HEALTH SERVICES AMENDMENT BILL 2019

Consideration in Detail

Clauses 1 to 3 put and passed.

Clause 4: Section 6 amended —

Mr Z.R.F. KIRKUP: Clause 4 deals with a range of definitions that have now been inserted as part of the amendments to the Health Services Act 2016. I am curious about one of the definitions that was flagged during the briefings that we had much earlier in my time as shadow Minister for Health.

Mr R.H. Cook: Before you had a beard; right?

Mr Z.R.F. KIRKUP: That is exactly right; I think even before the pandemic.

I am curious about whether we can get a definition of "financial difficulty". I know we can deal with it later in the legislation, but perhaps the minister can explain under the definitions why it was included in this case and then we can go from there.

Mr R.H. COOK: I am advised it is to simplify the overall structure of the act. "Financial difficulty" is referred to throughout the act. This will simply bring it forward to be dealt with in one hit. "Financial difficulty" means —

> … the health service provider is unable to, or will be unlikely to be able to, satisfy any of its financial obligations from the financial resources available, … to it when the financial obligation is due;

The definition of financial difficulty has been included to clarify the intent and operation of section 66 of the act, which sets out a process that must be followed when a health service provider is in financial difficulty.

We have an amendment in relation to this. I move —

> Page 5, lines 15 to 20 —
>
> To delete the lines.

Mr Z.R.F. KIRKUP: If I read the amendment right, we are removing the definition of "contracted health entity". Is that correct?

Mr R.H. COOK: Yes. Member, this amendment deletes the definition of "Minister for Works", which was to be inserted by clause 4. The definition is to be deleted because the term "Minister for Works" will no longer be used in the act.

Mr Z.R.F. KIRKUP: My apologies, minister. I was on the wrong page. In that case, given the definition of "financial difficulty" is in this clause and is referred to later, is the minister willing to discuss financial difficulty now or does he want to work through it when we get to a later clause?

The ACTING SPEAKER (Ms M.M. Quirk): The amendment relates to something else, member, and the minister has moved it.

Mr Z.R.F. KIRKUP: In that case, I am comfortable that the amendment is put.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 5 to 11 put and passed.

Clause 12: Section 20 amended —

Mr R.H. COOK — by leave: I move —

> Page 11, lines 7 and 8 — To delete "*State Supply Commission Act 1991* and the *Public Works Act 1902*.""
>
> and substitute —
>
> *Procurement Act 2020*."
>
> Page 11, line 13 — To delete the line.

Mr Z.R.F. KIRKUP: I would appreciate some clarification on why the amendments, which have been accepted by this house, were moved in the first instance. I would like more information on why the State Supply Commission and the Public Works Acts are being deleted and replaced with the Procurement Act.

Mr R.H. COOK: I thank the member for the question because it deserves some clarification. When the bill was originally drafted, it was anticipated that it would pass before the Procurement Act 2020. That did not come to pass, so we have to take out those references to provisions that have been made redundant by the passing of the Procurement Act and put in arrangements in the Procurement Act, essentially. This particular amendment deletes

a reference to the State Supply Commission Act 1991 and the Public Works Act 1902 and substitutes it with the Procurement Act 2020. The subsequent amendment refers to the fact that the Procurement Act has amended section 20(2) of the principal act to replace references to the State Supply Commission Act 1991 and the Public Works Act 1902 with a reference to the Procurement Act 2020. This change is being made to reflect that the commissioning and delivery of capital works under the act must be performed in accordance with the requirements of the Procurement Act 2020.

Mr Z.R.F. KIRKUP: I therefore assume that all the amendments for this bill standing on the notice paper are in relation to that wrinkle, I suppose, from the Procurement Act. We will undoubtedly get to clause 80 this evening, which the government intends to oppose rather than just delete. Is there some rationale for why that might be the case?

Mr R.H. COOK: That is a really good question. I asked it myself. I understand that is the wording we use when we are completely extracting a clause from the bill. It is parliamentary counsel's words—those wizards.

Mr Z.R.F. Kirkup: Long may they reign.

Mr R.H. COOK: Yes.

Amendments put and passed.

Clause, as amended, put and passed.

Mr Z.R.F. KIRKUP: Madam Acting Speaker.

The ACTING SPEAKER: Member for Dawesville.

Mr Z.R.F. KIRKUP: Sorry; I spoke in anticipation that we were on clause 13. I apologise; I was a little too keen.

The ACTING SPEAKER: Thank you very much. Just sit down so that I can get my thoughts back in order.

Clause 13: Section 20A inserted —

Mr Z.R.F. KIRKUP: Thank you, Madam Acting Speaker. I appreciate your ever valiant stewardship of this chamber.

The ACTING SPEAKER: It was what we call a premature interjection, member for Dawesville.

Mr Z.R.F. KIRKUP: I will take Madam Acting Speaker's word for it.

A range of provisions in this bill seek to charge the department CEO and health service providers with the capacity to undertake their own capital works projects. I assume that proposed section 20A, "Works and clinical commissioning", is one of those provisions that seek to ensure that the department CEO and, in this case, the health service providers can deliver those capital works projects. Notwithstanding that there is an amendment to this clause, can the minister provide the house with some insight on why this is considered necessary and give examples of where this might be implemented?

Mr R.H. COOK: I acknowledge that the member raised this issue in his contribution to the second reading debate, but, because of time limitations, I could not address it in my response. The roles and responsibility for the commissioning and delivery of capital works and maintenance works currently under the act provides that commissioning and delivery of capital works and maintenance works is a function that only the department CEO can perform. This does not reflect the actual performance of this function by the WA health system and overlooks the accountabilities and responsibilities of the health service providers in delivering capital works projects. In practice, the department CEO takes responsibility only for managing the commissioning and delivery of capital works for high-risk facility projects, and more routine capital works projects are managed by the health service provider. For instance, we understand that the director general would take a very keen interest in the commissioning of a new hospital, like Perth Children's Hospital, but we would not expect the director general to oversee maintenance programs and other small capital works programs. However, the delegations to personnel within the health service providers does not allow the department CEO—the director general—to impose performance standards on the health service providers for the delivery of the works and to ensure health service providers are held accountable for the delivery of the works within budget. The amendments to sections 20A, 34 and 46 of the principal act are to ensure that the service agreement between the department CEO and the health service providers can set out the capital works projects that the health service provider is responsible for managing and the budget constraints that they must meet.

Essentially, at the moment, the CEO is delegating those tasks to the health service providers because obviously it is a complex system and one person cannot oversee it all. In the current act, we lack the mechanisms that we would expect the CEO could take advantage of to keep health service providers accountable for those minor capital works and things of that nature. The health service providers will have responsibility for managing the project budget and for ensuring the delivery of the project within the scope and providing the Department of Finance with the specifications required for the commissioning of the facility. The amendments will ensure that oversight by the Department of Finance and the Minister for Finance is retained under the Procurement Act 2020.

The ACTING SPEAKER: I note that the minister explained the amendment but he has not moved it yet.

Mr Z.R.F. KIRKUP: I appreciate the minister's extensive response. Is there a value threshold for a minor project that a HSP would undertake? How would that otherwise be determined?

Mr R.H. COOK: There is no value proposition or specific amount. It is more about the risk profile of the particular capital works. Obviously, something like the development of a new ground-level car park would not be something the director general or CEO would take a key interest in. They may pay closer attention to a major redevelopment or minor capital works in situ in an operational phase of a hospital that is assessed as a high-risk profile. It is about making sure that the CEO has delegation capability while retaining accountability mechanisms.

Mr Z.R.F. KIRKUP: Is there any capability in the bill for the minister to instruct the director general to take an interest in a project that a health service provider is overseeing? I will use the WA Country Health Service and a regional hospital as an example. The director general there may not have a keen interest because it is not a high-value project. I would imagine that WACHS would have a better understanding of more disparate project developments, but then the project overruns and becomes a contentious issue for the government. Can the health minister, who is responsible for the delivery of that project, instruct the director general to then take an interest in it? I think it is a good move to devolve this power to the HSPs, but I am trying to understand whether the minister has the capability to instruct the director general to take a keen interest if the director general has not otherwise done so.

Mr R.H. COOK: I will provide some more colour and movement to my previous explanation. This all comes down to the interaction of the Procurement Act 2020. Under the Procurement Act 2020, the Minister for Finance can issue an agency-specific direction to the Department of Health that provides that the director general may undertake works up to the value of $2 million without the involvement of the Department of Finance. The director general may undertake works above the value of $2 million with the approval of the Department of Finance's CEO. In the absence of approval from the Department of Finance's CEO, the director general must engage the Department of Finance to undertake the procurement of the works. Under section 20(1)(g), the director general may delegate his power to the health service provider to commission and deliver works when the value of the works is under $2 million, and, for works over $2 million, when he has received approval from the Department of Finance to undertake the works.

The oversight that the member refers to comes from both the Minister for Health and the Minister for Finance. If the Minister for Finance takes a particular view, it will obviously inform the approach by the department CEO. But, ultimately, under the Health Services Act 2016, the Minister for Health could direct the director general or the department CEO to take carriage of the particular bill.

The Health Services Act, part 3, section 18, "Administration of this Act", reads —

> Subject to the general control of the Minister and any directions or instructions given under the PSM Act section 32 by the Minister to the Department CEO, the Department CEO must carry out the administration of this Act.

The member asks: does the minister have that power? Yes, he or she does have that power, but, potentially, in terms of that oversight, that power would rest with the Minister for Finance.

Mr Z.R.F. KIRKUP: Minister, I appreciate the response. Unless I misunderstood, and to clarify, is there a value threshold of $2 million? In the previous question we were trying to ascertain whether that was the case.

Mr R.H. COOK: This is more about the interaction with the Procurement Act 2020, not so much about the functioning of the Health Services Act.

Mr Z.R.F. Kirkup: Right. Thank you very much.

I move on to proposed sections 20A(2) and (3) in which the department CEO and the Minister for Works have to agree in writing on works commissioned and delivered under the act. The minister can exempt certain works that can be undertaken. I assume this is to ensure, as part of procurement arrangements, that the Minister for Works has appropriate oversight into projects. Why does the Minister for Works need to provide approval to the health department CEO?

Mr R.H. COOK: Thank you, member. I am perhaps remiss, Mr Acting Speaker, in not moving the amendments that we had lined up for this clause earlier. The proposed subsections that the member refers to will be deleted under amendments that exist in my name. By leave, I move —

> Page 12, lines 12 to 27 — To delete the lines.
>
> Page 12, lines 29 and 30 — To delete the lines and substitute —
>
> (a) the *Procurement Act 2020*; and

Amendments put and passed.

Clause, as amended, put and passed.

Clauses 14 to 19 put and passed.

Clause 20: Sections 36A to 36E inserted —

Mr Z.R.F. KIRKUP: Proposed section 36A, "Joint arrangements", states —

> (1) A health service provider may enter into a joint arrangement with the Minister or Ministerial Body in relation to health property.

Can the minister provide some background on what a joint arrangement might look like and how the ministerial body will interact with the HSP?

Mr R.H. COOK: The joint arrangements referred to in this proposed section provide for arrangements to be entered into between a health service provider and the minister or the health minister or body in relation to health property. It is intended that this proposed section will allow the minister to give health service providers the power to deal with land and property, which is subject to a joint arrangement on behalf of the minister or health ministerial body; for example, the terms of the joint arrangement may permit a health service provider to grant and terminate leases or licences up to a maximum term of 21 years on behalf of the health ministerial body or minister.

The health service provider will not require the approval of the minister or the health ministerial body prior to granting the lease or licence. However, the extent of the power to deal with the property will be subject to the terms of the joint arrangement. Under this proposed section, actions taken by the health service provider are taken to be done by, and are binding upon, either the minister or the health ministerial body. For example, the East Metropolitan Health Service was given control and management of the Royal Perth Hospital site, so the intention was that the health service providers would control the management of the sites for the purposes of performing their broader function.

I will go out on a limb here and say that I think this comes down to the leasing of a shop or a childcare centre or a cafe space. At the moment, I am required to sign off on all those and the member would understand that some of these are quite small, but there are obviously multiple things to sign off. Therefore, the idea is to give the health service providers, within the scope of the leasing arrangements, the ability to manage that lease.

Mr Z.R.F. KIRKUP: As part of his response, the minister said that although the health minister would not be routinely included in the arrangements—for example, in the lease arrangements—they would ultimately be responsible for them. I can easily imagine a situation in which a health service provider enters into some sort of arrangement for a health property without the minister of the day necessarily being a participant in that process. But if something goes awry, the Minister for Health is held accountable. Why has the government decided not to include the health minister as an ongoing interest in the level of responsibility that would be taken into account when entering into a financial arrangement on a health property?

Mr R.H. COOK: I thank the member for the question. Ultimately, member, this would come down to a range of factors not yet articulated and certainly not articulated within the bill. What we are talking about is multiple small value leases that health service providers enter into and the threshold or nature of that joint arrangement of them entering into those arrangements on the government's behalf would really depend on its risk appetite but it would also depend on the health service provider involved. One could anticipate in the future a health service provider that does not have the maturity or a track record so the minister and the department may want to take a different view about that particular HSP as opposed to an HSP that has been managing a complex building and set of leasing arrangements over a long period. It really just comes down to what is considered good policy in the management of those arrangements.

Mr Z.R.F. KIRKUP: In that case there is in-built flexibility in that the director general could take an interest in any arrangement that an HSP enters into. There is the capacity for the minister to determine that ahead of time according to a range of factors that the minister stated, such as risk and the like. If a health service provider was not particularly mature and did not have a track record, could the minister instruct them? What is the formal instrument used to grant north, for example, more leeway than east?

Mr R.H. COOK: The government would enter into that joint arrangement with them whereby the chief executive officer and the minister are happy to delegate up to a certain threshold, a certain range or a certain intent in those leasing arrangements. From that perspective, it is really about just the policy framework in which it decides to work. It is about accepting the reality of the situation that hospitals are now very complex buildings and operations and, from that perspective, government cannot oversight every single small commercial arrangement that exists within those buildings. A level of delegation goes on but it really depends on the policy framework that sits over that.

Mr Z.R.F. KIRKUP: I will extrapolate the minister's point about the property use that an HSP might enter into as part of this arrangement. An incoming health minister may not appreciate the intent of an operating property, or a health property might not appreciate the clinical services that might be offered. I can think of any number that might exist. Ultimately, does the minister have the capacity to terminate those leases and stop a clinical provider from providing services that the minister might consider contentious?

Mr R.H. COOK: The short answer is no; they could not do that. What the HSP is doing is entering into a binding contract on behalf of the minister so the minister would be bound by the leasing arrangements and transfer of rights

that go with those leasing arrangements. In the event that a lease expires or something to that extent, maybe that would represent an opportunity to intervene. We would hope that a minister would respect the health service providers and what they are doing but obviously the minister is bound by the usual arrangements of procurement and appropriate financial administration.

Mr Z.R.F. KIRKUP: In the course of the time that the member has been the Minister for Health and has had to sign off on these arrangements, as a matter of curiosity, has he come across any lease arrangements or arrangements for a health property that he has found incongruent with what he would expect to operate in a health facility?

Mr R.H. COOK: No is definitely the answer. The one that is perhaps the furthest away from the provision of clinical services is childcare centres, but most of the time it is things like cafes, gift shops and snack shops. Occasionally, we anticipate that we would be leasing a professional space to a private clinical provider but by and large they are usually fairly small leases and from that perspective their execution is fairly straightforward. The idea is that the minister should not execute such small and multiple matters.

Mr Z.R.F. KIRKUP: I refer to the public–private partnership at St John of God with Ramsay. If, for example, the government of the day sought to remove a private operator south of the river, is this where this type of relationship comes into account—when joint arrangements are decided on by an HSP on a health property? In the case of St John of God at Midland, which was obviously done by the former government, we provided them access to the hospital and the existing arrangements remit and St John of God operates its own lease arrangements on that property and any other ancillary services that might be provided.

Mr R.H. COOK: I might answer that in the generality rather than the specifics because I do not necessarily have a working knowledge of the details of that arrangement. Under a classic PPP model, the private operator operates all the facilities. For instance, at Joondalup, Ramsay runs the leases for all the outlets that exist, such as the cafe and chemist. That is not a function of government. Obviously, the PPP is not a leasing arrangement. That is a very complex government contract that would blow these provisions out of the water. That is a major exercise of procurement.

Mr Z.R.F. KIRKUP: I refer to the medihotel at Joondalup, which exists on Ramsay's area of operation. I assume that it does not operate the lease or the arrangements for the medihotel and that that would be the responsibility of the HSP. In that case, going to the point about a private operator having entire control over the facility and hospital—this does not really fall into this—if a third party, such as a medihotel, is added into these joint arrangements causing an overlap, does the private operator have any role to play and could they determine whether a facility such as that can go ahead? If it is the government's intent to put a medihotel in every public hospital, for example, and that is extended to Peel, Joondalup and Midland, can they veto that entirely? Could they go against the HSP in that case?

Mr R.H. COOK: It really depends on the rights and interests of the private operator. For instance, in the case of Joondalup, Ramsay has control of that site as part of the contract with the government so we certainly could not walk in there and say, "By the way, we're going to build a medihotel in the area that you've got set up as a crèche and someone else is going to run it."

The contracts are simply much more complex than that. From that perspective, these provisions would not relate to a public–private partnership environment. Whether it is Peel, Midland or Joondalup, the private operator runs not only the clinical services but also the ancillary services. Obviously, they usually exercise those through subcontracts or leasing arrangements.

Mr Z.R.F. KIRKUP: I will refer to the same clause, but a different area of interest in this case. I move to proposed section 36B, "Power to borrow", still under clause 20 on page 17. In this case, the HSPs are being empowered to borrow money. I assume the money will be borrowed from the state, or will it be some other financial arrangement? Does that not exist at the moment? Why will the Treasurer have a role to play in this, rather than solely the minister?

Mr R.H. COOK: The member will forgive me for providing this lengthy information, but it goes something like this: generally, health service providers do not need to borrow money to operate—I asked this question myself. However, a recent change in Australian accounting standards has led to certain leasing arrangements being treated as a form of borrowing—for example, the leasing of medical equipment used in public hospitals. Because these leasing arrangements sometimes involve very expensive equipment, they are now treated as borrowing arrangements. There are over 2 000 of these leasing arrangements in place within the WA health system. The amendment was initially sought to allow health service providers to continue with their leasing arrangements. The Treasurer's Instructions were amended in June to address this issue, but the amendments are still useful. It is also possible that a health service provider might need the ability to overdraw their bank account if a supply bill is delayed—for example, when a new government is elected—or needs more funds to operate than the advances authorised under section 24 of the Financial Management Act 2006. Under the Western Australian Treasury Corporation Act, the Western Australian Treasury Corporation can provide its services only to agencies that have the power to borrow in their enabling legislation. Health service providers do not currently have the power to borrow—they must go through a complex arrangement through the Department of Health to manage their foreign exchange risks.

Mr Z.R.F. KIRKUP: I thank the minister for his response. I assume that this has to be done in concert with the health minister. Proposed section 36B(1) states —

> A health service provider may, with the approval of the Treasurer —
>
> (a) borrow or re-borrow money; or
>
> (b) otherwise arrange for financial accommodation to be extended to the health service provider.

There is a separate proposed subsection about the minister making an order, with the consent of the Treasurer and published in the *Government Gazette*, to exempt a transaction or a class of transactions. Going back to proposed subsection (1), is the interaction solely with the Treasurer? I assume there is a requirement for the HSP to come to the minister to say that it is about to run out of money and needs to get some more. Unless I am reading it wrongly, it will not have to do that entirely or exclusively in concert with the health minister—it can go straight to the Treasurer. I just want to understand the logistics of how that might work.

Mr R.H. COOK: Obviously, at the end of the day, no level of borrowing can occur without the consent of the Treasurer. Some arrangements might be under the delegation or the authority of the Treasurer, but, ultimately, it has to be the Treasurer. Under normal protocols within government, the health service provider will be required to go through the minister and the department CEO. This proposed section clarifies the transactional relationship and not the communication or accountability relationship. The member is right: ultimately, the Treasurer has to be able to say yea or nay to these things, but it will be managed by the minister. In addition, there is a specific requirement for HSPs to be able to exercise provisions under the financial difficulty arrangements through the Minister for Health. At all stages, the Minister for Health will remain in the loop. I think this just recognises the primacy of the Treasurer. I can imagine the Department of Treasury going, "We want you to insert the Treasurer in this particular section." Any aspect of government that involves an agency borrowing money or going into debt has to be with the consent of the Treasurer.

Mr Z.R.F. KIRKUP: I assume that this will become a cabinet decision or a cabinet submission. If it was a significant amount of money, under the previous government it would probably have gone to the Economic and Expenditure Reform Committee and then on to cabinet for a final decision. I assume that it will be a similar process.

Mr R.H. COOK: That is right. The Treasurer has certain delegated authority under the Expenditure Review Committee, but for significant amounts, they all have to go through those processes.

Mr Z.R.F. KIRKUP: My final question on this part concerns the transparency of arrangements like this. When an HSP has got into so much debt that it needs an advance or something like that from the government, how will that be published? If it is a cabinet decision, it will be exempt from any freedom of information requests. The answering of parliamentary questions will be at the behest of the minister. Is there any formal publication of them? My reading of proposed section 36B(2) is that if the Treasurer does approve an order, it has to be published in the *Government Gazette*. Is that for all transactions? I am seeking some clarification. I apologise if I have misread this, minister. Does every transaction for money that is borrowed have to be published in the *Government Gazette*; and, if not, what is the method by which there might be public exposure so that people would know that, for example, the North Metropolitan Health Service got $100 million in advance because it was financially unsound?

Mr R.H. COOK: Issues of financial difficulty are dealt with under another clause; I am sure we will come to that shortly. Ultimately, this is about a specific transaction or a group of transactions that the Treasurer believes do not need to be approved in the normal manner. It is those classes of transaction that need to be listed in the *Government Gazette* to provide a level of transparency. In general terms, though, obviously every health service provider is required to provide an annual report, which will specify all the details in relation to the financial health or otherwise of an HSP—whether they are running a deficit or a surplus; and, if they are running a deficit, the extent to which it had to be topped up and any other arrangements that were entered into.

Mr Z.R.F. KIRKUP: I appreciate that we will get to that under clause 33, with the insertion of the proposed section on the notice of financial difficulty and the like. We raised a concern during the second reading debate and, I think, during the briefing that if that is the case, there will be no public articulation of those financial difficulty notices; that is, there will be no external exposure of that. There will be exposure within the agency—the CEO and, I assume, the minister will be notified that there is some financial difficulty—but the public will not be informed of that. I appreciate that it might be in an annual report, but the opposition might not be told until the end of the financial year that an HSP is haemorrhaging for some reason. Does the minister not consider that there should be some up-front arrangement if there has been a significant class of transactions to ensure that a health service provider can meet its lease arrangements, for example, or whatever it might be? Should there not be greater public oversight of something like that?

Mr R.H. COOK: I think I get what the member is saying: basically, if an HSP is under significant financial stress, ultimately the public has a right to know. Of course, that is the nature of budgets, estimates hearings and things of that nature. It has always been thus. I certainly acknowledge and respect the principles that the member is talking

about in that context. These specific arrangements do not actually go to the heart of what we could call financial mismanagement or grave financial difficulty. Again, we will come to those sorts of discussions. Ultimately, there may be times when an HSP legitimately has to enter into a borrowing arrangement, maybe because of lack of supply or something like that. People still need to get paid and patients still need to be seen. This is to ensure that there is proper oversight by Treasury in that context.

Mr Z.R.F. KIRKUP: I am still on clause 20, but moving to proposed section 36E, "Health service providers may provide services to each other". This insertion effectively allows for a number of HSPs to enter into commercial operations or combine contracts with another. Why is this amendment considered necessary?

Mr R.H. COOK: This proposed section will give health service providers the power to enter into contractual arrangements with one another to, firstly, provide health services to or receive health services from one another; secondly, provide health services on behalf of the first provider; or thirdly, provide services other than health services to or receive other services from the second provider. For instance, in the first example, if health support services provide support services like ICT or human resource services to health service providers, this proposed section will provide them with the explicit power to enter into an arrangement for those matters. For the second case, PathWest, for example, provides pathology services on behalf of other health service providers for their patients. For the third case, an example would be when a health provider provides facilities management services, gardening services or clinical incident review services to another health service provider. For instance, traditionally the North Metropolitan Health Service has been the home of big, statewide services like PathWest. That is now set up as a separate health service provider, but it is an example of the sorts of things that a health service provider might provide on behalf of other HSPs, either for reasons of efficiency or ease of delivery. In the future, I think we could also have a situation in which an HSP might develop a particular specialty or efficiency. For example, it could be gastric banding operations. It is a really good idea to do that in high volumes in a single space so that they become really good at it. An HSP may provide that service on behalf of other HSPs and things of that nature. We are not necessarily talking about things of a clinical nature, but it is to provide the opportunity for HSPs to really cross-examine themselves and work out the best way to deliver both clinical and nonclinical services.

Mr Z.R.F. KIRKUP: That seems quite straightforward from my perspective. In that case, using PathWest as an example, how will it operate if this is considered a necessary insertion? How does it otherwise operate at this moment?

Mr R.H. COOK: Member, I will answer that in two sections. Firstly, I will provide a little bit more context around the agreements. There are limitations to preserve the overarching framework of the act. The limitations placed on the health service providers' power to enter into contracts and arrangements with one another is to preserve the overarching governance framework established by the Health Services Act. Firstly, health service providers must comply with the requirements of sections 37 and 38 of the act when disposing of land or entering into transactions. Secondly, the provision of any medical, nursing or allied health services, or public health programs, must not be inconsistent with the health providers' health service area as determined by the minister. Thirdly, the provision or receipt of any kind of service must be consistent with the terms of both health service provider service agreements. Currently, the way they do that is by the chief executive officer altering the service agreement that exists between different HSPs, rather than the HSPs undertaking a bilateral arrangement. Every time an HSP wants to move into this sort of arrangement with another HSP, they currently have to have their service agreement altered by the chief executive officer, rather than providing them with greater capacity to reach agreements with each other.

Mr Z.R.F. KIRKUP: Thank you, minister, for that response —

Mr R.H. Cook: Do you want me to clarify it?

Mr Z.R.F. KIRKUP: No, it was great! I have just noticed that I stood up when I have no further questions on this clause!

Mr R.H. COOK: I have no further comments!

Clause put and passed.

Clause 21: Section 37 amended —

Mr Z.R.F. KIRKUP: This clause seeks to insert proposed section 37(3), which states —

> A health service provider may only dispose of health service land if —
>
> (a) the health service provider has the Minister's written agreement to dispose of the land;

There is also a gazettal requirement. How does a health service provider dispose of land at the moment?

Mr R.H. COOK: This proposed section further clarifies the rights and capacity of health service providers to enter into leasing arrangements. The disposal of land is essentially captured in a leasing arrangement. This is to clarify what they have to go to the minister for, which is around the disposal of land or any interest in land vested in or held or required by the health service provider. The term "dispose of" refers to leasing, subleasing and licensing of land.

As a result, a significant volume of licences, leases and subleases that currently require the minister's written approval, many of which are low risk, are entered into by health service providers. Essentially, this is to streamline the process by clarifying what health service providers can do.

Mr Z.R.F. KIRKUP: I have undoubtedly misunderstood, so I seek some clarification. In this case, disposal means leasing, subleasing et cetera; and, if that is the case, how will this streamline that process if the continued written agreement of the minister is needed to dispose of land? In my mind, of course, disposal means they are getting rid of it, out of the custody of the HSP.

Mr R.H. COOK: The member is quite right. This requires the minister's written agreement. However, the amendments give the minister the power to exempt certain types of disposal from the agreements made under proposed section 37(3) by way of order published in the *Government Gazette*. Essentially, this is the mechanism by which the minister can set the limitations and parameters around those powers for lease and disposal.

Mr Z.R.F. KIRKUP: In that case, of course, if the health service provider were to enter into a leasing arrangement, the minister would not have to provide written consent or agreement, and then the HSP could go about its business without the need to get the minister's support in writing. Is that right?

Mr R.H. COOK: A good example is housing for staff in a country context. This simply provides the HSP the opportunity to get on and do these things without having to have reference to the minister all the time.

Mr Z.R.F. KIRKUP: In that case, I am assuming there is the capacity for the Minister for Health to bring about a class of disposals that could mean the sell-off of health department land. For example, if the minister wanted to get rid of swathes of Royal Perth Hospital and the heritage precinct, he could effectively just say, "This is now the responsibility of the HSP rather than mine", and he could just exempt it, writ large, and the land sale process and title could just be offloaded to each HSP, if that is what the minister of the day intended to do.

Mr R.H. COOK: The member is entering into some extreme scenarios tonight. I now have grave fears were the member ever given the reins of the portfolio! No; that would be captured under other government arrangements under the responsibility of the Minister for Lands. For example, with the Princess Margaret Hospital for Children site, we do not get the opportunity to enter into an arrangement with someone else around the disposal of that land; that is the role of the Minister for Lands. The land is transferred to the minister and the minister then disposes of it in the usual manner.

Clause put and passed.

Clauses 22 to 30 put and passed.

Clause 31: Section 58 replaced —

Mr Z.R.F. KIRKUP: Minister, I obviously refute that; I am not advocating large swathes of land sales or anything like that!

Mr R.H. Cook: By way of interjection, I am sure the member would never do that!

Mr Z.R.F. KIRKUP: Every government seems to get a report every term on what to do with places like RPH. Everyone just waits for the land to be worth a little bit more before they make a decision, I suspect. Just on the liability for, and right to recover, compensable charges for health services, I am assuming this process can be undertaken at the moment. Is that the case? If so, to what does this proposed section give effect?

Mr R.H. COOK: Member, it is good that we discuss this. This is a particularly tricky part of the legislation, but a very important part, for reasons that I am sure the member will come to appreciate greatly in just a jiffy. Essentially, at the moment, when someone comes into a hospital setting and receives healthcare services, we do not necessarily know whether that person is a compensable patient or a patient who is non-compensable. As a result, they may claim for compensation later. The process for the hospital to then be able to retrieve the cost of those services through the compensation system is very complicated and sometimes impossible. This proposed section is establishing the primary right of a health service provider to claim those compensable moneys in the event that the patient at that point does not know that they are compensable, but later finds that they are compensable. It simply provides an opportunity for the health service provider to claim those moneys from, primarily, the insurance company involved.

The current section 58 was intended to achieve this result through regulations. However, the regulation-making power in section 58 is considered unclear and insufficient. It is intended that the new scheme will allow for a more effective recovery of treatment costs by health service providers from insurers and other compensation payers and will give greater certainty for compensable patients regarding the fees that will be charged for health services received. Obviously, this is an important point, because, at times, there are situations in which the taxpayers of Western Australia are paying for someone's health care that would otherwise be naturally picked up by an insurance company. As the member knows, a lot of the amendments that we are considering in the Health Services

Amendment Bill 2019 are very technical in nature to clarify, tighten up and otherwise make more workable the original act, and this is a great example of that.

Mr Z.R.F. KIRKUP: I thank the minister; I appreciate his clarification. The only part that was of particular interest to me in this case was the relationship between a patient's estate if that person dies and the opportunity for their charges to be recovered. Is there the facility for that to occur at the moment? That would undoubtedly be quite a contentious aspect, especially if the person died in medical care. I am just curious whether that is an option that is available at the moment, before these amendments are brought about?

Mr R.H. COOK: That is not provided for explicitly in these changes. Obviously, I think it will ultimately come down to the health service provider and the management in the usual course of events with claims that may be appropriate or inappropriate to claim against an estate. If a Western Australian comes in and receives health care, they get that free of charge. I guess I can think of some situations such as an international traveller who has travel insurance and then goes into a hospital environment and passes away. Maybe that is a scenario whereby one could contemplate that sort of thing, but, ordinarily, no.

Mr Z.R.F. KIRKUP: Just to clarify, I am sure the minister did not mean it when he said that that is not provided for in the changes; it is provided for in these changes. I am assuming that the minister means it is not provided for in the act as it stands at the moment and is being provided for in these changes.

Mr R.H. COOK: Yes.

Mr Z.R.F. KIRKUP: Further to that, I imagine a scenario would be the international passengers who contracted COVID-19, went into the state's care and then died. They were international arrivals. Is that a situation in which the state would seek to recover charges from their estate? Sorry; is that the capacity for which this amendment is being proposed? If that is not the case, I would appreciate the clarification.

Mr R.H. COOK: These particular provisions do not address the issues around international patients. This comes down to those people who come in, receive a service free of charge as a Western Australian or an Australian taxpayer and then are later compensated as though they had paid fees to the health service provider. The essential elements of the scheme for the recovery of fees and charges for the treatment of compensable injuries are as follows. A patient who has already received compensation, or established their entitlement to receive compensation, for the injury for which hospital treatment is proposed to be provided will be classified as a compensable patient and charged pursuant to proposed section 55 of the act. When a patient is treated as a public or private patient at the time of admission and the patient subsequently receives compensation or establishes an entitlement to receive compensation for treatment of the injury, or the patient already has received compensation or established an entitlement to receive compensation for the treatment of the injury but the health service provider was not aware of this at the time the health service was provided, the fee or charge that a health service provider or a form of public hospital could have charged for a service at the time it was provided is a compensable charge from the compensation. In the scenario that the member talked about of someone dying and the state receiving a fee for treating them before their death and them receiving compensation as if they had paid that fee, it would be claimable against that person's estate. This is only in the scenarios in which someone has either established or later received compensation for health care that they have otherwise not paid for.

Clause put and passed.

Clauses 32 to 34 put and passed.

Clause 35: Section 66 replaced —

Mr Z.R.F. KIRKUP: Pursuant to the conversation we had earlier in the evening about financial difficulties, to be perfectly frank, I do not have much more to explore on this, because I think we have already covered it. The only aspect I am keen to get a greater understanding of is the previous refrain about the level of public disclosure that exists when a notice is provided. The notice of financial difficulty is issued, and I understand it goes from the HSP to the department to the CEO, and it provides reasons that the HSP is in financial difficulty. I imagine that it is quite a significant undertaking. I do not know how common the minister thinks it might be, but I imagine it is relatively rare. I am stepping through the process. There is then an obligation for the CEO to provide the minister with the notice that the HSP is in financial difficulty and the action that should be taken, so effectively the director general says to the minister that something must be done about the situation, otherwise the HSP will collapse, for example, or whatever. The minister then has a requirement to respond to that—that is, to provide the notice and information to the Treasurer and initiate the advised action or any other action that the minister thinks is important to undertake. I appreciate there might be commercial sensibilities as part of that process and I appreciate this might have to happen relatively quickly, but as far as I am aware there is no gazettal and there is no tabling in Parliament. I could be wrong, and I look forward to the minister disabusing me of that notion if I am incorrect. There is no gazettal, no public information is provided and nothing is tabled in the house. I imagine it is probably canvassed in the annual report, which could be 12 months or 11 and a half months from when the notice of financial difficulty was issued. I suspect

it would be impossible to secure information under the Freedom of Information Act, if it is commercially sensitive—maybe, I do not know. I guess the only other avenue would be through parliamentary questioning. Is there any reason that the government has taken a measure not to provide information publicly that financial difficulty has been encountered by a HSP? Why was it not considered important that the public or the Parliament be informed of that?

Mr R.H. COOK: There is nothing deeply untoward or extreme about these provisions. They are standard provisions to allow an agency to continue to operate, even though they might be under some financial stress, particularly towards the end of the financial year when push is coming to shove. From that perspective, both at the time the bill was drafted and today, these things would be managed in the normal course of events. It is not so much about commerciality, although obviously it might make people think twice about entering into a contract with a HSP if there is particular publicity around it. For the member's information, two notices of financial difficulty have been raised by a health service provider under section 66 since July 2016. In each instance, the notice was triggered mainly due to a forecasted budget deficit position at the end of the financial year rather than an imminent cash shortfall, and it was effectively managed within the WA health system. The amendments will allow the policy frameworks to provide more detailed guidance to health service providers on when it is appropriate to issue a notice of financial difficulty. For instance, at the end of the third quarter I usually have meetings with the department that go to which health service provider is looking like running over or under and how they are managing their budgets as they come to the end of the financial year. It is not unusual for some to run a slight deficit; however, it is more usual that they run slight surpluses, and we want to get as close to that as possible. I take the point the member is making that this potentially could be a serious breach of financial management, but the provision is not in the bill as that element. It is simply there to facilitate the end of financial year balance that HSPs have. I understand the point that the member is making that there should be a declaration, tabling, gazettal or something like that, but this is no different from any other aspect of government in which we manage agency budgets on a year-to-year basis.

Mr Z.R.F. KIRKUP: I thank the minister; I appreciate the response. To the best of my knowledge, during the time I was policy adviser to the former Premier —

Mr R.H. Cook: He has blamed you for everything!

Mr Z.R.F. KIRKUP: For all the sins of government!

If an agency looked at getting over, it was quite a significant trigger for the cabinet from what I recall.

Mr R.H. Cook interjected.

Mr Z.R.F. KIRKUP: Yes. If there was a prospect, it was not considered to be a routine situation. It was quite a significant event to have an agency looking like it would have a significant shortfall—that it might come a cropper, especially in a third quarter, for example. Largely, my concern is not necessarily that we will be running a bit close to the wind come April or May; it is more if there is a significant decline and there is some massive blowout in a HSP, the people of Western Australia would not otherwise be informed. Effectively, from what I can establish, if there was a blowout in a HSP, it would confer with the DG, who would provide recommendations to the minister who would consult the Treasurer and things would be tidied up, and that is effectively it. We would not know whether there was mismanagement within an entity, let us say. The people of Western Australia would not have any understanding about the level of impairment if that only comes out in an annual report. As the minister expects from the opposition, I am probably thinking of the worst. I appreciate that the minister is undoubtedly thinking it will not get that bad and not to worry about it. He feels quite comfortable with it, otherwise he would not have brought legislation before this place. I am just flagging that that is an area in which there could perhaps be some improvement. It is just providing that notice. If there have only been two instances since 2016, it is not such a big deal to provide that information to Parliament, but it is up to the minister. I appreciate his response thus far.

Mr R.H. COOK: Again, I understand the principle that the member is talking about. He is talking about the time he was working in government. I know the history of some of the health service providers. I know, for instance, that the North Metropolitan Health Service would have been in deficit for pretty much all the years the member was a staff member in government. These things are managed appropriately within the holistic nature of the Department of Health's budget. These are issues that would arise principally in April–May each year. Probably the earliest they would be clarified would be in the annual report, once the full accounts have been settled at the end of the financial year. I understand and agree with the principle that the member talks about, but in terms of application, we are not talking here about wholesale funding shortfalls; we are simply talking about the management of the end-of-financial-year cash flows.

Clause put and passed.

Clause 36: Section 76A inserted —

Mr Z.R.F. KIRKUP: Thank you very much, Acting Speaker. It is very good to see you this evening.

The ACTING SPEAKER (Ms S.E. Winton): Nice to see you, too.

Mr Z.R.F. KIRKUP: Is there no capacity for a board member to be removed from office at this point in time? What is the necessity for the insertion of the misconduct considerations?

Mr R.H. COOK: Acting Speaker, at this point we are moving to a different section of the bill, so with your indulgence I will switch out a couple of advisers.

This clause moves the minister's power to remove individual board members from section 77 of the act into a standalone section. This change has been made because section 77 deals with administrative matters relating to board members, whereas the minister's power to remove a board member is not an administrative matter. The clause expands the definition of misconduct to cover a board member's breach of duty under section 79 of the act under the Statutory Corporations (Liability of Directors) Act 1996 or a breach of a duty found in the common law and equity. It sounds as though it is a bit of housekeeping, member.

Mr Z.R.F. KIRKUP: Is there no capacity at this time for a board member to be removed if there are concerns about misconduct?

Mr R.H. COOK: Yes, there is currently, but it is covered under section 77 of the act, which is under administrative matters relating to board members, whereas the minister's power to remove a board member is not considered to be an administrative matter. It will now come under its own section.

Mr Z.R.F. Kirkup: So formatting; we are doing it like it is just a hiving off?

Mr R.H. COOK: I think the member would admire the elegance of it and from that perspective would respect and usher it through with great speed.

Clause put and passed.

Clauses 37 and 38 put and passed.

Clause 39: Part 8 Division 2 Subdivision 2 heading replaced —

Mr Z.R.F. KIRKUP: We can see the difference between a government backbencher and an opposition backbencher at this point, can we not?

During the second reading stage we raised concern about the lack of publication of conflict of interest and in this case as it is captured under a duties and personal interests section. I think we raised this matter when we debated the Infrastructure Western Australia Bill 2019 and other legislation that the government brought to this place in which boards that have quite significant functions in the role of the state were being created. I appreciate the intent in clauses 39 and 40—that is, specifically the duties and personal interests—and would like to deal with these two clauses pushed together, if I can. I understand the intent. I think it is very important and quite relevant. I am curious how conflict of interest might be identified in a board member. The minister knows far better than I that the skillset of an HSP board member would involve a lot of cross-contamination across the very small Western Australian community and that people might very well be qualified, but they might have a lot of conflicts of interest. Although those conflicts, perceived or actual, might properly be articulated amongst the minister and the department and into the Parliament itself, I would like a better understanding of the means that people will have to interrogate conflicts of interest of board members as they arise.

Mr R.H. COOK: I have with me a bit of information that has been put forward. I appreciate the member wants to dig into this section, so we will take our time. By way of generality, the clause amends section 79 to replace a number of express obligations on board members and committee members, some of which are additional obligations that are not covered by the general law obligations that are imposed on board members under the Statutory Corporations (Liability of Directors) Act 1996 or common law or equity. The amendments are intended to make sure that board and committee members are aware of the duties that they owe to the health service provider and to the state, with particular emphasis on the management of personal interests. The new provisions create a high level of transparency and integrity with respect to personal interests held by board members by enshrining in the legislation, under proposed section 79(3)(b), that board members are required to notify their board of any personal interest conflicts with the interests of the health service provider. This will allow the board to assess the personal interest and to determine whether it is a matter that will affect the board member's ability to perform their duties to the health service provider and to act in the public interest. The purpose of paragraph (c) is to make clear that the board member is responsible for avoiding and appropriately managing their conflicts of interests. Due to the nature of the health service providers' operations, the significance of the services that are delivered to the public and the relative size of the budgets that they manage, a high level of transparency and accountability by the board over board members' personal interests is required beyond that already provided in section 80 of the act. This will tighten and heighten the role that conflicts of interest might play.

Under this policy the board must ensure that it implements appropriate strategies and practices for the identification of reporting and management of actual perceived and potential conflicts of interest; have in place a conflict of

interest register to ensure all declarations of actual perceived and potential conflicts of interest are recorded and managed appropriately; and ensure that they have adequate escalation procedures in place to ensure that actual perceived and potential conflicts of interest are managed appropriately by the relevant body when the conflict of interest cannot be managed by the board. This is obviously a very important aspect of a board member's duties and it is appropriate that a penalty of $25 000 applies for breaching these provisions. Such disclosures are also required to be recorded in the minutes of the board and committee meetings.

We do not believe it is necessary to include a statutory requirement for HSP boards to make public a register of conflicts of interests held by members. This is not necessary because amendments to the act, along with provisions already included in the act, provide stringent conflict-of-interest reporting requirements. This includes the provisions in section 80 of the act whereby declarations of material personal interest are to be made in relation to matters considered at board and committee meetings; a penalty of $25 000, as I mentioned earlier; when members have a material or personal interest in a matter, they are not permitted to vote on these matters or be present when the matter is being discussed; and the amendments provide even greater clarity on the duties of board members on managing conflicts of interest. Obviously, the conflict of interest register will be subject to freedom of information applications, as members would anticipate in these sorts of things. Additionally, the current provisions in the "Health Service Provider Board Governance Policy" requires that boards ensure that they implement appropriate strategies and practices for the identification, reporting and management of actual, perceived and potential conflicts of interest for board members, and that these strategies and practices are documented. In essence, member, this provision clarifies and heightens the role regarding conflicts of interest and puts in other provisions consistent across government around how they are managed.

Mr Z.R.F. KIRKUP: I appreciate the minister's extensive response. Will the minister be furnished with a copy of the conflict of interest register when one is made or updated?

Mr R.H. COOK: No.

Mr Z.R.F. KIRKUP: The minister in his contribution said that the conflict of interest register will be subject to FOI applications. As best as I understand, a board member is not considered to be a public officer under the act and therefore their information is considered to be personal and private, so I am curious about the minister's comment about it being subject to FOI applications. What does the minister envisage would be captured as part of a successful FOI application for information on the conflict of interest register of a health service provider? What would that encapsulate?

Mr R.H. COOK: The member is right; it would be considered under the usual nature of freedom of information applications. It would obviously consider those issues that go to kernel of the nature of the freedom of information inquiry, but would be captured in the normal manner that one would expect under that act.

Mr Z.R.F. KIRKUP: In that case, I flag my suspicion that very little would be captured if an FOI application were lodged because, undoubtedly, it would list the individual and the conflict that they had notified the board about in that register format. It is likely, I imagine, in Western Australia, that that would be a commercial interest, a property interest or perhaps a personal financial interest, and those details would not be released. Effectively, if a person were to put in an FOI application on the COI register for an HSP for an individual or the entire register, it would come back fairly blank, because most of the information would not be applicable as the FOI act currently stands—that is, to look at decisions of government officers and agencies. I think that is a significant shortcoming in that respect. If we are going to rely on the board being subject to FOI applications, I suspect there will be a shortcoming there. In fact, it is more likely that information would not be provided publicly. I assume, therefore, similarly, that if an opposition member were to ask the minister a question on notice to table the conflict of interest register, the minister of the day's response would likely be, "I don't discuss the financial arrangements of any particular individual", which, again, shows the limitation of the amendment to the act. I appreciate all the work that has gone into this amendment to the act and, otherwise, the requirement for integrity that the minister has provided to this place is very thorough and strong, but I still have concerns that the register cannot be inspected. Given that HSPs have wide and varied work—particularly agencies like the WA Country Health Service, which covers anything outside of metropolitan Perth, for example—a lot of financial arrangements will allow the HSP to be entirely autonomous with not much ministerial oversight if it is under a certain value, threshold or risk matrix.

It is good that a lot of commercial operations and maintenance and commercial contracts can be entered into, and I appreciate the devolved government model, which I think works very well, but the public accountability of HSP board members is important. I think, for whatever it is worth, that the COI register is an important part of that. We raised this issue with the Premier; Minister for State Development, Jobs and Trade about Infrastructure Western Australia. For example, we noted that Infrastructure New South Wales has a register that can be inspected. It is not public—as in, it is not online—to the best of my recollection, but a member of the public, a member of Parliament or a journalist can inspect it at any given time. If we look at health service providers' financial decisions, we see an unfortunate history. The minister is well versed in some of the financial issues that have come up. To

be perfectly frank, I appreciate the government's response, but it would be prudent to provide the information publicly. If the government is not willing to look at that, I think there should be a greater mechanism by which the register could be inspected. I suspect that is not what the government will go ahead with, but I am flagging that concern. The minister and I both know that the Minister for Health will be ultimately accountable which, as I said at the time to the Premier; Minister for State Development, Jobs and Trade, would leave him exposed. We have seen plenty of times when boards have made decisions that blow back on the minister or the Premier because they otherwise allowed it to occur. I think there is some risk for the minister as an elected member in this place and for executive government. Ultimately, perhaps, concerns could be raised about misconduct or unethical behaviour if a COI register cannot be scrutinised by the public. I think that leads to some areas of concern, but I appreciate the government's amendment to the act.

Clause put and passed.

Clauses 40 to 51 put and passed.

Clause 52: Section 123A inserted —

Mr Z.R.F. KIRKUP: This clause seeks to insert new section 123A, "Acting health executives". How does this arrangement work at the moment, if this is considered a necessary amendment to the act?

Mr R.H. COOK: This provision reflects current practice on the appointment of acting health executives. There is nothing wrong with what we are doing at the moment. This bill deals with the role of the chief executive officer and explicitly deals with the acting chief executive officer, so it was thought for completeness that we should incorporate those changes into the Health Services Act to reflect current practice.

Clause put and passed.

Clauses 53 to 62 put and passed.

Clause 63: Section 187 amended —

Mr Z.R.F. KIRKUP: I am mainly interested in the provision in proposed new section 187(1AA) that empowers the inquirer to enter the premises of a health service provider and any other hospital or facility controlled or managed by an HSP for the purposes of an inquiry. This is a bit of an extrapolation. This provision will ensure that an inquiry can take place in a private hospital as well. That is effectively where I am going. I am trying to understand —

Mr R.H. Cook interjected.

Mr Z.R.F. KIRKUP: Even though they have a service agreement or something like that in place, it does not have anything to do with the private arrangement.

Mr R.H. Cook: No.

Mr Z.R.F. KIRKUP: Okay. That is great.

Clause put and passed.

Clauses 64 to 79 put and passed.

Clause 80: Part 20 Division 3 inserted —

Mr R.H. COOK: This is a dreadful clause. Clause 80 was to insert part 20, division 3, which preserves orders made by the Minister for Works under section 20(4) of the act, which will be repealed by the bill by providing that these orders are taken to be an order made by the Minister for Works under the new section 20A(3). Due to the changes brought by the Procurement Act 2020, it is no longer necessary for the amendment bill to preserve the orders made by the Minister for Works under section 20(4), because the orders no longer have effect. In essence, we will be obliterating clause 80 and voting against it.

Clause put and negatived.

Clauses 81 to 86 put and passed.

Clause 87: Act amended —

Mr Z.R.F. KIRKUP: I will deal with clauses 87, 88 and 89 altogether. I am sure the Acting Speaker will give me that leniency at this late hour?

The ACTING SPEAKER: I will indeed!

Mr Z.R.F. KIRKUP: Clause 88 simply inserts the word "private" as part of the Motor Vehicle (Catastrophic Injuries) Act 2016. What effect will this have?

Mr R.H. COOK: When we were initially legislating for this bill, there was a bit of a dance in terms of timing with the Motor Vehicle (Catastrophic Injuries) Act 2016. As a result of that, the MVCI act makes reference to the

Hospitals and Health Services Act 1927, and so that simply changes the reference to refer to the Private Hospitals and Health Services Act.

Clause put and passed.

Clauses 88 to 90 put and passed.

Clause 91: Section 13 amended —

Mr Z.R.F. KIRKUP: Why is the amendment being made to the Queen Elizabeth II Medical Centre Act 1966 necessary?

Mr R.H. COOK: Clause 90 explains that part 5 of the bill amends the Queen Elizabeth II Medical Centre Act 1966. The consequential amendments made by this part were previously included in the act; however, the amendments did not commence due to a drafting error, which would have caused the QEII act to become inoperable, and have been corrected in this bill. The purpose of the amendments is to replace a by-law-making power held by the Queen Elizabeth II Medical Centre trust, under the QEII act, with a regulation-making power to be held by the Governor to make the QEII act consistent with other health legislation, which has moved away from the use of by-laws.

Clause 91 deletes and replaces section 13(2e) of the QEII act. The new section 13(2e) has been amended to remove paragraph (b), which provided for the delegate to make regulations or by-laws in respect of the site. Importantly, new section 13(2e) continues to permit the delegate of the trust to exercise the powers of the trust in respect of the portion of the QEII site that has been set aside under subsection (2a). The clause also replaces section 13(2g)(b)(i) with a new subparagraph (i) that clarifies that the delegate of the QEII trust is to pay money collected from the fees paid pursuant to the regulations made under the QEII act, into the designated count.

I cannot really provide any more clarity than that. It seems to be absolutely straightforward! As long as the member for Nedlands, who is an engineer, can understand that particular flow, I think we are on safe ground.

Clause put and passed.

Clause 92 put and passed.

Clause 93: Sections 22 and 23 inserted —

Mr Z.R.F. KIRKUP: My question relates to the transitional provisions for the Health Services Amendment Act 2019, as defined in this insertion. The member for Balcatta will appreciate that it is fantastic to see a medical facility named after our Queen. It is great to see the sovereign represented, albeit on a complex site.

Under new section 22, transitional arrangements are being repealed. I appreciate that this is perhaps a relatively complex amendment that the minister is moving in this place. Do the transitional arrangements cover any by-laws currently in place? Are those by-laws still activated even though they might be referenced under a part of the act in which the head of power no longer exists? Is that correct?

Mr R.H. COOK: Yes, it is a bit like that. What it is essentially doing is providing transitional provisions. It repeals the by-laws so that they can be replaced with regulations. References to the by-laws made under the QEII act, in written law or in other documents, such as parking infringement notices and things of that nature, are taken as a reference to the regulations made under the act rather than what were previously by-laws.

Clause put and passed.

Clauses 94 and 95 put and passed.

Title put and passed.

House adjourned at 9.30 pm