendment put and passed.

Mr R.H. COOK: I am just interested in subclause (2)(k), which will become subclause (2)(l) under the amended form of the bill. It deals with the provision of health services through contracted health entities. I was wondering if the minister could outline for us the limitations in relation to a health service provider contracting a private health entity. What is the extent of these powers?

Dr K.D. HAMES: Ms Brown or Ms Daniels will know that. This goes to the subject of limitations of contracting out.

Mr R.H. COOK: That is right.

Dr K.D. HAMES: You said that there are financial limitations. Some of a certain level have to go to the minister and others can be done by the health service provider. To what level can they go and contract out services before having to bring it to either the director general or the minister? Who knows the answer to that?

Ms R. Daniels: It has not been decided what level it will be. The department CEO may issue a direction around it. I am unaware of what limitations the State Supply Commission puts on the arrangements for the provision of contracted health entities.

Dr K.D. HAMES: There are limits.

Ms R. Daniels: It limits those. I do not know the detail of what those limits will be. It will be the subject of further discussion and subject to the State Supply Commission.

Dr K.D. HAMES: Will it be done by regulation or by policy? What will set the level? I do not want health service providers going out to contract for services certainly not at a Serco level but even well below that level. Although if they want to contract out some services at the lower end, that is up to them.

Mr R.H. COOK: That is right. Yes. They might want to —

Dr K.D. HAMES: I do not want them suddenly contracting all cleaning services, which has happened before. That is our favourite subject at Royal Perth Hospital. There need to be set limits. How do I have control over where those limits are?

Ms R. Brown: There are two parts to this. Obviously, health services have an ability to enter into contracts subject to any department CEO direction. This would be in respect of the policy framework. The department CEO would issue a policy framework with regard to procurement and contract management—all elements of it. That would be compliant with the State Supply Commission Act requirements and policies and procedures.

Currently, the Department of Finance provides assistance to Health for all contracts greater than $250 000 for the procurement of those contracts. This clause also needs to be read in conjunction with clause 38 around transactions that require agreement or approval. What is anticipated is that, through regulation, the limit will be set with regard to the matters by which the department can enter into contracts—bearing in mind the provisions of the FMA and the State Supply Commission apply—the limits by which the department CEO can enter into contracts, the limits by which health services can enter into contracts and the limits by which any contracts, particularly large ones, would need to be considered by both the minister and, in certain circumstances, the Treasurer.

Dr K.D. HAMES: There are quite a few examples where we go out to contract for service with Aboriginal communities. A good example is that recent one where we funded the health staff. I had in mind 0.3 Aboriginal FTEs across the state. They have been very hard to get. So what we are doing in some instances is going out to contract with the Aboriginal medical service to provide a person who goes and does those services at a group of communities instead. Those contracts do not come to me for approval. I have approved the overall concept and budget. That goes to WACHS. WACHS then has responsibility for providing that service. It is quite free—in fact, it is encouraged—to contract Aboriginal groups to provide a service rather than doing it ourselves.

Sitting suspended from 4.04 to 4.17 pm

The ACTING SPEAKER (Mr I.C. Blayney): The question is that clause 34, as amended, stand as printed.

Mr R.H. COOK: I want to go back to the issue of the discretions that health service providers have in engaging contracted health entities. We have talked about the $250 000 ceiling. Is this a question of policy or a question of statute in terms of these limitations? For instance, in the future could a CEO, under the direction of the minister—or maybe the minister himself—seek to alter the framework documents such that they could exceed that $250 000, or is everyone locked into that?

Ms R. Brown: The partial exemption that WA Health has currently under the State Supply Commission Act allows WA Health to purchase goods and services up to the value of $250 000 without the requirement for Department of Finance involvement. The changes being proposed across the Department of Finance now will retain that limit at $250 000. That essentially means that, whenever we go to procure, they are involved in the development of procurement planning documentation to stick on Tenders WA.

Ms J.M. FREEMAN: This may not be the spot to do it, but we did talk about a code of conduct around consumer complaints and then we put in a paragraph relating to consumer complaints, and I thank the minister for that. But, other than consumer complaints, I assume that there are other codes of conduct. Codes of conduct are really important and very helpful documents in terms of operation and principles and things like that. Is there any provision in the legislation for codes of conduct to give them some legislative imprimatur as they do with public health? With public health, there is a whole section on codes of conduct. I understand it is on the basis that public health is setting parameters and principles and operations for local government. It is an aspect of bringing in a code of conduct, so you do not have something as serious as a regulation or as serious as legislation, but, depending on the size of your organisation, your resources and your capacity, you can rely on codes of conduct. It sets something like a high-water mark that is above regulation. So, is there?

Ms R. Daniels: As public sector employees, they are adopting the principles of the Public Sector Management Act as part of their process.

Dr K.D. HAMES: And that has a section on codes of conduct?

Ms J.M. FREEMAN: But that is not my question.

Ms R. Daniels: Section 9(a) of the Public Sector Management Act says —

> …
>
> (i) this Act and any other Act governing their conduct; and
>
> (ii) the Commissioner's instructions, —

That could be taken out and "Director General's instructions" could be put in —

> public sector standards and codes of ethics; and
>
> (iii) any code of conduct applicable to the public sector body or employee concerned;

They will be picked up most likely in policy frameworks.

Ms J.M. FREEMAN: We should do this later when we deal with the Public Sector Management Act, but you do not pick up section 9; you just pick up part 6 of the PSM act. You do not pick up the whole of the PSM act.

Ms R. Daniels: That is correct. The principles of conduct are to be observed by all public sector bodies and employees, so the statutory authorities are public sector bodies and their employees.

Dr K.D. HAMES: What that suggests to me is that we do not need it in our legislation because it is in the Public Sector Management Act. These people are going to be public sector employees, so they have to abide by all those things.

Ms J.M. FREEMAN: Okay.

Clause, as amended, put and passed.

Clause 35: Commercial activities —

Dr K.D. HAMES: I move —

> Page 30, line 6 — To delete "hospital" and substitute —
>
> health

I think that is just a misprint there. It should say "health service provider" and it says "hospital service provider". It is just a typo.

Mr R.H. COOK: I have some questions around subclause (1). If we consider the minister's amendment now, I will not have a chance to ask those questions. Is that right?

The DEPUTY SPEAKER: We will just amend the clause and then we can talk about the clause.

Dr K.D. HAMES: We have got to consider the clause as amended.

Mr R.H. COOK: So I will still be able to go back to subclause (1).

The DEPUTY SPEAKER: Yes. My preference would be to deal with the amendment first.

Amendment put and passed.

Mr R.H. COOK: My curiosity is piqued by subclause (1), which talks about "engaging in commercial activities". I just want to get an understanding of the parameters of that. What is envisaged by a "commercial activity" and does this include commercial activities in relation to clinical services?

Dr K.D. HAMES: That is a good question. Who knows the answer to that? Ms Brown? Presumably, treating private patients becomes a commercial activity, does it?

Mr R.H. COOK: No. I think that comes under fees and charges, does it not?

Dr K.D. HAMES: What about when we run a cafeteria?

Mr R.H. COOK: Yes.

Ms R. Brown: Or lease function rooms and things like that.

Mr R.H. COOK: Otherwise known as wards, but you can move the beds out of them! They can become a theme park as well!

Ms R. Brown: Theatrettes and conference rooms that they have, and many government agencies do that.

Dr K.D. HAMES: Or A childcare centre. The new childcare centre at the kids' hospital would have the capacity to take extra money.

Ms R. Brown: It would be activities that cannot be inconsistent with and do not have an adverse effect on the performance of their core functions.

Ms J.M. FREEMAN: So you cannot have a pub there!

Ms R. Brown: You cannot have things that would impact on its core functions, which is the provision of health services. The other point is with regard to a health service provider, which at subclause (6) states —

> … is taken to be expressly authorised by Parliament for the purposes of the *State Trading Concerns Act 1916* …

They must operate under those broader principles and requirements.

Mr R.H. COOK: In relation to a commercial activity that is not inconsistent with the performance of a hospital or a health service's functions, would it include activities such as selling cigarettes at a retail outlet in a hospital?

Dr K.D. HAMES: No. We do not allow the sale of cigarettes at any of our retail outlets.

Mr R.H. COOK: Because they are unhealthy?

Ms L. Harvey: The activity has to be likely to be of benefit to the WA health system.

Dr K.D. HAMES: I think that rules that out then.

Mr R.H. COOK: Would it include a commercial activity which involved the sale of junk food or lollies?

Dr K.D. HAMES: I was waiting for that next question, because we do allow the sale of food in our hospitals.

Ms R. Daniels: It would not be the hospital that would be selling the lollies. It would be the commercial organisation that we had contracted with to provide food, which would be in your contract.

Dr K.D. HAMES: But I would not allow them to sell cigarettes

Mr R.H. COOK: But you would allow them to sell lollies and other high-energy, sugar-laden foods?

Dr K.D. HAMES: I do, and most of it goes to the staff, who work their guts out there and are dying for a fix of something.

Mr R.H. COOK: They are probably dying for a ciggie as well, so why do you not let them have one of those?

Ms L. METTAM: Everything in moderation!

Dr K.D. HAMES: This all came about because Jim McGinty, in the hospitals, was going to stop provision of all but green food. You could have a chocolate bar, but it could only be that big. You could not buy chocolates for patients.

Mr R.H. COOK: As the member for Vasse said, all things in moderation.

Dr K.D. HAMES: Sure, but what I was about was choice. People might only have a large chocolate bar once a year, but, if that was the day they wanted to do it, then they could buy that or buy it as a gift for a patient, as long as there were alternatives for them and, if they wanted healthy food, it was available for them. So, yes, that was a policy that I replaced. I presume in the future it will be a ministerial. If you ever get to be health minister, I presume you will turn the clock back to Jim McGinty and stop them eating those yummy foods.

Mr R.H. COOK: Given that we are now marching forward in a non-nanny state environment, why are you not selling cigarettes, given they are legal products?

Dr K.D. HAMES: Because I do not want to.

Mr R.H. COOK: Do you accept, therefore, the double standards you have brought to that decision?

Dr K.D. HAMES: Yes, basically.

Ms J.M. FREEMAN: I note that the health service provider is taken to be expressly authorised by the Parliament for the purposes of the State Trading Concerns Act 1916, and that establishes —

> **Minister responsible**, in relation to a financial entity, means the Minister within the meaning of the *Financial Management Act 2006*.

So who is actually the minister responsible in outlining the commercial activities that can be undertaken in a hospital? I would have thought the minister responsible, in relation to a financial entity, within the meaning of the Financial Management Act, is probably the Treasurer.

Dr K.D. HAMES: Who knows that? Ms Daniels?

Ms R. Daniels: I do not.

Dr K.D. HAMES: No? I reckon you have got them stumped this time!

Ms R. Daniels: Do you have in front of you the State Trading Concerns Act?

Ms J.M. FREEMAN: I do, and section 4A(2) states —

> A trading concern is authorised for the purposes of section 4(2) if —
>
> (a) the trading concern is carried on by a prescribed financial entity;
>
> (b) the trading concern consists of a prescribed activity involving the provision (in the State or elsewhere) of —
>
> (i) goods, information or intellectual property;
>
> (ii) scientific, technical, educational, training, management or advisory services; or
>
> (iii) advertising opportunities or opportunities to participate in arrangements in the nature of advertising or having a purpose similar to advertising
>
> and
>
> (c) the amount of any fee or charge imposed by the financial entity in the course of carrying on the trading concern has been approved by the Minister responsible for the financial entity.

Who is the minister responsible?

Dr K.D. HAMES: This does say that a health service provider is taken to be expressly authorised. It does not say it has to be expressly authorised; it says it is taken to be expressly authorised. Does that make a difference?

Ms J.M. FREEMAN: No. It is an implied term.

Ms L. Harvey: Section 4(2) states —

> No trading concerns … shall unless expressly authorised by Parliament or under section 4A be … carried on by the Government …

Clause 35(6) is saying that trading concerns by health service providers are expressly authorised, so they do not have to look to section 4A.

Ms J.M. FREEMAN: They are only under section 4(2), so they do not have to refer to section 4A?

Ms L. Harvey: No.

Ms J.M. FREEMAN: Just to section 4(2), which states —

> No trading concerns, other than those to which this Act applies or shall apply, shall unless expressly authorised by Parliament or under section 4A be hereafter established or carried on by the Government of the State or by any person acting on behalf of such Government or under its authority.

If it is expressly there, then it is exempt from that. That is what you are saying?

Ms R. Daniels: Yes. It is taken to have been expressly authorised.

Dr K.D. HAMES: So "taken to be" does make a difference.

Ms J.M. FREEMAN: So the minister responsible is still the minister. So he is still saying that he cannot sell cigarettes but can sell lollies.

Dr K.D. HAMES: Yes, and potato chips and chocolate.

Ms J.M. FREEMAN: Does that also mean that, because it is expressly authorised under the State Trading Concerns Act 1916, under that section 4A normally the minister would actually have to approve the fee and charge? Under section 4A(2)(c) is it expressly assumed that the minister has approved the fee or charge, by virtue of the fact that it is expressly authorised? You have got in here that you can do a payment of charges as the health service provider determines from time to time but, if this were in accordance with the State Trading Concerns Act—let us say you did not have that clause that said you do not have to comply—you would have to get that okayed by the minister, whatever the fees were. But does this mean that the payment of charges as the health service provider determines from time to time does not need to be authorised by the minister?

Ms L. Harvey: Yes.

Dr K.D. HAMES: Yes.

Mr R.H. COOK: In relation to subclause (1), would it be okay for a hospital or health service provider to have a tavern or a restaurant selling alcohol at a facility? Who makes the decision about whether that is consistent with the provision of health care?

Dr K.D. HAMES: I would have thought no, but I do not know who makes that decision. I do not think that that fits within "not inconsistent with, and do not have an adverse effect on, the performance of its other functions". I would have thought a tavern or bar is inconsistent with its other functions. Part of that component was about providing a health service. But someone might have a better answer than that. Anybody? No. My answer is as good as you are going to get.

Mr R.H. COOK: If it did undertake a commercial activity, would it be subject to the Trade Practices Act?

Ms R. Daniels: What section of the Trade Practices Act are you thinking of?

Dr K.D. HAMES: What a good comeback!

Mr R.H. COOK: I am wondering what authorises the minister to be able to determine what is or is not sold and what commercial activities get undertaken. If the minister can authorise the selling of products which are clearly unhealthy, why is it that the minister can ban other products being sold from commercial premises on a hospital?

Dr K.D. HAMES: It depends what you are talking about. If you are talking about alcohol, clearly you would need a licence, and that is governed by the liquor licensing act and a whole range of issues around that. You could not sell liquor unless you got a licence, but I cannot imagine anyone giving a licence to sell liquor on a hospital site, where you are supposed to be providing health service consistent with the act. I cannot see that that would be possible, but you look as though you have got a stronger answer than me.

Mr R.H. COOK: But you have just contradicted yourself, because you have said —

Dr K.D. HAMES: I have done that already before.

Mr R.H. COOK: — you are happy for them to sell lollies and other products which are not good for you and are contrary to your health.

Dr K.D. HAMES: Only if you eat them to excess—surely?

Mr R.H. COOK: That is the same for alcohol, is it not?

Dr K.D. HAMES: Yes, but to drink alcohol, you need a liquor licensing approval—a permit. If you wanted to sit down in the restaurant in my hotel and have a glass of beer and then go, if I had a licence, I probably would not object, but really it is not the purpose of the service. The purpose of the service —

Mr R.H. COOK: Is to sell lollies.

Dr K.D. HAMES: The purpose of the hospital is to provide —

Mr R.H. COOK: Junk food? Fizzy drinks?

Dr K.D. HAMES: — a health outcome, which also provides opportunities for people to eat and drink.

Ms R. Brown: In the development of the bill, advice from the State Solicitor indicates that despite there not being a definition of commercial activities, subclause (4) sets out that the health service provider must ensure that the activity is consistent with its service agreements and any relevant policy framework—so to the extent that the minister or others may wish to limit those commercial activities that could be achieved through "any relevant policy framework". It is likely that a whole range of activities would be inconsistent with the service agreement. The other point is the provisions within the Competition and Consumer Act would be relevant to the application of any commercial activities subject to those being consistent with subclause (4).

Dr K.D. HAMES: I think you are getting bogged down on the issue trying to make a point. I could equally make points about them growing medicinal marijuana on the roof under your government or —

Mr R.H. COOK: I have got no problem with that.

Dr K.D. HAMES: — in the backyard. I would think it would be more appropriate on the roof of a hospital.

Mr R.H. COOK: I was just wondering whether the minister could point out to the committee the likely benefits to the WA health system of selling sugary foods, chocolate, junk food and high-energy foods at a hospital?

Dr K.D. HAMES: I think it is critically important. People who are sick might get psychological benefit from a present of a box of chocolates. They might not necessarily even eat them on the premises. They might consume them on a later day. Medical staff who are suffering from hypoglycaemia in the course of their duties might wish to elevate their blood sugar levels by consuming a sugary beverage.

Ms J.M. FREEMAN: Do you also agree with Harry Potter that chocolate gets rid of Dementors?

Dr K.D. HAMES: Yes, that is entirely possible.

The ACTING SPEAKER (Mr I.C. Blayney): I might rule out any more Harry Potter questions.

Mr R.H. COOK: The minister has pointed out what the benefits to the people purchasing the unhealthy foods might be, tenuous although those claims may be. Of course, everyone knows that if you are having a hypoglycaemic episode you need a small amount of glucose and long-acting, low-glycaemic foods. I am not quite sure how the minister's recipe for ill health in our hospital system would actually provide that through chocolates and so on. However, the clause actually requires the activities to be of benefit to the WA health system. In testing out this clause I am keen to know how the current activities and policies that the minister is implementing in our hospitals would be consistent with subclause (4)(b).

Dr K.D. HAMES: This is a bit like when you are in Parliament and you guys jump up and talk about relevance. "Relevance" means related to and my second cousin is related to my great-aunt. The point is that if you are talking about benefits to the health system, the health system benefits enormously by having doctors and nurses who are fully capable of being able to carry out their duties without the psychological or philosophical sufferance of lack of food and/or other nutrients. It is certainly of benefit to the health system to have highly performing doctors, nurses and other allied health staff.

Mr R.H. COOK: That was absurd.

Ms L.L. BAKER: And history will show!

Ms J.M. FREEMAN: We keep talking about the fact that the minister has to approve this but, given what I asked about —

Mr R.H. COOK: They never actually ascertained that the minister had to approve it. They said that he or she probably would be required to approve it.

Ms J.M. FREEMAN: That is what I want to go back to. This is about a health service provider earning revenue by engaging in commercial activity. We know now that the health service provider is taken to be expressly authorised by the Parliament, so it does not actually have to comply with any of the provisions of the State Trading Concerns Act, where a minister has to actually approve things like the fees and other stuff. We know that when engaged in a commercial activity the health service provider must ensure that the activity is

consistent with its service agreements and relevant policy framework. The policy frameworks are on page 22 in clause 26. I am yet to see there where the policy frameworks go to how you earn revenue by engaging in commercial activities. Is it not actually a ministerial decision about whether you provide lollies at a hospital? Will it become the health services provider's decision about what will be determined in terms of those commercial activities as long as they are consistent with the service agreements around the policy frameworks and are likely to be of benefit to the WA health system?

Dr K.D. HAMES: Good question. So, while ministers have made the decision in the past, will we be able to in the future? Is that another ministerial responsibility you are taking away from me?

Ms R. Brown: Clearly, the minister retains the responsibility to issue directions on any of the matters, but you could set in policy and through the policy framework what sorts of commercial activities.

Dr K.D. HAMES: I think that means that in some ways the member for Kwinana will get his way in that a minister will no longer be able to say to a hospital, "This is the food product you will be providing", unless they do it by direction and no minister in his right mind is going to direct them to provide the sorts of foods that the member for Kwinana is talking about. So it will come down more to being up to individual health service providers what they do in their hospital, except the opposite can apply. In which case a minister might well set a policy that all hospitals will provide healthy foods, like you do in schools. So you are much more likely to get the outcome you desire under the rules that are being put in place than the ones we have got now where I have a direct input, so you should be happy.

Clause, as amended, put and passed.

Clause 36: General powers —

Ms J.M. FREEMAN: I am really intrigued by the general powers in subclause (3)(c) which states that a health service provider may for the purposes of performing any of its functions —

> participate in any business arrangement and acquire, hold and dispose of, shares, units, or other interests in, or relating to a business arrangement;

What is envisaged there? I assume they are not going to do something like what local governments did at one stage and enter into the subprime mortgage market. It looked like it was a great investment and they had a AAA rating and then they lost lots of money. I am interested to know some background to that. What is expected with that? It just says it is subject to sections 37 and 38. Clause 37 is "Restrictions on power to dispose of land" and clause 38 is "Transactions that require agreement or approval". It does not necessarily say there that the transaction that requires approval is in terms of their shareholdings and what their shareholdings are. This does not seem too unlike clause 35 in talking about it being subject to the policy framework. My concern is that you have a health service provider that will say, "We can build our capacity if we invest in these shares". I am interested to know whether basically we will be allowing them to do share trading.

Ms R. Brown: Probably the first response is that any activities of health service providers must comply with the Financial Management Act and Treasurer's Instructions.

Ms J.M. FREEMAN: Which is what the local governments did.

Ms R. Brown: They do not have the ability to borrow. They are subject to clauses 37 and 38. Clause 38 will be supplemented by regulations that define —

Ms J.M. FREEMAN: Where does it say regulation?

Ms R. Brown: Paragraph (b) of the definition. Certainly the way in which this will be operationalised will be further managed through both even though it does not say by policy frameworks but it is implicit in there. Any other activities, particularly those related to subclause (3)(c) will come under the policy framework and certainly clause 38 in regulation will further define what they can and cannot enter into in regards to business arrangements.

Dr K.D. HAMES: What if we pay, under activity-based funding, the south metropolitan board $1 billion a year and the board decides that it wants to park its money in an investment fund to get better interest before it spends it? What is there to stop it from doing that? Local governments have lots of spare money from people paying rates, they invest that, normally on the long-term bond rate —

Ms J.M. FREEMAN: No, they did not do it on the bond rate; it was shares.

Dr K.D. HAMES: Normally they do it on the long-term bond rate—three and six months—to get the maximum interest rates for their ratepayers. Quite a few of them decided that a AAA credit rating–approved market in the US, which was Fannie Mae and Freddie Mac —

Ms J.M. FREEMAN: It was a group of them.

Dr K.D. HAMES: Yes. They thought that was a good place to park it and they lost piles of money and went broke. So what is to stop those boards from making a decision to invest the money that we give them to run the health service in that sort of operation?

Ms L.L. BAKER: A high-risk futures market or something?

Dr K.D. HAMES: Yes, anything like that.

Ms L.L. BAKER: Hedge funds is what I am thinking of.

Dr K.D. HAMES: Does anyone have an answer?

Ms J.M. FREEMAN: Again clause 36(3)(e) says that a health service provider may "produce and deal in any equipment". I have two questions about that. What do you mean by "deal"? Does that mean that you can have a situation where you have a deal with another hospital in terms of selling it to another hospital? I am wondering what "deal in any equipment" means. It states, "produce and deal in any equipment". It states that the health service provider may produce, which is interesting in itself, and deal in any equipment, facilities or system associated with the performance of its functions.

Dr K.D. HAMES: Do you want that held over as well? Did you have another question relating to that?

Ms J.M. FREEMAN: When Ms Daniels said "transact" —

Dr K.D. HAMES: I did not hear her officially say that.

Ms R. Daniels: No.

Ms J.M. FREEMAN: Okay.

Dr K.D. HAMES: She was just talking to herself.

Ms J.M. FREEMAN: She was talking to herself. Let us say for the purposes of me getting clear what I am asking, that that is part of the issue. If there is a transaction in any equipment, can that transaction also mean the health service provider buys the whoop-de-do, fantastic, arthroscopic knee-operation machine that the minister talked about yesterday —

Dr K.D. HAMES: The Mako.

Ms J.M. FREEMAN: The Mako, so another hospital that does not have that can compete with Joondalup. So you start having competition between our real public hospitals and our privatised health systems that have a public service aspect to them.

Dr K.D. HAMES: That is good. You think our private hospitals are unreal. We think the same.

Ms J.M. FREEMAN: That is really my question. When you say "deal" does that mean to transact? I am also interested in what you mean by "produce". Does that mean they can make them? If "deal" means transact, does that mean purchase as well as sell?

Mr R.H. COOK: I am just wondering whether subclause (3)(g), and potentially also paragraphs (d), (e) and (f), would be subject to the provisions regarding commercial activities? For instance, with regard to selling advertising opportunities or sponsorship, would they need to be consistent with clause 35(4) or clause 35(1) for the purposes of exercising general powers under clause 36?

Dr K.D. HAMES: Does anyone have an answer to that now? I think you have them stumped on this. We will deal with them all at the end when we have had some study done. I move that clause 36 be considered at a later stage of the sitting of the committee.

Further consideration of clause postponed, on motion by Dr K.D. Hames (Minister for Health).

Clause 37: Restrictions on power to dispose of land —

Mr R.H. COOK: This is the capacity to dispose of land. Clause 37(1) relates to land vested in a health service provider under this act or land acquired by a health service provider. Is it envisaged that the health service provider will in fact be the owner of all the lands on which they have hospitals where they operate—without of course those hospitals that are on QEII—or is it envisaged that they would have some landholdings and the rest of the landholdings would be held by the department? I am seeking some clarification of how you see clause 37 working.

Dr K.D. HAMES: How are we doing this? Are we transferring all the land and health department to the area health service providers or not?

Ms R. Brown: It is a combination and it depends upon the land itself and who has ownership of the land existing, particularly with regard to crown land, the Minister for Lands' responsibility —

Dr K.D. HAMES: We are talking about land that is under the ownership of the Department of Health. Do we continue to own all that land through the head office of the department or do we transfer to the corporate bodies the land on which their hospitals stand? Some of those will have land adjacent. What are we doing?

Ms R. Daniels: My understanding is that the land that is presently within the "remit" of WA Health has various statuses. Some of it is crown land. For some of it we have the certificate of title or fee simple. In other circumstances the land appears to be owned by boards or entities that never existed or existed in the past. In the first instance, the land from WA Health will be placed in the ministerial body and then the control and management of it will be transferred to the health service providers, but it will stay within the ownership of the state. There is also land that we have buildings on that is crown land. It will all become part of the state, but it may be under the Minister for Health, the ministerial body, or crown land.

Mr R.H. COOK: If I may try to interpret what you have said, you are basically saying the ministerial body will hold on to all the land so it will not come under the auspices of the health service provider or the board. Or would there be occasion that the health service provider may take ownership of some land? Maybe there is a small parcel which they would buy off a local business, or something like that, for the sake of their operations. I am just trying to ascertain why we have a capacity to dispose of land. From what I gather, you are saying that the minister will continue to hold on to this.

Dr K.D. HAMES: There is more to it than that. It is because there is land under the control and management of the Minister for Mental Health as well. Although, I think after that it is still land that comes under my control as the minister, even though it is her administration. The reason I know all this is that we had a piece of land up Roleystone way, or something, that was no longer being used by the Minister for Mental Health. They wanted to use that land, so they came to me. I had to ask the Minister for Mental Health if they had any purpose for it. The answer was no. Then we had to go and see if other government departments had a purpose for it. Only then could we proceed to do something with that land. In fact, I do not think it has even got through that process yet. Can you answer in the context of all that, Ms Daniels?

Ms R. Daniels: The land in the first instance will be under the responsibility of the ministerial body. In the future, there may be circumstances in which the "ownership" of that land could be transferred to the health service providers. But in the first instance and in the near future, it is my understanding that the policy behind putting that particular thing in there was that they may in the future want to allow health service providers to dispose of the land.

Ms J.M. FREEMAN: In terms of the health service land and the disposal of the land, does that include land such as the Swan district land—the land that is now no longer hospital owned as such?

Dr K.D. HAMES: I think it is still Department of Health land, or is it crown land? I think it might be crown land under our responsibility. Do you know?

Ms R. Daniels: No, I do not.

Dr K.D. HAMES: I am pretty sure it is crown land. It is the same with PMH and Shenton Park. The requirement of government is that the Minister for Lands is responsible for any disposal of government land. That is why we nearly had trouble with the Mirrabooka one. I am required, I guess, by government policy to hand over that land for disposal to the Department of Lands.

Ms J.M. FREEMAN: Yet the act gives a capacity to dispose of land. The general powers, which we have gone through, are: acquire, hold, manage, improve, develop, dispose of and otherwise deal in property.

Dr K.D. HAMES: The answer was that, even so, under our policy they would have to do it under the requirements of the Department of Lands. If they chose to sell something, they would probably still have to do that back through the Minister for Lands.

Ms J.M. FREEMAN: So they do not actually dispose of it as such. All they do is make a policy decision to dispose of it, and then the Minister for Lands disposes of it or the approval through that.

Dr K.D. HAMES: That is the advice I have, yes.

Clause put and passed.

Clause 38: Transactions that require agreement or approval —

Ms J.M. FREEMAN: I find this really interesting because, with the transactions that require agreement or approval, you say that they can be prescribed by regulations, and then you just say that, despite that, you have to have written agreement from the minister, but the minister must obtain the Treasurer's approval before giving any written approval. Basically, health service providers have no capacity regarding the exemption. It then goes on and refers to the exemption, but clause 38 seems to extinguish the exemption. When you read clause 38, it looks like it extinguishes the exemption from clause 39, or is my reading of that wrong?

Ms L. Harvey: Under clause 38(3), you must have the minister's agreement before you enter into a transaction, unless it is an exempt transaction. If it were exempt under clause 39, you do not need to get the minister's written agreement.

Mr R.H. COOK: I think this is one of the sections that the AMA would probably regard as far too restrictive in establishing the boards. There—I have said it.

Dr K.D. HAMES: That is interesting.

Mr R.H. COOK: Yes, it is.

Clause put and passed.

Clause 39: Exemptions from section 38 —

Mr R.H. COOK: Under this section, a board is provided with an exemption in relation to the other restrictions that would be on a transaction. From that point of view, I am wondering whether in some respects this is a backdoor method for getting around the framework. What is a typical transition that the minister would see as eligible for an exemption?

Ms R. Daniels: It is, in fact, putting in place certain exemptions. My understanding is that normally we will set classes of things for which we want exemptions from the Treasurer. Is that correct? There will be occasions—for perhaps classes of transactions—when our minister seeks exemptions from the normal Treasury instructions for that class of transaction. That is my understanding.

Clause put and passed.

Clause 40: Delegation —

Ms J.M. FREEMAN: Clause 40 states —

> A health service provider may delegate any function of the health service provider under another provision of this Act to —
>
> (a) a member of the health service provider's board;

Does the member that they are delegating to have to be an employee—not a staff member but an employee—of the health department?

Ms R. Daniels: You are referring to clause 40(1)(a)?

Ms J.M. FREEMAN: Yes.

Ms R. Daniels: In fact, if they are a member of the health service provider's board, they cannot be an employee of the health service provider. Later on when we get to the boards, we will see that staff members or employees of that actual health service provider cannot be members of the board.

Ms J.M. FREEMAN: The health service provider can delegate any function to a member of the health service provider board and that member will not be an employee or a staff member of the health department.

Dr K.D. HAMES: That is correct.

Ms J.M. FREEMAN: Would "a committee", as referred to in paragraph (b), be a committee of the health service provider board?

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: None of those people would be staff members of the health department.

Dr K.D. HAMES: Correct.

Ms J.M. FREEMAN: Obviously, a staff member of the health service provider is an employee of the Department of Health.

Dr K.D. HAMES: Yes.

Ms J.M. FREEMAN: Why has the minister enabled "any function of the health service provider under another provision of this Act"? I do not know which other provision. It does not say "any provision of this act"; it says "under another provision of this Act"—to be delegated to someone who is not an employee of the health department?

Ms R. Daniels: I do not actually understand the question.

Ms J.M. FREEMAN: If you are delegating any function of the health service provider—I am not sure which other provision of the act it is delegating—you are delegating that responsibility for the health service provider to one individual who is not an employee and is, therefore, not covered by the code of conduct in the Public Sector Management Act that we talked about or those sorts of provisions. How is it that we have decided that that can be delegated to someone who is not an employee? I do not understand.

Ms R. Daniels: I have to ask the question again. Somewhere else in the bill, you are suggesting that we allow a delegation from a health service provider to someone not having any connection whatsoever to the health sector.

Ms J.M. FREEMAN: No, no. They have a connection because they are a member of the health service provider's board—they have that connection—but they are not covered by the Public Sector Management Act and they are not—

Ms R. Daniels: All right. You are looking at paragraph (a).

Dr K.D. HAMES: Depending on whether a committee might —

Ms J.M. FREEMAN: It does not matter. Let us not confuse it. Let us stay with paragraph (a) because it is the same thing.

Ms R. Daniels: Those persons who are members of the health service provider board are statutory appointments by the minister, and they would have responsibilities on that board that could have and will have codes of conduct for how those board members behave, conflicts of interest and those kinds of things. Rebecca may be able to talk more about that. As a board member or as a committee member of that board, they will have responsibilities.

Dr K.D. HAMES: All right. Do you want to expand on the responsibilities of a board member? Even though they are not covered by the Public Sector Management Act and the required codes of conduct, presumably there are rules in place around the board itself as it goes off and undertakes tasks.

Ms R. Brown: There are two parts to it. The overall management and responsibilities of public sector boards are governed either through the establishing piece of legislation, which is partly this, or through the Public Sector Commission's responsibilities. They have, obviously, a role to play in overseeing the governance of boards and committees more generally. With regards to health service boards, what will be established under policy framework is a statutory board operations framework that sets out a range of responsibilities on the boards. As Robyn has picked up on, obviously some of those are the management of conflicts of interest, the way in which boards will be established and required to operate, and insurance processes. We are going through the process in understanding what their legal responsibilities will be in that process, but we will have a policy framework in place that actually guides the statutory board operations, consistent with other jurisdictions that have health service boards and quite substantial statutory board operations in place.

Ms J.M. FREEMAN: Clause 40(1) states —

> … delegate any function of the health service provider under another provision of this Act …

Which is the other provision of this act?

Ms L. Harvey: That is in there to say that you cannot delegate your delegation function. You can delegate any function that you have under another provision of the act but you cannot delegate your delegation function.

Ms J.M. FREEMAN: I see what you are saying.

Ms L. Harvey: It is standard wording; we use it in all of them.

Ms J.M. FREEMAN: Clause 40(3) states —

> A person or committee to whom a function is delegated under this section cannot delegate that function.

Now you have completely confused me.

Ms L. Harvey: We do say it twice.

Mr R.H. COOK: To make it really sure.

Ms L. Harvey: No, no.

Unidentified adviser: It is a delegated function, is it not—not delegation?

Ms L. Harvey: A different thing. The health service provider cannot delegate its delegation function, and a person to whom a function is delegated cannot delegate that function.

Clause put and passed.

Clause 41: Execution of documents by health service provider —

Ms J.M. FREEMAN: I have not really looked at this, but this goes to the common seal and all that sort of stuff. Where is the bit that allows you to do it by facsimile? Oh, there it is, with the facsimile mentioned. I am very happy. Thank you very much.

Clause put and passed.

Clause 42 put and passed.

Clause 43: Terms used —

Mr R.H. COOK: We have this particular service—the alcohol and drug health service. There are obviously definitions provided under clause 43. I am wondering why we have actually decided to distinguish alcohol and drug services as opposed to all the other health service providers and the various forms that they would take.

Dr K.D. HAMES: Ms Harvey knows about that.

Ms L. Harvey: It is a policy decision of the department. Alcohol and drug health services are provided by a different department.

Dr K.D. HAMES: Helen is the minister responsible for alcohol and drug services, Hon Helen Morton. She has that as part of her portfolio.

Ms R. Daniels: Originally, the head agreement was about mental health services, but the Mental Health Commission delivers, or contracts for, mental health services and it also contracts for drug and alcohol services, so that is why it was put in there. There was a suggestion that "mental health services" was not broad enough to include drug and alcohol services. It was a request by the Mental Health Commission to put that in to make sure that, with that, they could purchase drug and alcohol services, particularly in the country, from the public health system.

Mr R.H. COOK: This is one of the reasons I was so opposed to the actual amalgamation of the Mental Health Commission and the alcohol and drug service, because it used to come under its own legislation, and it made sense that it had its own legislation, because we would confront these situations. For some reason, we have this one, but it still strikes me as unusual. Surely we are not suggesting that alcohol and drug services are exclusively for that role, and surely at some point in the future we might have a completely different way of visualising the way we deliver those sorts of services, so why would we bind ourselves now to a particular form of service delivery?

Dr K.D. HAMES: I do not know that this binds us to a type of service delivery, because service delivery changes. These are just the terms used in the document. We talk about alcohol and drug services now, because that is the service that exists. I might read in my boat in 10 years' time that you have changed the way it operates. I look forward to that day!

Mr R.H. COOK: It just confirms my suspicions that at the time it was more about ministerial empire-building than it was about decent health legislation.

Clause put and passed.

Clause 44: Head agreement between Department CEO and Commission CEO —

Mr R.H. COOK: In the likelihood that the Mental Health Commission contracts the Department of Health to deliver some of its mental health services, this provides the framework by which the CEO of the Department of Health will be engaged through a head agreement, which will then inform the service agreement which is struck between the CEO of the commission and the health service providers. I want to confirm that the minister envisages that you would have a situation where, potentially, the Mental Health Commission does not contract the Department of Health or the health service providers to deliver health services on behalf of the commission.

Dr K.D. HAMES: At this stage we certainly do not envisage doing that, but that is not to say that that will not change in the future. That will be a choice for the government of the day, including our government. If the Premier decides to change the way the system operates in the future then that is the decision that will be made.

Mr R.H. COOK: Is that why the word "may" has been put in in subclause (1), rather than "must" or "will"?

Dr K.D. HAMES: The word "may" has been put in by someone entirely other than the government. Ms Daniels.

Mr R.H. COOK: Are you accusing her of doing it or are you asking —

Dr K.D. HAMES: I presume they rate it, and so they did not do it under any direction from government.

Ms R. Daniels: My response to that is that I agree with the minister: he did not say to put "must" or "may" in. It allows for flexibility.

Clause put and passed.

Clauses 45 to 48 put and passed.

Clause 49: Term of service agreement —

Mr R.H. COOK: This clause talks about the term of a service agreement being for not longer than one year. I am keen to get an understanding from the minister of how he would see this operating. I assume we are not talking about the financial agreement that would come in relation to the service agreement. The service agreement is simply advising or informing the financial arrangements that are in place in terms of what the health service provider will be contracted to do. I ask this question because a service agreement for a term of not longer than one year, in a modern government environment, seems drastically short.

Ms R. Brown: The service agreement, which is obviously a legally binding agreement, and linked to the financial allocation to health services, is therefore linked to the annual appropriation process, which is only one year. Therefore, they are also required to produce and table an annual report that relates to their service agreements. It does not rule out the possibility, through a policy framework, that you could provide a three-year forecast period based on WA Health's forecast more generally, but, in terms of having a term of a service agreement, it cannot be longer than the actual appropriation period.

Dr K.D. HAMES: Can you explain subclause (2)?

Mr R.H. COOK: A "Commission service agreement" is the mental health one, by the sounds of it.

Ms R. Brown: As long as it is not that one. It must cover the forecast period set out in the relevant policy framework. So, under the financial management policy framework or the resource allocation, you might have something linked to the forward estimates.

Mr R.H. COOK: At the risk of exposing deep and profound ignorance of the financial arrangements of government processes, how does that work for a contracted entity? Surely they would be looking for a contract which goes longer than a year—any NGO that is contracted. I am trying to reconcile it with this terminology. I apologise for having to take you back to financial management 101.

Ms R. Brown: In this instance with the statutory authority and the department, through the annual appropriation process—that is their fixed annual allocation—when it comes to entering into a contract with an external party, the agency that enters into that contract must have a secured financial resource to do that, either through —

Mr R.H. COOK: A decision of cabinet.

Dr K.D. HAMES: I am glad you do not understand it, because I do not fully understand it. Say the service agreement is with WA Country Health Service, it has a service agreement that guarantees it funding up to a certain amount for one year only, but it constantly enters into contracts that are three-year contracts, particularly for the Aboriginal Health Service. Under this, they do not have secure funding for the second and third year of that, because the service agreement only covers one year. So how does that work?

Ms R. Brown: Under the appropriation arrangement agencies are under, what is legally binding is the annual appropriation. Governments can make changes in future years. Under a contract, you do need to be able to demonstrate at that point in time there is a funding source. If you change your contractual arrangements, that is a breach. Under the conditions of the contract, the state would include penalties.

Dr K.D. HAMES: I understand that, but how does the WA Country Health Service guarantee that it has the funding supply for the second and third year of the contract if it is only guaranteed funding for one year? It seems to be contradictory. The government, at the end of the day, still has to provide the money, but it is the WA Country Health Service that is doing the contract. I am sure it is doing it on behalf of government. I presume that is the cover—because it is doing it on behalf of government, it is sure of the funds. Presumably it is in the forward estimates; otherwise it would not be allowed to do it. Is that right, Ms Daniels?

Ms R. Daniels: I would suggest that, in the circumstance of WACHS, it was predicting that it would have sufficient resources in the next year so that, if the money were reduced by, say, 10 per cent, it would still have sufficient resources to continue to fund that contract with the Aboriginal medical service for years 2 and 3. As my colleague here says, it is the same with employees. We say, "You will be here this year, next year and the year after." You cannot predict that you are going to have money for all of those.

Mr R.H. COOK: Kim might have a spectacularly bad year in the ERC!

Clause put and passed.

Clause 50: Procedure to amend service agreement —

Mr R.H. COOK: Under subclause (2), the CEO has to step in and decide the term and advise the health service provider around the changes or the amendment to the service agreement. Does that have legal ramifications? I think you mentioned earlier that the service agreement is a legal document. Does that mean that a person engaged by the service agreement does not have a right in that process? Is there a mediation? Or am I starting to misinterpret the role of the service agreement?

Ms R. Daniels: The first thing I would query is that a service agreement is binding and it is a "contractual" arrangement between the system manager and a health service provider. Within government there are not normally legally enforceable contracts; it is far more likely to be an MOU-type arrangement, because governments do not sue each other. So, in our deliberations around what we would do when there was a stalemate, we ruminated on it for quite some time and decided that, as the system manager, he or she can make decisions about the system. Trying to override another minister and his or her processes was difficult. So we ended up with that clause.

Mr R.H. COOK: I apologise: sometimes these examples get a bit absurd. Say the minister or the CEO or the health service provider amended the service agreement with a contracted private entity like Ramsay Health Care for Joondalup Hospital or something like that And said, "We now no longer want you to do this procedure. We are going to do that elsewhere within our health service provider area, because we have now had a change to our service agreement." Would the private entity then be able to say, "Hang on a minute. You gave us a service agreement at the beginning of the year that said that we were going to do 20 arthroscopies this year, and now you have come back to us to say you are going to do them elsewhere. You are breaking the contract. You are saying, 'Hang on—it is just a service agreement.'" They say, "That might be, Sunshine, but we have employed a whole bunch of people and expect to be able to do that service."

Ms R. Daniels: Two different things. One is the service agreement between the system manager and the health service provider. The other circumstance that you talked about was that the health service provider has a contract, which is legally binding. What I would suggest that the health service provider would do in entering the contract, perhaps with the Aboriginal medical service, which we used as an example, is have as a term in their contract that the contract is for three years, but will be subject to the flow of funds for that. I would suggest, in the old NGO area, that that is what is written into the contracts that Health, Child Protection, whoever, does that, while the health service provider has an MOU-type service agreement between the system manager and the health service provider, when the health service provider goes outside and has a formal contract. Yes, it would be a breach of contract if they said, "We are not going to do it anyway."

Dr K.D. HAMES: I can think of two examples, one if you look at Ramsay. We have decided to give some bariatric surgery. If we suddenly decided we did not want to do that anymore, too bad for us. We have a written agreement. We have to pay that funding. Another example is in Peel Health Campus, where we have a contract in place that has not run out yet, and we are in that contract period for negotiating a possible extension. What we are negotiating is a change in that contract. If they agree, we will make the change. If they do not agree, they can say, "Get stuffed." We then have the ability to not extend the contract.

Clause put and passed.

Clauses 51 to 54 put and passed.

Clause 55: Fees and charges for the provision of health services —

Ms J.M. FREEMAN: I was just looking at the Hospitals and Health Services Act and I could not see this provision. Is that a new provision or has it come from a provision in the existing act?

Ms R. Daniels: There is an ability to charge fees in the Hospitals and Health Services Act. Is that the question?

Ms J.M. FREEMAN: Is proposed section 55 a new section or does it come from a section that already exists in the Hospitals and Health Services Act 1927?

Ms R. Daniels: Fees and charges for the provision of health services is within the Hospitals and Health Services Act. The concept in proposed section 55(1) of a "non-chargeable health service" is a new term, but it is an existing circumstance. We have non-chargeable items or health services which are the Medicare-designated services.

Ms J.M. FREEMAN: The definition of "non-chargeable health service" reads —

> (a) a health service provided to a person in respect of which it has been agreed under the National Health Agreement …; and
>
> (b) a health service in respect of which the Minister has made an order under section 56(2)(b), but only if the order is in force at the time the service is provided.

So the minister can make an order of what is a non-chargeable health service, plus what is in the National Health Agreement. That is new. You have never had non-chargeable health services before. I suppose I want to know why it was felt necessary to put it into the legislation.

Ms R. Daniels: My colleague has shown me at section 37(3) of the Hospitals and Health Services Act 1927 —

> Regulations may be made under this section —
>
> (a) so as to apply —
>
> (i) at all times …

Do you want me to keep reading or can you find it?

Ms J.M. FREEMAN: It is section 37(3) from here?

Ms R. Daniels: It is section 37(3) from the Hospitals and Health Services Act. It was in regulation before. It goes all the way through to —

Ms J.M. FREEMAN: So, the non-chargeable health services in regulation previously?

Ms R. Daniels: Yes, particularly paragraph (ad), which reads —

prescribing that no charges are payable in respect of any class of service, any class of patient and any public hospital or class of public hospital; …

Ms J.M. FREEMAN: I cannot find where you are talking about, but that is all right. I heard what you said, but I could not see it. Which section was it again?

Ms R. Daniels: Section 37(3) that commences "Regulations may be made under this section". Then the one I read out was paragraph (ad).

Ms J.M. FREEMAN: The interesting thing is that that was "prescribing that no charges are payable in respect of any class of service"; this is, I suppose, an expanded definition of that, is it not? These are actually putting non-chargeable health services in the national health agreement into the act. Is that in response to the threat from the national government of bringing in a gap payment or anything like that?

Ms R. Daniels: No.

Clause put and passed.

Clause 56: Minister may fix fees and charges —

Ms J.M. FREEMAN: On the fixing of fees and charges, clause 56 states —

> (2) The Minister may, by order published in the *Gazette* —
>
> (a) fix a scale of fees and charges for the provision of health services …

Does that include car parking fees or is that in clause 59?

Ms K. Seneviratne: No, it is not car parking fees, and car parking fees are not in clause 59 either. It is under part 16, which provides for management and control of traffic which includes parking fees.

Ms J.M. FREEMAN: So clause 56(2)(a), "fix a scale of fees and charges for the provision of health services by health service providers", is that to do with getting operations, services, physiotherapy, occupational therapy or those things at the hospital?

Dr K.D. HAMES: That is correct, is it not?

Ms K. Seneviratne: Yes, that is all health services.

Ms J.M. FREEMAN: That specifies that will go, as I note that clause 56(7) will be subsidiary legislation, before Parliament?

Dr K.D. HAMES: The answer is yes.

Ms J.M. FREEMAN: I am assuming that this legislation is not going to add anything more to that schedule; it is this just putting it in this legislative instrument in this form. You are not looking at increasing what has been published in the *Government Gazette* thus far?

Ms R. Daniels: That is our present intention. It will largely replicate the fees and charges that we are presently, from the point of view of the minister, publishing or fixing—the scale of fees. Our present intention is to pick up what we do now and put it into the new act.

Mr R.H. COOK: Does this clause provide for a health service provider to provide health services outside of their service agreement for a fee? I guess typically that would be whether they can sell private health services on top, if they have some spare capacity over and above their service agreement contracted services. I guess they should be able to, should they not?

Dr K.D. HAMES: We were just thinking under arrangement (a) and (b), people who —

Mr R.H. COOK: I believe they can, and therefore they do.

Dr K.D. HAMES: I think what can happen is that where there is capacity in a hospital now, doctors who operate privately can bring a private patient into hospital.

Mr R.H. COOK: Under (a) or (b) or whatever it is.

Dr K.D. HAMES: Yes, whichever one it is, (a) or (b). I never know.

Mr R.H. COOK: Good, because I do not understand it either.

Question put and passed.

Clause 57: Liability of persons for health service fees and charges —

Ms L.L. BAKER: I would just like to have a bit more understanding of clause 57(2) and the circumstances under which —

> A health service provider may waive, or refund, the whole or any part of a fee or charge.

It probably goes on now already, but it would be really interesting so that I know, if I am ever in need of a fee waiver, what excuse I should pull. Could you just describe some of those and give a bit of an example for me?

Dr K.D. HAMES: I will answer the bit that I know about what happens now with me as the minister. There are two things that occur. One is when we have a patient who elects to be a private patient in a hospital and we waive the gap. I have to sign off regularly on a form that waives the gap. That is for legal reasons. Part of the problem was that most health insurance funds have an agreement to pay 65 or 85 per cent of the fees, or whatever the amount of it may be. If we said, "Okay, we are going to accept that as full payment", the insurance companies say, "Well, your full fee isn't what the full fee was; it is 85 per cent, so we are only going to pay 85 per cent of that", and down and down we go. The legal way for us to get around that was to charge the full fee, have the patient pay their 85 per cent through their private insurance fund, and then I officially waive the gap. That is the way we got around that.

The second is that I have the capacity to waive fees, and I do it on regular occasions—without telling the Treasurer, I might add. There was a great example of, I think, someone in the member for Rockingham's electorate. Someone down there went to Rockingham hospital. She was in a de facto relationship and she was able to use Medicare—I think she was a New Zealander—because she had a partner who was Australian. She went to hospital and had her child, and by the time she came out they had separated.

Ms J.M. FREEMAN: He had done a runner.

Dr K.D. HAMES: He had done a runner. She was then left with the total bill for the hospital service, so I wrote off the bill.

Ms J.M. FREEMAN: That is Kwinana for you!

Mr R.H. COOK: It sounds like one of my constituents!

Dr K.D. HAMES: I have done things like that on a number of occasions. It is a similar thing with people coming from overseas, from Georgia in particular. The Georgian ambassador thinks I am wonderful because on a couple of occasions he has had to come when people have been in dire straits for whatever reason—a mess up with their insurance. They come here and some young person has had an accident and ended up with a big bill and a total incapacity to pay, so we have written those things off. It is a regular thing that occurs. They are only the two bits that I know. I will need to get staff to answer the rest.

Ms J.M. FREEMAN: All of that sounds wonderful, but there is no system in that other than your bleeding heart.

Dr K.D. HAMES: No, there is not.

Ms J.M. FREEMAN: On the basis that this is now —

Dr K.D. HAMES: Except for the first bit.

Ms L.L. BAKER: He is a Lib; he does not have a bleeding heart!

Mr R.H. COOK: You cannot get blood out of a stone!

Dr K.D. HAMES: For the first bit there is the system. We automatically do that.

Ms J.M. FREEMAN: So the gap one is automatic?

Dr K.D. HAMES: That is right. What this does is give the board of the health service provider the ability to do that.

Ms J.M. FREEMAN: So this takes the waiving decision away from you as the minister?

Dr K.D. HAMES: The "bleeding heart" decision; correct.

Ms J.M. FREEMAN: It takes it completely away. Is that the case?

Ms R. Daniels: Correct.

Dr K.D. HAMES: It is very unreasonable.

Ms J.M. FREEMAN: Ms Daniels said "correct"; the minister said "unreasonable". He could amend it if he chooses to. I have another question about that. The health service provider may waive the fee. The actual fees are going to come before Parliament as pieces of legislation which can be adopted through Parliament. But with the way that they are waived or refunded—the whole fee or part of the fee—there is no outside critical eye to that

process; it will all be based on the health service provider. I have just looked to see whether this is determined in the functions and powers, and I cannot see where it is determined in the functions and powers. How do they waive? I want to know what the process is, apart from the minister caring enough when someone's partner did a runner or some Georgian person got injured. I understand that the gap is a reason so you can get a partial payment to a public health system from the private health system, and there is a method of doing that that therefore makes that possible—you waive the gap after the payment. What is the process other than that, how will it be transparent and why will it not be put before Parliament in the same way the fee is put before Parliament?

Ms R. Daniels: We were trying in that clause to get it to the level of persons who would understand and know. In the past, to waive a fee it had to either go through the route of the FMA or the health minister, as the board, had to explore the financial circumstances and go through a very detailed process to work out that the member for Maylands did not have the resources to pay that fee.

Ms J.M. FREEMAN: It is because she is paying too much for veterinary fees!

Ms R. Daniels: By putting it at the health service provider, they are the ones who would get the complaint or the plea and deal with it.

Ms J.M. FREEMAN: I am not suggesting that they cannot have the complaint or the plea; that is perfectly reasonable. But, for example, if you sit on a board of the superannuation companies, you can release funds for someone under hardship provisions. But ASIC, or whoever regulates it, actually outlines what you have to show to get that, so that way that does not occur. My concern is that you could get a board that is quite harsh versus another board that is quite lenient. If I went and got my operation at Royal Perth Hospital and circumstances changed and my husband did a runner on me and he had the Medicare card, I could get that waived or I could end up with a payable service.

Mr R.H. COOK: So who describes the criteria?

Ms J.M. FREEMAN: Yes. Where is the criteria, how is it analysed and who does it? Is that determined by functions and powers?

Ms R. Daniels: This is the policy decision, not a legal response. The policy decision was to leave it at the health service provider level and not put criteria into it, in that it would then introduce a complexity. Perhaps it could be set in a policy framework, but, again, the member for Maylands, with her plea, may not fulfil those criteria, so it is then she could go to the minister.

Dr K.D. HAMES: The description you gave could just as easily apply to any minister. If you had the current Attorney General there, nobody would have got a dollar. It depends on the person who is there. At the end of the day for government, we have a responsibility.

Ms J.M. FREEMAN: But it should not depend on the person who is there.

Dr K.D. HAMES: You could change that if you wanted as a government by setting policies in place.

Ms J.M. FREEMAN: You could put a framework in, but where does it say that? That is the point.

Dr K.D. HAMES: It does not say you have to, but under the clause that says that directions can be given and governments can set frameworks, which we have already dealt with, a government or a CEO could set a framework around which those decisions are made. That is probably the fairer way to do it.

Ms J.M. FREEMAN: We have an ad hoc process of deciding how it may be waived or refunded on the basis of saying that the people it has been referred to have a level of knowledge and information that you want to give them that decision-making capacity. Let us say, for example, that they do not allow the woman who was a New Zealander and whose husband left and who was left with that fee because previously she did not come under—she does now—the Medicare provisions. How is that fine enforced under clause 57? Is there an enforcement further on in the back that covers clause 57? What is the fine? Is the fine just pursuing the outstanding charge, and where is the linkage in terms of the legislation to enforce that debt to the Department of Health or to the health service provider? Where is the linkage for the health service provider to pursue that debt?

Dr K.D. HAMES: It would be whenever we cover any debts, because debts occur for other reasons.

Ms R. Daniels: There is no fine associated with it.

Ms J.M. FREEMAN: Sorry, I have confused the conversation by bringing "fine" into it. How do you enforce the debt?

Ms R. Daniels: You may not choose to enforce the debt.

Ms J.M. FREEMAN: No, I get that.

Dr K.D. HAMES: But if you do.

Ms J.M. FREEMAN: In this piece of legislation, where does it give you the right to enforce the debt?

Dr K.D. HAMES: Just suppose, for example, under the previous system where we had someone who chose to use private insurance and we chose not to write off the gap, they would have a debt to the hospital. If they do not pay that debt, there must be standard mechanisms in the bill for recovering moneys owed by individuals to the health service.

Ms L. Harvey: Clause 230(2)(c) enables the making of regulations about the recovery of fees and charges.

Ms J.M. FREEMAN: Subsection (2) states —

> Without limiting subsection (1), the regulations may provide for, authorise, prescribe, require, prohibit, restrict or otherwise …
>
> (c) fees and charges payable under this Act and the recovery of those fees and charges;

If they contravene —

Dr K.D. HAMES: That would be pretty standard, presumably, in any act, when people owe money.

Ms J.M. FREEMAN: Yes, I just wanted to show where it was, that is all.

Clause put and passed.

Clause 58 put and passed.

Clause 59: Fees and charges for other services, goods and facilities —

Ms J.M. FREEMAN: We have established that clause 56 is for physio or having a baby and not being on Medicare. Is "other services, goods and facilities" only for health services or is that facilities like using a function room or those sorts of things? What does "fees and charges for other services, goods and facilities" entail?

Ms K. Seneviratne: Examples of some of the ""other services, goods and facilities" would be running training courses, publications, provision of hospital reports, hiring out facilities and the provision of patient entertainment systems.

Ms J.M. FREEMAN: That is absolutely important. I note that, unlike clause 56, which will be placed before the Parliament as subsidiary legislation, this is not being placed before the Parliament as subsidiary legislation. Is there a reason for that?

Ms R. Daniels: In the past we have not charged unless it has been through regulation. For entertainment, it will be at cost. Given the past difficulties of putting it through the regulatory processes of Parliament for each of those statutory authorities—having to work out what the cost is and then having to adjust the regulation every time, say, the price of televisions goes up by 10 per cent and so on—the decision has been not to bother. This is an attempt to collect money that is spent within the public health system that is available for collection and is a legitimate collection—it will only be at cost—without having to go through the regulation. Under the current arrangements, you cannot even have automatic adjustment for the CPI. If it goes up by the CPI, that has to come back to the standing committee on fees and charges. It is an attempt to collect money that is spent on hospitals or health services under that act.

Ms J.M. FREEMAN: **I** just want to make it very clear: the fees and charges for these goods and services would only be cost recovery? Anything above cost recovery would be a tax and would be outside the capacity of the state government to levy those charges.

Ms R. Daniels: Correct.

Dr K.D. HAMES: And it would have to go to the committee for —

Ms J.M. FREEMAN: No, it does not have to go to the committee.

Dr K.D. HAMES: If it were above cost recovery.

Ms J.M. FREEMAN: No, it does not have to go to the committee. You have not made it so that it has to go to the committee. You have made it so it does not have to be done by regulation. You have given yourself the capacity to recover costs for other services, goods and facilities—the provision of training, the provision of facilities and the provision of entertainment. But we are very clear that it is simply cost recovery.

Dr K.D. HAMES: Yes, that is true.

Clause put and passed.

Clause 60: Minister may give directions —

Mr R.H. COOK: This relates to some of the powers that the minister has. I want to understand the relationship between a ministerial direction and a CEO direction and whether one has greater power than the other. Do the

same restrictions that apply to a CEO direction apply to a ministerial direction? Earlier, you said that a CEO direction cannot influence, for instance, industrial agreements and things of that nature. Do the same sorts of limitations apply to the directions of a minister?

Ms R. Brown: A ministerial direction overrides a CEO's direction.

Dr K.D. HAMES: Did you answer?

Mr R.H. COOK: Did you want to add something?

Ms R. Brown: I said no; I think it relates to a minister's direction overriding any other instruments.

Mr R.H. COOK: To date most of the communication has been between a health service provider and the executive—perhaps a better description is that it has been through the CEO. Why did you decide to give the minister an extra power to enable him to circumnavigate or get around the CEO?

Ms L. Harvey: Every act in the state that establishes statutory authorities has exactly this power in these words because the minister must have ultimate capacity to direct.

Ms J.M. FREEMAN: They never do.

Dr K.D. HAMES: I do not know about that. You are right that you never do it; that is because you actually do not need to because you have the ability to do it. On occasion I have said, "I am happy to give a direction if you want one", and they have said, "No, it is okay; we will go and do it." That is the normal conversation. They do not want to have to be directed.

Ms J.M. FREEMAN: There are 101 things you can say about that, are there not? You are saying there is no public accountability.

Mr R.H. COOK: What is the purpose of subclause (2)? It says —

> A direction given under this section cannot be—
>
> (a) about the nature of a health service to be provided to a particular person; or
>
> (b) in any other way in respect of a particular person.

This is to stop you helping the Georgian ambassador's friend.

Dr K.D. HAMES: No. This subclause stops me from having somebody come to me with a problem and me directing the health service to put that person higher on the list. That is appropriate. I encourage them to put people on lists if they have been, in my view, mismanaged. Often, they are people you or others have referred to me. But there are other people on the list above them, normally, who would be displaced by that person going forward. So it is a two-edged sword and you have to be very careful about doing it. It is right that I do not have the power to do that, but we encourage. I might write a letter back saying, "In my view, this is seriously inappropriate and the person should be seen sooner—someone should reassess that." But, at the end of the day, they make the decision about whether they do that or not—not me.

Ms J.M. FREEMAN: Where is the ministerial direction in the current Hospitals and Health Services Act 1927?

Ms R. Daniels: I do not think there is a direction. It is a very old act.

Dr K.D. HAMES: There is no statutory authority in that. We are saying this is a standard provision when creating a statutory authority, which is what we are doing.

Ms J.M. FREEMAN: This has boards, so you had to have —

Dr K.D. HAMES: A board is not the same. I am the board. Is that the one where I am the board or is that the previous one?

Ms J.M. FREEMAN: Yes. It is the 1927 act, so you are the board. There is no ministerial direction in the current act?

Ms R. Daniels: No. Under the current act the minister has control of general administration. Section 5 says —

> The general administration of this Act shall be under the control of the Minister.

My recollection is that there is no ability to direct the present board.

Ms J.M. FREEMAN: Are you sure? You have just told us, in answer to a question, that the capacity to direct is the capacity that exists under all legislation.

Ms R. Daniels: That came in after the Burt commission.

Ms J.M. FREEMAN: The act has been amended a number of times. It was amended in 1996, 1984 and so on.

Ms L. Harvey: By that stage the boards were the minister —

Ms J.M. FREEMAN: Under the current Hospitals and Health Services Act 1927, is there a clause that limits the minister's authority established in section 5, "Minister to control general administration", around not being able to have any influence over the nature of the health service to be provided to a particular person?

Ms R. Daniels: I am going to ask Kirsten to answer that, as she has the full act in front of her.

Ms K. Seneviratne: There is a power for the minister to give directions in writing to an agency.

Ms J.M. FREEMAN: Where is that?

Ms K. Seneviratne: It is in section 7D, "Minister's powers with respect to agencies".

Ms J.M. FREEMAN: Section 7D(2) states—

> … may give directions in writing to an agency that is not constituted …

Is there anything in clause 60 that says he cannot give directions? Subclause (2) states —

> (a) about the nature of a health service to be provided to a particular person; or
>
> (b) in any other way in respect of a particular person.

Ms K. Seneviratne: It does not appear to have that, no.

Dr K.D. HAMES: To be honest, I do not mind if it does or not. That is an appropriate clause to have. That is the correct thing to do, whether it was in the other one or not.

Clause put and passed.

Clause 61: Minister to have access to information —

Mr R.H. COOK: Clause 61(5) does not entitle the minister to have personal information unless —

> (c) the information is for the purpose of enabling or assisting the Minister to respond to or deal with a complaint or query made by the individual; or

That is obviously appropriate because you do not want people just giving out information about things generally. I am just wondering whether this captures a situation in which an individual's family or parent is making the complaint rather than the individual themselves. The individual might be a minor or incapacitated. They might also be dead, but I assume a whole bunch of other laws would kick in with respect to the release of that information.

Dr K.D. HAMES: This is a clause for which, if you were to become a minister, you would be extremely grateful, because it allows you to answer questions. I can get information now as the board, but when I am not the board, that information is severely restricted. If you as a member of Parliament come to me about a patient, then, as you know, I cannot give you that information unless you get authority from the patient for me to release that personal information. I can release it to the person who writes to me with a complaint, but in this case that person has gone to you to get information. Under the current law, when I am not the board, I am not allowed to get information about that patient for you.

Mr R.H. COOK: I am not saying you are getting too much information; I am wondering whether you are getting enough, if it is not the individuals themselves coming to you. If it is a family member—a husband, a wife or a parent—should this clause give you greater opportunity to get that information?

Dr K.D. HAMES: I need advice about whether that is the case. If someone goes to the media, for example, or goes to the member for Kwinana and says, "We have significant problems with my brother, who is an invalid—can you find out what is happening and help us?", I cannot provide information about that. I cannot provide that information that unless they get authority from either the patient or the guardian. But I still need to be able to get information about the patient from the health service provider to ensure that that person is being looked after and is being managed properly. Does this stop me from getting that advice if it is not the individual who authorises it? I have to say that the issue I had from some within my party was that they thought I should not have access to that information without being authorised.

Mr R.H. COOK: I can understand that you would want to be very careful about the information.

Ms J.M. FREEMAN: Yes, but what if something goes wrong and then someone is on the news saying, "I rang you and told you that this was happening"?

Dr K.D. HAMES: The issue is: what do you want to stop? If I hear someone say that the former Leader of the Opposition had depression, and I then tell the department that I want to know the medical history of the former Leader of the Opposition, that would be totally inappropriate. So we had to make sure that we stopped any minister from being able to get access to information that was not appropriate to the management of that patient within the hospital system.

Mr R.H. COOK: I think this is a really well-crafted section. I just had that query about that one particular issue.

Dr K.D. HAMES: From my reading of it, I think we might not be able to give that information to another person. I would have to seek authority from the patient concerned, or the guardian of the patient, to get information about that patient—unless they themselves specifically wrote to me and asked me for it. I think that is the answer. It does limit my capacity to a degree. As the board, I could get that stuff, but under this new bill I would not be able to. We have to be careful about how far we extend that capacity to get information. This was a compromise. I did not realise it was quite like that, but now you have pointed it out to me, it is something I can live with, because it would not be that difficult to get the family to give the authority. We are at three lengths away, not two. If it is the parent or guardian, what happens there? If it is the parent of the child, is that okay?

Ms R. Daniels: The parent speaks on behalf of the child.

Dr K.D. HAMES: It has to be an adult. If the brother of someone came and asked, I would have to get authority from the person, or their guardian if they were disabled, before I could get information about them and provide the answer. But that would be pretty uncommon and not that difficult a situation to deal with.

Mr R.H. COOK: Do we need to be more explicit about this situation?

Dr K.D. HAMES: No, because it opens it up too much when you start getting third parties asking about others. What if it is the husband asking about the wife, and they have a relationship whereby the wife does not want people looking into her medical details, me included? I think we have to have some restrictions, because we do not know the personal circumstances.

Ms R. Daniels: One needs to be very cautious about privacy and invasion of privacy, because it does not impact only on their health. Let us say someone had a complaint about a brother, and it is AIDS—that is the easiest one to think about. AIDS not only has a social stigma attached to it, but also could impact on a person's ability to be employed and to attract insurance. If I had AIDS, I think I would like that to be in my hands—as opposed to those of my mother, my sister, my brother or the minister.

Dr K.D. HAMES: I can imagine, yes.

Ms R. Daniels: Balancing giving the minister what he or she requires while trying to protect the privacy of the individual was mulled over for some considerable time.

Mr R.H. COOK: In this section we envisage two different scenarios. One is when the person comes has a consent form and the other is when they make a complaint or query. I guess it comes down to the definition of what is a complaint or query. Say that someone is given a spray on *Today Tonight* because of some mishap, is that a complaint? They are certainly complaining about the service they received. They may not have given consent to see their records, but could you then go to the health service provider and say, "Well, have a look at this newspaper article. They're complaining about the service. I want to see the records"?

Mr K.D. HAMES: I have been treating it now as before. My view is that if someone goes public about their medical condition, it is in the public eye. I expect that you are going to ask me questions about it and I will need to know the answer. It has limits, for example. That child who is claiming to have a *Pseudomonas* infection of the eye who was taking us to court was treated at Princess Margaret Hospital. I may have sought information about whether they actually have a streptococcal infection or not, but because they are taking legal action I am staying miles away from it and it will be up to them to prove in the courts from the records of their notes. It is to some extent a matter of judgement, but it is used politically to a degree.

Mr R.H. COOK: Yes, absolutely.

Mr K.D. HAMES: You will yourself, if you are there. If you jump up and say that someone has waited 10 years to have their knee operation, I would ask for the records. When I get the records, I say, "No, they've only waited a year." So you come up and ask in Parliament, "Why have you let this patient wait for 10 years?" I will say, "Well, that is actually not the case; they have waited for a year."

Ms J.M. FREEMAN: But that is different, because that comes under paragraph (d).

Mr K.D. HAMES: Yes.

Ms J.M. FREEMAN: That is different to what you guys are discussing.

Mr K.D. HAMES: Yes; it is.

Ms J.M. FREEMAN: That is different from what you were discussing.

Mr K.D. HAMES: No, clause 61(5)(c) states —

> the information is for the purpose of enabling or assisting the Minister to respond to or deal with a complaint or query made by the individual;

Ms J.M. FREEMAN: Yes.

Mr K.D HAMES: That might be a public complaint or it might be a private complaint. They might complain publicly about the service that they have and I can find out the details. What often happens is that their complaint has substance. I hear the complaint and go to have a look. I say, "You guys have stuffed this up; sort it out." But if I do not know the circumstances behind it, I have no way of taking any action.

Mr R.H. COOK: The member for Mirrabooka is spot on. This should enable us to not to have to come to you with a consent form.

Mr K.D. HAMES: Yes, I know; that is what I am saying. This enables me not to have a consent form. What we are saying is that the third party —

Mr R.H. COOK: It enables me not to have a consent form as well, because I am a member of Parliament.

Ms J.M. FREEMAN: Yes.

Mr K.D. HAMES: Where does it say that you can have the information?

Mr R.H. COOK: Because it states —

> … or deal with a question asked or matter raised by a member of Parliament, …

And I am sure that is not what the minister intended.

Mr K.D. HAMES: Let me think about that. Generally, when someone goes to a member of Parliament, puts forward an issue to the member and asks the question, we assume that you are asking on their behalf

and that implies consent, because they have been to you, so we provide the answer back to you. We do not provide the information back to you, if it is about a third party. I think that is the case, it is it not? Is that not what we do?

Mr R.H. COOK: No.

Mr K.D. HAMES: We do get consent forms, but sometimes —

Mr R.H. COOK: For instance, when my office comes to you about a particular patient, which it does regularly, your office says, quite rightly, "Well, before we have a chat to you about that, we need a consent form." I have no problems with that; I think that is appropriate. But my reading of this section is that that is no longer required because the minister will have the entitlement to access that information on the basis that I, as a member of Parliament, have raised it with you.

Mr K.D. HAMES: Yes, that means I can access it. It does not mean that I can give it to you. Where does it say that I can give that information to you?

Ms J.M. FREEMAN: It states —

> … prepare for, answer, respond to or deal with …

Mr R.H. COOK: I guess you could respond in a manner that does not in any way divulge information but that would be an unusual response.

Mr K.D. HAMES: No, because that is what we do. Sometimes we will say, when someone does not have that consent, "Thank you for that information. We've inquired into the circumstances you present and we are satisfied that such-and-such has happened", or we say that will we deal with it or we will make changes. I think that is appropriate.

Ms J.M. FREEMAN: Just for clarity—there is a whole bunch of members of Parliament sitting around this table—if a member of Parliament requests information regarding a patient because they are representing the patient—the individual—will the minister provide that information on the basis of this or are we still required to do a consent form?

Mr R.H. COOK: To the extent that it does not require him or her to divulge their information, yes.

Mr K.D. HAMES: I think that is the answer. I think the answer is that I can get information and I can respond to you, to reassure you that everything is okay. But if you want detailed personal information about that patient, then I need your consent.

Ms J.M. FREEMAN: It is not my consent; you need the consent of the patient.

Mr K.D. HAMES: No; the consent form from the patient. I think that is the answer.

Mr R.H. COOK: Yes.

Ms J.M. FREEMAN: What power does the CEO of Health have in the prior instance in which it is a brother or sister of a patient responding to a complaint or query for an individual?

Mr K.D. HAMES: My understanding is that the CEO has full access to any information, but it is the provision of that information to a third party that is the issue. He must protect the privacy of that person.

Ms R. Daniels: They can use the FOI act to get that information.

Mr K.D. HAMES: I do not understand what you are saying. I am talking about an issue with a patient in our hospital. Then, the director general of Health can get access to that information; he does not need an FOI.

Mr R.H. COOK: He or she can do whatever they like!

Ms J.M. FREEMAN: And would that be a similar power for the board? Could it get whatever information it required about the individual?

Mr K.D. HAMES: Yes.

Clause put and passed.

Clauses 62 to 68 put and passed.

Clause 69: Local governments may fund health services —

Ms J.M. FREEMAN: Can a local government become a health service under this clause?

Mr K.D. HAMES: No.

Ms J.M. FREEMAN: I mean a health service provider. No? Okay. So you cannot find one when the health service provider has to do that. But under this, local government can fund a health service?

Mr K.D. HAMES: And often do, particularly under subclause 2(c), which is a thing they do commonly.

Mr R.H. COOK: But not to the effect that it is more than three chooks and a goat!

Ms J.M. FREEMAN: Just stay with me, please! Does the service that is funded by local government then come under the department's health services—so, the board—for the management of the delivery of that health service, or does it stand outside that, like a private hospital?

Mr K.D. HAMES: Does anyone know the answer? I would have thought that there are two options. If you think about the country, that is probably easier than in the city. There are two services. When they fund a health service, they might subsidise, for example, a district nursing scheme—I believe Meekatharra or one of those, Leonora—offered to do that and to put funds in to help support additional nursing staff beyond which we had the capacity or desire to pay. They wanted a high level of service, so they funded that. But sometimes they might go to the Aboriginal medical service, for example, and not to us, and fund a health service. But what if they decided —

Ms J.M. FREEMAN: I am asking this: they have come to you, and they have funded —

Mr K.D. HAMES: For the one where we are the service provider?

Ms J.M. FREEMAN: The district nursing scheme, where they have come to you, that comes under —

Mr K.D. HAMES: The Aboriginal medical service has not come to us.

Ms J.M. FREEMAN: No, I understand that. I have got you —

Mr K.D. HAMES: They have come to us; it is provided under us—

Ms J.M. FREEMAN: If they have come to you and they have funded the district nursing scheme, then it falls under the health service provider.

Mr K.D. HAMES: That is right, yes.

Ms J.M. FREEMAN: So if they then have a complaint about how that money has been expended for that service, they are effectively contracting to the health service provider and so their complaint goes to the health service provider?

Mr K.D. HAMES: Yes.

Ms J.M. FREEMAN: Okay. If they then deliver a service through the Aboriginal medical service or decide to run it through another service, then it does not come within the remit?

Mr K.D. HAMES: No—nothing to do with us.

Ms J.M. FREEMAN. Okay—no worries.

Clause put and passed.

Clause 70: Health service provider may be governed by board or chief executive —

Ms L.L. BAKER: I just have a quick question, and it is probably explained somewhere else. I do apologise, but I could not find it when I was flicking through. Are the boards allowed to pay stipends or honorariums, or pay their board members?

Mr K.D. HAMES: All of our board members do get paid. Their pay schedule has been determined by the Public Sector Commission—unless they work for government. If somebody works for government, then they do not get paid.

Ms L.L. BAKER: Thank you.

Clause put and passed.

Clause 71: Constitution of health service provider's board —

Mr R.H. COOK: I am just interested in the clause which details that a board consists of at least 6 but not more than 10 persons. How did you arrive at that particular number? Is that a number that you can see flowing from year to year, depending on your enthusiasm towards the boards? And would you envisage a situation in which, for instance, south metro has eight but you have 10 on north metro, or something like that?

Mr K.D. HAMES: There is no intention to be consistent with the number of members on separate boards. So if we had seven on one, that would not stop us from having nine on another. In terms of that choice of numbers, I think we covered the range of numbers that different people wanted to have. Ms Brown might be able to give a better answer.

Ms R Brown: We also looked at public sector boards more generally and health sector boards across the country, and evidence for better performing boards. Generally, six to 10 was fairly consistent. That is largely how it was.

Mr K.D. HAMES: It is good to have that flexibility, because different boards have different requirements. A country health service board is different to a children's board. It is not my intention to have six on any of them, to be honest; I think that is a bit of a low number.

Mr R.H. COOK: I agree.

Mr K.D. HAMES: I think that seven to nine is a pretty reasonable number to have. You want different skills on a board. Sometimes you might get someone who has more than one skill—they might be a doctor and a lawyer—

Mr R.H. COOK: That would be a troubled person!

Mr K.D. HAMES: But other skills might be from two separate people. My mother wanted me to do rural nursing because I kept arguing with her all the time!

Mr R.H. COOK: About her health, or—

Mr K.D. HAMES: Lure of politics, rather—I liked arguing!

Mr R.H. COOK: Subclause (2) states —

> Before appointing a member the Minister must seek and have regard to the recommendation of the Department CEO.

What does that mean?

Mr K.D. HAMES: Ms Brown—presumably?

Ms R. Brown: I think, effectively, it is the support that the department CEO provides in ensuring that the legislative requirements are met and that any conflict of interest or probity screening is done in advance. Ultimately, it is the minister's decision, but he must have regard to the recommendation of the CEO to ensure those aspects.

Mr K.D. HAMES: I did not include that clause!

Mr R.H. COOK: I am sure you did not!

Ms J.M. FREEMAN: Which clause?

Mr K.D. HAMES: Clause 71(2)—that I have to listen to the department CEO.

Mr R.H. COOK: In relation to that, would it not be more appropriate to have, say, "Before appointing a member the minister must seek and have regard to the recommendation of the department CEO with respect to the appropriateness of the appointment"?

Mr K.D. HAMES: I think we should delete the clause altogether!

Mr R.H. COOK: Just leave it up to the minister.

Mr K.D. HAMES: Yes! I think that covers it. You have to have regard to what he says. He will say, presumably, what is relevant to the situation.

Mr R.H. COOK: It does not actually say that it has to be relevant to the situation.

Mr K.D. HAMES: No, but he is a CEO; he is not going to give advice that is not relevant, is he? Why would he?

Mr R.H. COOK: The CEO might take the view, "Minister, you merely need to seek my recommendation; you don't have to pay attention to me or my recommendation does not have to mean anything, really. If you want to appoint your mother-in-law to a board, over to you."

Mr K.D. HAMES: But remember, I have to get it through cabinet at the end of the day. It is similar to all those things about consulting. You have to consult someone and there are lots of ways to consult people, but you do not always have to listen to what they say.

Mr R.H. COOK: Yes.

Ms L.L. BAKER: I refer to subclause 5(g), which states —

> … any other background, skills, expertise, knowledge or experience that will enable the effective performance of the health service provider's functions.

At the very beginning, when we first sat down, we talked about consumer representation. Would you envisage that out of that cluster of skills and experience that being a consumer in the system would be regarded as a skill, or experience, or knowledge and experience to enable the effective performance of the provider's functions?

Clearly, minister, I am trying to see where the consumer comes into this. We did this a minute ago in a clause that we just sent back for discussion later, but that is the only place where I have seen the word "consumer" mentioned. I am just wondering—

Mr K.D. HAMES: I will seek the advice of my staff about consumer rights.

Ms J.M. FREEMAN: Can we put an amendment in to have a consumer rep on there? We could put "any other background skills, expertise, knowledge or experience, including consumer experience, that will enable the effective performance of the health service provider's functions".

Mr K.D. HAMES: During the second reading debate I think that three or four members made the point that there should be consumer representation on there, and we often do that in other legislation, so I am not insensitive to the concept.

Ms J.M. FREEMAN: Would you put an amendment in there to—

Mr K.D. HAMES: I think I probably would. I was waiting to see if you raised it or not.

Ms J.M. FREEMAN: Okay, so let's put it in there then! "Any other background, skills, expertise, knowledge or experience, including consumer—

Ms L.L. BAKER: "Including as a consumer of health services that would enable the effective"—yes? We do not want a consumer of Big Macs!

Ms J.M. FREEMAN: Did you get that?

Ms L.L. BAKER: "As a consumer of health services". After the word "experience" insert the words, "as a consumer of health" —

Mr K.D. HAMES: A suggestion might be "and/or carer"?

Ms J.M. FREEMAN: "And/or carer"? Yes.

Ms L.L. BAKER: "Consumer and/or carer".

Ms J.M. FREEMAN: It is a very long sentence —

Mr K.D. HAMES: It is.

Ms J.M. FREEMAN: The drafter might be having a little bit of a nervy heart attack apparently.

Ms L.L. BAKER: It does not then make sense. You cannot say, "As a consumer and/or carer of the health system."'.

Mr K.D. HAMES: I think you are being a bit soft!

Ms J.M. FREEMAN: What do you mean?

Dr K.D. HAMES: I think that you should include in there an extra clause that says, "A consumer representative".

Ms J.M. FREEMAN: I am all for that!

Mr R.H. COOK: Because we wanted to make it easy on you!

Mr K.D. HAMES: I was thinking about it during everyone's speeches. I think it is not an unreasonable request.

Ms J.M. FREEMAN: Okay, so we need paragraphs (f) and (g) and then to insert "(h) a consumer representative, and/or carer, of health services".

Unidentified speaker: Is it an "or"?

Mr K.D. HAMES: Yes.

Mr R.H. COOK: "One or more of the following".

Ms J.M. FREEMAN: "A consumer" or "experienced background experience".'

Dr K.D. HAMES: "An individual with consumer and/or carer background". Is that all right?

Ms L.L. BAKER: Thank you, minister. Let us just see it now then.

Ms J. M. FREEMAN: A consumer of health services, we gather. I can ask some more questions while you do that so that you have a bit of time to make sure it is a well-drafted and well thought out provision. My question is, and it could be another amendment: in human resources management, does that include industrial relations expertise and experience?

Dr K.D. HAMES: I do not know, but it was not something that I had envisaged. It is an easy thing to get around. You might put that in there, but anyone who runs any business has got experience in industrial relations. Most doctors would have it. Most doctors deal in workers' compensation issues or MVIT issues.

Ms J.M. FREEMAN: Yes, but you have not got workers' compensation or MVIT. What you have not got here is someone who would have a union background.

Dr K.D. HAMES: No.

Ms J.M. FREEMAN: You may find that there is someone good with a union background—say, Jim McGinty, for example—who would be perfectly capable of sitting on a health services board.

Dr K.D. HAMES: He would, but that would come under any other background skills. He would get in under that one easily —

> background, skills, expertise, knowledge or experience that will enable the effective performance of the health service provider's functions.

In fact, there are people who are going to be on the board that would fit that role.

Ms J.M. FREEMAN: Yes. I am sure that that is the case, but the issue is that human resource management used to include industrial relations capacities, but it is now divided into two separate fields, and industrial relations and workers' compensation and equity issues around bullying and equal opportunity all come into that industrial relations area versus the human resource management aspect of it.

Dr K.D. HAMES: My view, and that of any committee, is that you can go and get down to whatever level of representative you want. Remember that we want business managers who can understand public health but run a billion-dollar business, and they can seek advice from wherever they choose to seek advice. It is a bit like Healthway, and I know that is a sensitive argument, but with representative groups on there. The reality is that if you get a board, they can go and seek those representative views as far and as wide as they like. If they need industrial management advice or human resources advice, they will have staff.

Ms J.M. FREEMAN: But you have got human resources here as a particular area.

Dr K.D. HAMES: It is an option.

Ms J.M. FREEMAN: I am saying that if you consider human resources management to include industrial relations expertise and experience, then that is the end of the story.

Dr K.D. HAMES: I consider it to include that. I am just going to pause. We have an amendment that we are waiting for.

Now I have the amendment, I move —

> Page 57, after line 28 — To insert —
>
> (fa) experience as a consumer of health services or a carer;

Amendment put and passed.

Mr R.H. COOK: Subclause (3) deals with the number of people on the board who come from a health professional background. Notwithstanding the minister's obvious desire to ensure that all three of the health professionals are doctors—I am sure that is what he wants—he has accepted that the three would simply be health professionals. Could he let us know why he went for three? Would health professionals, as we expand the registrations of different health careers such as paramedics, and I think there is one that they are working on at the moment around natural medicines, too fall under the category of someone who is registered under the Health Practitioner Regulation National Law (Western Australia)?

Dr K.D. HAMES: We are not working on natural therapy—it is an option—but we are working on paramedics. There is also a proposal for social workers to be on there. It includes Aboriginal health workers, as you know. There was, I think, 10 altogether. The reason I chose that wording is the AMA wanted to have at least two of them as doctors. My view was that if we did that, we would then have to have two nurses and two allied health professionals and two of whatever else. Although I think it is important to have doctors on there, and the boards that we are proposing do have doctors there—in most cases they have two or three doctors on them—I do not want to tie a future minister to having to do that. Mind you, I think a future minister would be silly not putting doctors on there when they are running a health service. An example I used was Robyn Collins, who has a nursing background, who is an entirely suitable person to have running a health service board and was on one of the government councils. So I have left it to future ministers to decide. I think three was chosen because there is a board of six to 10, and three seemed to be an adequate number to have. It does not mean there cannot be more, but I would have thought fewer than three who have some sort of health professional experience on a board of six to 10 was not adequate. Looking at other boards in other states, that was the sort of composition that they had. Do you want to add to that, Ms Brown?

Ms R. Brown: I suppose we have looked at other jurisdictions in terms of composition. It is fair to say that other jurisdictions have far less prescription, albeit Queensland does have prescription around health professionals. That is probably about all.

Dr K.D. HAMES: There is nothing further to add.

Ms J.M. FREEMAN: I have the Health Practitioner Regulation National Law. Is there a list in that particular legislation of who is registered under it?

Dr K.D. HAMES: Yes. We all have lists, because there is a full registration system.

Ms J.M. FREEMAN: But is there a list in the actual legislation, or does it sit separate to the legislation in regulation?

Ms R. Daniels: I do not know.

Dr K.D. HAMES: A list of what?

Ms R. Daniels: Of who is registered. As the minister said, there are 10 and you are asking for that list of 10 professions; is that the question?

Ms J.M. FREEMAN: Yes.

Dr K.D. HAMES: I can tell you the list of 10, if I can remember.

Ms J.M. FREEMAN: You could tell me, and that is okay, but what I am more interested in is where it is.

Dr K.D. HAMES: Where did you find the list?

Ms J.M. FREEMAN: Is it in the Health Practitioner Regulation National Law?

Ms R. Daniels: Yes.

Ms J.M. FREEMAN: What clause is it?

Ms R. Daniels: It is in the schedule which is attached to the national law.

Dr K.D. HAMES: It would be in our legislation, because we did mirror legislation so we have that list.

Ms R. Daniels: So we adopted the national law.

Ms J.M. FREEMAN: I understand that. If you wanted to add anyone to that list, does it require a change to legislation or to regulation? You have 10 at the moment. If you wanted to add any more to that list —

Dr K.D. HAMES: You would have to change the legislation I think. In fact, an Australia-wide change to legislation is required. Some of the other states do legislation based on the base legislation in Queensland. Others, like us, do not accept doing it, so we did mirror legislation. We would have to amend our act to add in other professions. Sadly, I will not be there anymore to drive getting paramedics registered, so I will have to rely on other people to do it. I am sad that I will not be there to get that through.

Ms J.M. FREEMAN: I will move on to a different issue. One in four Australian people are born overseas, and 52 per cent of the population are women and 48 per cent are men. How will the minister ensure that the boards reflect the diversity of Western Australia? How would that be reflected in this legislation?

Dr K.D. HAMES: It is not reflected in the legislation. Those things get reflected either through policy or practice. It is our practice every time we appoint board members to assess how many males and how many females. We do not go through and do diversity of ethnic origin, although, particularly with our country board, we are making a strong effort to make sure there are Aboriginal people represented. But we have not gone out of our way to make sure that other ethnic groups are represented, because that is too difficult.

Mr R.H. COOK: I asked the question on 12 March 2007. Regarding subclause (6), if someone is an employee of the health department, is this envisaging a situation where you could have a doctor that is perhaps working in north metro and is capable of being on the south metro board?

Dr K.D. HAMES: Yes, that is true.

Mr R.H. COOK: But you could not have a doctor who is at Fiona Stanley Hospital on the south metro board.

Dr K.D. HAMES: That is correct.

Mr R.H. COOK: Does that include those with the use of private lists and access to theatres? They would not be employees in that situation, is that right?

Dr K.D. HAMES: Do we then have private lists for people who are not employees? I do not think that we do have private lists for people who are not employees. Where the difficulty comes sometimes is where you get people who work across different areas. Nevertheless, there is normally one area where they do not work and where, if you think they are suitable, you could put them on the board.

Clause, as amended, put and passed.

Committee adjourned at 6.53 pm