PUBLIC HEALTH BILL 2014
PUBLIC HEALTH (CONSEQUENTIAL PROVISIONS) BILL 2014

Second Reading — Cognate Debate

Resumed from 23 April.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [3.30 pm]: I take great pleasure in addressing the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. In doing so I observe that I am the lead speaker for the opposition and inform members that I avoided speaking until this point because I wanted to hear the members for Fremantle and Mandurah make their very important comments on the legislation.

Dr K.D. Hames: Important, but nothing to do with the bill.

Mr R.H. COOK: Indeed, minister, their comments may have had almost nothing to do with the bill, but both members made a valiant effort to speak on the legislation, and, as the cricket expression says, they both played the role of nightwatchmen well. They did a great job and I am indebted to them for their efforts and their important contributions.

This is important legislation and has been long anticipated in this place, particularly by us on this side of the political fence, because by and large an Australian's health is determined by race, postcode, social demographic status and the interaction between all three of those factors. As a political party that is committed to overcoming the tyranny of inequality in our society, and in this context the inequality of health or ill health in the community, this legislation is particularly important because it is about how we create a better and healthier society. From that point of view, this is an incredibly important piece of legislation for Labor. Public health is the health of the population as a whole, especially as monitored, regulated and promoted by the state. That definition provides a deliberative and proactive role for the state to ensure that members of its community continue to have the best possible health in life and the least chance of ill health. Of course, in Australia, a lot of the important work in public health has been around immunisation, water quality and disease management, and as a modern society in an economically advanced community we have done remarkably well in all those areas.

The University of Pittsburgh provides a further nuance of the definition of public health that refers to the science of protecting the safety and improving the health of communities through education, policymaking and research, through disease and injury prevention. We have a broad scope and ambition in public health and it is not surprising, therefore, that we have these huge bills before us. It is pleasing to see that this legislation has at last come to this place and I am very happy to say that the opposition will support the bill, although in a qualified sense because the opposition has some very grave concerns about it.

These bills took some time to get to this place. I have met people who have proudly said that they had been members of the initial committee that reviewed the Health Act 1911. I have said to them, "Oh, so you must have been involved in the early 2000s", to which they replied, "No, we were involved in the early 1990s." The review of this legislation has, therefore, gone through the hands of about half a dozen health ministers, including Ministers Prince, Kierath, Day, Kucera, Foss and McGinty, and now Minister Hames. It is Minister Hames who has the enviable task of being the minister to get to the end of the show. However, it almost was not that way, because as we moved towards 2011, a number of members in this place and of the community wondered whether the Health Act 1911 was going to be 100 years old before it was reformed.

On 22 February 2011, the member for Alfred Cove, Dr Janet Woollard, asked the Minister for Health when the legislation would come to this place, and the Minister for Health said at that time —

> I expect that the bill will come to Parliament by the end of the year.

Then, in November 2011, I asked the Minister for Health whether the bill would come in at the end of 2011, and the minister said that he was committed to getting it in that year.

Dr K.D. Hames: Then we hit one of those things called a hurdle, called publically binding the Crown.

Mr R.H. COOK: I will come to the hurdle shortly.

I should acknowledge the role of Dr Woollard in the public health debate. It was almost as though from time to time we were playing a tag-team performance in holding the Minister for Health to account. In February 2012, following her question in February 2011, Dr Woollard again asked the minister whether he could advise the Parliament when the new Public Health Bill would come in, and reminded him that he said that it would be before the end of the year. The minister replied in one of his more verbose responses in this place and said that he expected the bill would be introduced in the first half of the year, and sat down. As I said, that was at the beginning of 2012. I respect the fight the minister has had on his hands since those heady days, because

I understand that at that point in time the bill had what we all knew to be one of its important components—that is, it had the capacity to bind the Crown. The Crown would be bound by the provisions of its own laws; what it expected from its citizens, it would also expect of itself. Other reforms were widely anticipated from this legislation that stakeholders were most eagerly awaiting, and this is a very important aspect of it. In September 2012, an article with the rather lofty title "New Public Health Act for WA will improve conditions in Indigenous communities" was posted on the website Australian Indigenous Health*InfoNet*, which discussed the issue of the new Public Health Bill. It went on to reflect the answer of the minister to say that the new Public Health Bill would be in Parliament before the end of 2012 and that the new legislation would be helpful in terms of binding the Crown and addressing the huge level of health inequality in Aboriginal communities. In that article Professor Ted Wilkes, professor of public health at Curtin University, says —

> Services like sewage, rubbish collection and water supply in Indigenous communities aren't up to scratch. "Sewage systems leave a fair bit to be desired to be honest," he said. "We've had situations where water mains and pipes are buried too shallow, so they're ruined after a few cars and trucks go over them. The infrastructure just isn't there."

The article paraphrases Professor Wilkes, observing the following —

> The new bill will include a clause to 'bind the crown', meaning those communities will have to meet the same standards as everywhere else. Professor Wilkes says it's long overdue.

Professor Wilkes is quoted as saying also —

> 'Before we were told nothing could be done when we complained about these facilities,' he said. 'But, if there are protocols in place, community leaders will have the confidence and knowledge to take issues like sewage to government and demand action. It gives residents more security and lifts environmental and health standards for the next generation.'

As I said, that was in September 2012. It was obviously a time of great anticipation. We expected the Public Health Bill to be introduced and passed to do those things that the community expected and which, in defence of the Minister for Health, was something I believe he wanted to do. However, he hit a mighty obstacle—in fact, what we now know from the history of the bill to be an immovable object. That was the regulatory gatekeeper in the Department of Treasury and Finance. I do not know who the regulatory gatekeeper is, but I know that the entire Department of Treasury and Finance was unable to stop the Premier and the cabinet from delivering this state into almost public financial ruin due to its debt and deficit scenarios we are now confronting in this state. However, seemingly there are some incredibly powerful little bods inside the Department of Treasury and Finance who form the regulatory gatekeeper, and who stood up to the minister —

Dr K.D. Hames: It wasn't the gatekeeper.

Mr R.H. COOK: It was, in fact, the Treasurer himself.

Dr K.D. Hames: Not the Treasurer—the Department of Treasury.

Mr R.H. COOK: Why is it that the department can stop such plain, simple, commonsense and morally sound legislation in terms of binding the Crown, yet it could not stop members opposite from putting this state into $30 billion worth of debt?

Dr K.D. Hames: I presume interjections aren't allowed!

Mr R.H. COOK: Of course, contrary to the usual case, the minister is not keen to interject on that question.

Binding the Crown is a very important aspect. This issue was tested in 1996 in a case that I think the Aboriginal Legal Service brought on behalf of the Atyeo v The Aboriginal Lands Trust in relation to the poor environmental health conditions of that community. In that case, the courts found that the Health Act did not bind the Crown. As a result, that community was helpless in seeking some redress for the poor environmental health conditions it was experiencing. Despite the health conditions of that community being, I understand, in clear breach of the Health Act, the community was incapable of bringing legal action to make sure the situation was remedied.

We were reminded recently by the Office of the Auditor General when he undertook an inquiry into remote communities and reported on 8 May on the drinking water quality across some of these communities of the following —

> Tests detected either E. Coli or Naegleria microbes in at least one community in every month in the two years to June 2014.

He said further on —

> In the same period, four communities exceeded safe levels of uranium in their water by up to double the level allowed for under the Australian guideline. Fourteen communities recorded nitrates above the safe level for bottle-fed babies under three months old in 2014.

The need for legislation to be brought into this place to force the government to be bound by this legislation is occurring now. The preconditions for making sure the government acts to comply with its own legislation are as ever present today as they were in 1996 when that legal case was heard. The legislation has now come into this place. As I said, this is very expansive legislation. The minister has proposed a unique way of dealing with the detail of it, and I thank him for that. We look forward to responding to that in the next day or so and on how we move forward on this.

The legislation will do some important things. We all know some of the more humorous aspects of the Health Act 1911, such as how often we should clean out soil closets; how many sheep we are allowed to keep in our basement; and what we must do if we get on public transport in the event we have a cold. I guess that typifies the current legislation, which is very prescriptive and seeks to name and constrain all those activities that it will address. The new legislation, of course, provides a better framework for this. It is a risk-based framework and very much reflects modern legislation, such as environmental protection legislation, occupational health and safety legislation and so on. Under that framework, it provides a general duty on members of the community to protect the public health. The general public duty of health is that a person must take all reasonable and practical steps to prevent or minimise any harm to public health that might foreseeably result from anything done or omitted to be done by the person. It seeks to provide a risk-based management framework for controlling public health and safety. It is obviously a welcome change to the legislation and it should provide government into the future with a good framework in which to continue to make regulations and policies for public health.

Another important aspect of this legislation is public health plans. We will have a statewide public health plan that will be informed by local public health plans put together by local governments. These plans are an incredibly important aspect of capturing both aspirational aspects around public health and in facilitating good works on the ground and in the community to ensure that we understand that throughout the role of supporting public health and ensuring we have good wellbeing in our community, they should operate at all levels of government and that what goes on at the local government area should continue to drive a wellbeing strategy right across the state. We have already seen a range of public health plans come into place notwithstanding that legislation has not come into this place. The City of Perth public health and wellbeing plan describes in part —

> Traditionally, the City has undertaken a health protection role through regulation and compliance of issues such as food safety, water quality and communicable disease control. While these regulatory functions are important, the City has identified the need to progress more proactive and innovative strategies, with a greater focus on education and capacity building, in order to strengthen the knowledge and skills of the community to manage environmental health issues.

That is one of the important aspects of this legislation; that is, we can aspire to so much more in what local governments can do to create healthy and vibrant communities than simply the processes that were allowed for in the old act.

The legislation makes some important changes, but as I said, the opposition shares the concerns of public health stakeholders and many other people about its failure to bind the Crown. This stands in stark contrast to the minister's second reading speech, in which he stated that the bill does bind the Crown. Clause 57 reads —

> **Application of Part to Crown**
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> (1) To avoid doubt, this Part applies to —
>
> (a) registrable activities carried on by the Crown in any capacity; and
>
> (b) licensable activities carried on by any individual in their capacity as an employee, agent or officer of the Crown.

The bill makes it quite clear that the Crown is bound by this legislation, except that clause 57(2) reads —

> This section is subject to Part 16.

That is where we get into some interesting debate indeed about how the Crown is bound. In part 16, clause 256 is headed "Minister may exempt Crown or Crown authority from certain provisions" and goes on to list aspects of the Crown's activities that will not, in fact, be bound by its own legislation. It reads —

> (1) The Minister may, by notice published in the *Gazette*, exempt the Crown or a Crown authority from the application of —

(a) one or more provisions of this Act; or

(b) one or more provisions of the regulations; or

(c) a combination of those things.

One would want to ask why on earth a Minister for Health would want to see the Crown do harm. Why would the Minister for Health allow a Crown authority or agency to be exempt from legislation that is fundamentally about the health and wellbeing of the community? The legislation provides us with some insight into this. This is where we fall upon very immoral ground indeed. Clause 256(3) reads —

> The Minister can exempt the Crown or a Crown authority from the application of a provision of this Act or of the regulations only if the Minister is satisfied that the Crown or, as the case requires, the Crown authority is unable to take the steps necessary to comply with the provision, whether because of a lack of financial or other resources or for any other reason.

I wonder why the legislation actually specifies financial reasons for exemption from the legislation. This comes back to the nub of the problem; that is, the Department of Treasury is really the agency that is in control of this legislation. That department will be tapping the minister of the day on the shoulder and saying that he may want to protect the community from the ill health resulting from the actions of a particular agency or department, but Treasury believes that it will cost too much. Despite the interests of the citizens of Western Australia, who are taxpayers and on whom our existence depends, we will actually exempt this department on the basis that it simply costs too much. This is a very unfortunate aspect of the legislation and no doubt a deal that the minister had to do in order to get this legislation through the department and the cabinet, and into this place. The minister has obviously made a calculated decision that it is better to come forward with flawed legislation than no legislation at all. It is better to bring forward legislation that fails to deliver on the single most important aspect that people see, if it delivers on other issues around a risk-based management framework and a new public health approach.

The minister may provide exemptions with conditions. It would be incredibly important for the minister to consider those conditions very carefully, and to make sure that those conditions do not allow a government agency to drag the public policy chain and continue to treat certain citizens of our community with contempt for their public health conditions. It is also very interesting that the conditions relating to exemptions come into force on the same day on which the bill is assented to. We will not actually know what those exemptions are until the day that the legislation is assented to. The minister is asking us to take on blind faith the exemptions and the vast array of regulations that will be crafted under this legislation. Quite frankly, that is a big ask, because one aspect of this bill that we were most anticipating—the binding of the Crown—as we see through closer analysis, is flawed.

If that were not bad enough, we move now to division 3 of part 17 in the legislation, relating to enforcement action against the Crown. Clause 281 reads —

> **Improvement notices may be given to Crown**
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> (1) An improvement notice may be given under this Act to the Crown in any of its capacities.
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> (2) An improvement notice to be given to the Crown under this Act may be given to the responsible agency.

Ultimately, a government agency can be called upon to improve its performance on actions under the act. However, clause 282 states —

> An enforcement order cannot be given under this Act to the Crown in any of its capacities.

This is saying that a government agency can be told that it has to lift its game. It may have been provided with exemptions for five or 10 years in relation to its actions. We would hope that the minister would seek to provide very tight conditions on those exemptions. However, when push comes to shove, the minister cannot do a single thing to force a government agency to act. Although the minister can call on a government agency to improve its performance, he cannot enforce that. For that reason the Public Health Bill becomes a toothless tiger. If it is incapable of forcing a government agency to act, as we have seen in past reluctance to do so, because of the issue of cost, the minister is powerless to do anything about it. He can provide an exemption in the first place, and then hopefully through that exemption form a relationship with that government agency to get it on a path of rectification and better performance, but the minister is powerless, when push comes to shove, to force that agency, when it gets towards the end of its exemption period, to do anything about it.

Another aspect of this legislation that I find curious is emergency powers. Under the Health Act, a minister may exercise emergency powers, but only after consultation with officers who are responsible for reporting to the minister. We have this curious process in which the minister has to almost seek permission from people within

his department rather than being able to take action himself. I am worried about the minister's powers in this bill. We know that the Minister for Health had a large role under the Health Act and typically has a large role to play in any act relating to health. Curiously, under the new Public Health Bill, the minister is almost missing in many of the powers because they are all exercised de facto by the Chief Health Officer. Those powers he does exercise either are at the behest of the Department of Treasury and Finance or can only be exercised after consultation with his own officers. It strikes me that under the new health bill, the minister seemingly has a very low priority role. I am sure that the minister will be able to respond to why "the minister" has been taken out of so many aspects of the bill, but I believe, although I have never had an opportunity to analyse earlier versions of the bill, that the minister had a much more deliberative role in how it would function. As I said, ultimately, we will be supporting this bill, but we would like to see aspects of it improved significantly. During consideration in detail, we will be taking the opportunity to ensure that we continue to analyse and put forward suggestions that we believe would improve the legislation.

As I said earlier in my speech, one of the single most important instruments in the Public Health Bill is health plans. I think the health plans will play an incredibly important role in a modern public health landscape. One of the things that has always frustrated me in the planning development of our local communities is that much of it is done in a way that is totally contrary to the wishes of the local community and the local council. Local councils are bound by other legislation in a manner that sees them having to approve developments or activities in their area that they would otherwise seek to change for the public health benefits of the community. In particular, I raise the issue of fast-food outlets and bottle shops. Although a very clear and present argument can be made that we should limit the amount of alcohol and junk food that is available in our community, councils are continually unable to make decisions that would protect the public health of their community because they are bound by very narrow planning decisions. For instance, opposite the Kwinana CBD in my electorate is Calista Primary School. I can stand in the playground of Calista Primary School and by line of sight see three bottle shops within about 200 metres. One of those bottle shops is more of a bottle Taj Mahal—one of those huge liquor barns that essentially market themselves as selling cut-price alcohol in order to encourage members of the community to buy more and more. From this playground, I can also see no fewer than four fast-food outlets. I ask myself: is that the sort of community that we want our kids to grow up in?

Dr K.D. Hames: It sounds like they put the school in the wrong place.

Mr R.H. COOK: I guess the school was put where it was needed at a time when people were not even thinking that shops would exist in that area.

Dr A.D. Buti: Harry Reid, the former Senate majority leader in the Senate in America, and who is still in that place, comes from a small town in Utah where they had a school and a brothel. There was a rule that there couldn't be a school and a brothel in the same town, so they removed the school.

Mr R.H. COOK: That is a great example of the madness that we find ourselves in at times when we seek to treat businesses as normal businesses without taking into account the public health implications of them being there.

The closest shop to another primary school in my electorate, Medina Primary School, is Liquorland. We could literally lob a honky nut from the primary school playground into the drive-through section of this particular Liquorland. I am not saying that we should not have bottle shops, but I ask the question: are these the dimensions of a healthy community that we aspire to in our schools and in society generally?

Public health will continue to play an important role in our society. As the minister will tell us, one of the greatest challenges in health is not treating patients who arrive at the hospital; it is creating a society that does not require people to present to hospital in the first place. This is fundamentally the point on which public health really turns. How do we create a society in which people do not need the services of our health sector? How do we measure the health of a society? We can go to a range of different measures. Typically, we go to tobacco use, alcohol use and rates of obesity. They are the three big indicators that suggest that we have good public health performance. We should be measuring these. They should be part and parcel of our health reporting. We have reports on elective surgery and access to emergency departments, but we have fragmented and disappointing processes of reporting on public health generally. I am not saying that the information is not out there. The Australian Institute of Health and Welfare has an incredible number of reports on a lot of these public health issues. Would it not be good if a single report came out once a year that looks at the behaviour and performance of a government and how it is increasing the public health of its community, particularly through these measures?

I want to look at three particular performance measures of this government and make some comments about how we could be doing better. While we continue to focus so heavily on hospital services and other health performance issues, we often forget these three dimensions or they go unreported. In Western Australia, we are seeing an increase in the amount of alcohol consumed. The per capita consumption of alcohol in Western Australia is higher than the national average. In 2009–10, the per capita consumption of alcohol in WA

for people aged 15 years or older was 12.4 litres compared with just 10.4 litres for the rest of Australia. We know that alcohol damages our community because we know statistics such as over 70 per cent of Australian adults reported being affected by others drinking in 2008 and almost half reported severe harm, such as property damage and physical or sexual abuse, attributed to alcohol. We know that we should be doing something about the incidence of alcohol use and the patterns of behaviour of the consumption of alcohol because we know that it has a huge impact on the wellbeing of our community and that it has such a huge cost burden for the Department of Health.

What are we doing to drive down the incidence of alcohol consumption? A very good report was recently prepared—the Atkins review—that brought about a whole range of ideas about how we should be addressing public policy on alcohol. I commend the government for saying that it wants to bring in secondary supply legislation, but that is just a part of it. If we continue to treat alcohol just like any other good to be consumed, we will continue to see the damage brought about by alcohol in our society. The question has to be asked: Why did the government not respond more robustly to the liquor industry's review? Why did the Minister for Health not take that as an opportunity to push for extra measures to protect our community? Why, for instance, are we not looking at controlled purchase orders, which the Commissioner of Police, Karl O'Callaghan, has called for time and time again? We know they are effective in reducing the amount of tobacco being served to young people and the police commissioner has been calling for these powers to have controlled purchases. It seems to be plain-face commonsense to move in this direction; the Atkins review actually recommended it, yet we are doing nothing. I am sure many of us observed the *Four Corners* report last night that showed just how much damage alcohol is doing to Aboriginal communities and we know that it also continues to damage all communities. Therefore, we should be acting and the minister should be moving more forcefully and publicly to bring about better patterns of alcohol consumption and reduce the level of alcohol availability in our society. A recent report stated that 70 per cent of young people under the age of 18 said that they found it quite easy to purchase alcohol. We have to get on top of this issue and show that we are serious about it.

Obesity is another public health issue that I have mentioned. One of the great burdens on our health system is the level of type 2 diabetes in our community. We all know the relationship between obesity and type 2 diabetes and we should be acting more forcefully to combat obesity levels in our community as well. To give members a measure of just how much of a problem it is, with a 28 per cent obesity rate and 37 per cent rate of overweight people, Western Australia has one of the highest rates of obesity and overweight people in Australia. I might add that it is not by a hell of a lot. Our rate is equal to that of South Australia, Tasmania and the Australian Capital Territory but it is more than Victoria, New South Wales, Queensland and more than the Northern Territory, which strikes me as unusual. We should be moving to make obesity a single mission to improve the health of our community and to lift public health, wellness and wellbeing.

Mr P.B. Watson: Prevention, prevention, prevention.

Mr R.H. COOK: The member for Albany is absolutely right in saying that prevention is the key. There is no silver bullet for obesity but we know that it is about diet and physical activity, and we know that it is about the health and wellbeing of young children, and also in utero. We know where the opportunities are, we know that there is a need and we know what the cost burden to our community would be if we do not address this issue, so we need to get on with it.

Tobacco remains one of the single biggest killers of people in our community. I think it is one of the areas that the minister has been most missing in action on in this government's public health efforts. The only legislation to tighten tobacco regulations that has come forward in this place since the member has been Minister for Health has been through the efforts of the former member for Alfred Cove, Janet Woollard, when she brought forward legislation in 2009–10. Since then, a review of the Tobacco Products Control Act in 2011 has still not been responded to. During the last election, the Minister for Health made six commitments to tobacco policy. He talked about strengthening and enforcing point-of-sale legislation, including an end to price boards; the strong enforcement of legislation prohibiting sales to minors; the adequate funding of mass media campaigns; the banning of all remaining forms of tobacco advertising and promotion; increased support to address smoking in disadvantaged communities and groups; and phasing in a reduction in the number of tobacco licences. I do not think we have seen a reduction of tobacco licences. We certainly have not seen a strong enforcement of legislation prohibiting sales to minors. I have not seen anything to do with the strengthening and enforcing of point-of-sale legislation and there certainly has not been an end to price boards. Nicola Roxon—a former Minister for Health and Ageing during a former federal Labor government—saved the government on the banning of all remaining forms of tobacco advertising and promotion with the changes that she introduced.

Dr K.D. Hames: With our strong support.

Mr R.H. COOK: Indeed, with this government's strong support. However, more needs to be done and the minister should have been and should be more active in this space.

Under this legislation, we have seen some of the most extraordinary political repositioning or attacks upon one of our most important weapons in the fight for better health promotion in this state; that is, the unwarranted and extraordinary attacks by the Premier and this Minister for Health on Healthway to essentially politically nobble that agency as performing a cynical political activity. I suspect it was also simply part of an exercise to ensure that the government gets its hands on those health promotion dollars. I was surprised, as many people were, at the force of the Public Sector Commission's report into Healthway; and also, like many people, including most journalists, was duped by its findings. However, under closer examination, we can see just what an appalling job was done on that report, and how the government used it to trash the reputations of the former Healthway chairperson, Dr Rosanna Capolingua, and staff at that agency.

I am indebted to Professor Rob Donovan, professor of behavioural research at Curtin University, who undertook a thorough examination of the Public Sector Commission's report. Professor Donovan states —

> The deficiencies described in this Comment concern the overall logic and accuracy of the relatively straightforward quantitative data analyses. Given the extent of these deficiencies, it is not unreasonable to expect that similar deficiencies might also be found in the more complex or nuanced qualitative analyses of the investigation.

Professor Donovan continues —

> The overall impression is of a haphazard if not erratic approach to the investigation that renders the conclusions and findings misleading, meaningless or tenuous at best. That the Report was placed in the public domain and presented to the Government in such a state suggests a gross inadequacy in quality control within an organisation charged with setting and ensuring high standards of quality and integrity in public sector organisations. In my opinion, the various deficiencies cast doubt on the competence and objectivity of all aspects of the investigation and the conclusions drawn, and, if unacknowledged and uncorrected, have the potential to undermine public confidence in the credibility and objectivity of the Commission. At the very least this Report indicates a woeful standard of investigatory expertise in the Public Sector Commission. The general public, the Government, and the subjects of the investigation in particular, have a right to expect and to receive a Public Sector Commission Report that does not contain such a large number of elementary errors.

Dr K.D. Hames: The Public Sector Commissioner has read that and totally and strongly disagrees.

Mr R.H. COOK: Quite frankly, I have seen other analyses, minister, that back up Professor Donovan's findings. Professor Donovan stated that the methodology was illogical, that the findings were misleading, that there was selectivity of the cases analysed and inconsistency in the units of analysis, that the calculation of the market value was spurious at any rate, that the sampling bias was unacknowledged and that this limitation on the "generalisability" of the findings was also unacknowledged, and that there were numerous numerical discrepancies and inconsistencies.

The one person who was in a position to defend Healthway was the Minister for Health; he is the one person who understood the importance of its work and the one person who owed support to the chair and staff of Healthway, yet was also the one person who was missing throughout the entire debate. I will come to the point where he did actually come into the debate. We know why Healthway came under this attack; it is because it gave money to the Western Australian Cricket Association in December 2013 —

[Quorum formed.]

Mr R.H. COOK: The commentary by the Premier and the reporting by the media on the issues surrounding Healthway were totally unfair and totally unjust, particularly with regard to the executive director, David Malone, who has been unable to defend himself in this matter. The character assassination that took place was absolutely extraordinary. For instance, according to the report, David Malone attended 25 events with VIP tickets over a four-year period. That works out on average to six events a year, which one would not think is an unreasonable number of events for an executive director of an organisation to attend. Over the same period he used 32 VIP tickets for family and friends. On face value, one could look at that and think, "That's pretty outrageous—32 tickets for family and friends! What's he doing? Why is he giving out all these tickets?" Of course, that requires closer examination—closer examination that appears to be missing from the Public Sector Commissioner's enthusiasm in this. It turns out that 25 of the 32 tickets for family and friends were used to take his wife to events. We all understand that if one is attending an event, particularly out of hours on the weekend

or something, that would actually be quite justifiable. Over a four-year period, seven tickets were used for people other than his wife. This is someone who has lost his job and whose career has, I suspect, been trashed because of what is essentially a political exercise by this government to attack Healthway, because it wants to get its mitts on Healthway's money.

Ultimately, the Minister for Health salvaged some of the dignity with which he ought to have conducted himself throughout this matter and defended the right of Healthway moneys to be dispensed without political interference; if the legislation to reform Healthway ever comes forward, may it reflect that. However, when the minister delivers his speech, he owes a sincere and unqualified apology to the staff of Healthway; the executive director, David Malone; and the former chairperson, Dr Rosanna Capolingua, for the character assassination that has been undertaken by his government.

I turn briefly to another issue. As I mentioned earlier, one aspect of public health is research. Last week I had the good fortune to attend the "Science Lands in Parliament" function. The Minister for Health made a comment at that function and I want to take the opportunity today to develop that further. He said—I ask the minister to please correct me if I am wrong—that the National Health and Medical Research Council funding for Western Australia had recently increased to around eight to nine per cent.

Dr K.D. Hames: I think I was told eight per cent.

Mr R.H. COOK: I just want to draw it to the minister's attention that, in fact, in 2014 our funding continued to languish around the 5.2 per cent mark. When the government came into power, that figure was around 6.6 per cent. I should add that it is up from a low point in 2012 of 4.5 per cent. We still need to do a lot of work to catch up to the other states with regard to medical research.

I want to spend the final minutes talking about what the future might hold for public health. I want to see local government authorities empowered to create healthy communities. I want to see them have the opportunity not to be bullied and pushed around by—essentially drug retailers—tobacconists and bottle shops. I want local government authorities to have the capacity to say, "No, we have enough junk food in our community; we aspire for a better way for our community in the future." Preferably, I would like to see these local health plans strengthened and improved. I want to see a greater effort on obesity in our community. Obviously, an important aspect of that is to continue to educate the community to improve its level of understanding around healthy eating and healthy lifestyles—that is what community members should pursue to ensure they lead healthier and happier lives. It was drawn to my attention recently that physical education is no longer considered a compulsory component of kids' time at school. If that is the case, it should stop. We should ensure that physical education is back in our schools and kids continue to have active lifestyles, which they will carry on from their time at school.

We have talked at length about closing the gap in relation to the Aboriginal community. As someone who has worked in that space for some time now, we have to continue to do more in relation to Aboriginal rights. Binding the Crown is an important part of that. We also need to be mindful that the difference in life expectancy between someone with mental illness and other members of the community is 14 years, and we must do more to address that.

MR P.B. WATSON (Albany) [4.51 pm]: It gives me great pleasure to talk on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. Firstly, while the minister is in the chamber, I have a couple of issues to raise—one is a text and the other is on my iPad, and I am afraid that I will lose them. One is from the Albany Community Care Respite Centre. I know the government has provided money to the centre before, as has the federal government, but they are in a crisis situation at the moment. I will read the text I received today from the Albany Community Respite Centre —

> With no ongoing funding we will not be able to continue to provide Respite Services.
>
> Our funding will finish on the 30 June 2015.
>
> Due to changes at the federal level there is no opportunity to apply for respite funding until 2017.—if the guidelines don't change yet again.
>
> Some facts
>
> - We can provide 43,800 hours of respite care for $370,000 per year
> - This is an average of $10.00 per person living in ALBANY

Or living in the region —

- The cost of 24 hour stay in Hospital is $1,500 per day per person.
- The cost of 24 hour stay in ACRC $370.00 per day per person.

- In a 12 month period we average 270 admissions.
- At least 4 part time staff will be out of work. Others will loose hours and may look for other work.

The Albany Community Care Respite Centre has had funding through, I think, royalties for regions and from the federal government. Those figures show how much money it saves not only the state but also the federal government, yet nobody wants to know about it. A lot of people in regional areas are out on farms and do not have the facilities that everyone else has. They do not have people who come to look after their families. They are in the outer towns. It is very important that they get some sort of respite. At the moment, it has been great—a huge number of people have gone through the centre, but now some people will say that they cannot look after these people and they will either have to go into a home or to hospital.

Dr K.D. Hames: Member, I know about that. I had two of my federal Liberal colleagues lobbying me about it, which I thought was somewhat ironic, because it was they who stopped the funding. I sent them back to speak to the federal Minister for Health and to say that they really shouldn't stop this funding because it is critically important.

Mr P.B. WATSON: As I said before—when the minister was reading—the state government has given money before, and I thank the state government. Can the minister use his power? We tried with the federal minister, but she says, "Oh, no; there is no funding until 2017." It is a very, very important part of our community.

Dr K.D. Hames: My federal colleagues are lobbying her right now.

Mr P.B. WATSON: I spoke to a chap at the airport the other night—this might seem minor—but I will tell members what he told me. He wished to express his concern that the hospital entertainment system requires patients to pay for free-to-air television, movies and internet access. He told me that although his stay in hospital was relatively short, he wanted to make this point for the sake of current and future patients who are far less fortunate than he is. He said, "One might say that is just entertainment and that if a patient does not want to pay for it, they can choose not to use it—indeed, they can—however, I consider it to be much more important than mere entertainment." He said that when he was first admitted, he was unsure of the severity of his injuries. The injuries were relatively minor compared with the circumstances of many other patients. Many patients unexpectedly find themselves in hospital having suffered a traumatic incident, which, for many, causes life-changing circumstances. It is often a life-threatening illness or injury. It is natural for a patient to be scared about their future and what to expect from upcoming treatment. Without the distraction of the entertainment system, patients have little else to do than to lie in bed and think about their circumstances. Therefore, this chap considered the entertainment system to be an essential element to maintain good mental health; it allows patients to maintain contact with the outside world through news programs. In his opinion, the patient entertainment system is administered by Serco. However, he was not familiar with the contractual arrangements between Serco and the Western Australian government, and therefore did not know which organisation benefited from the revenue generated by this service. In his opinion, it is disgraceful that either organisation would benefit from revenue raised by this system. He told me that the system costs $9 a day or $63 a week for the standard service, which is free-to-air television only, and $15 per day or $105 per week for the premium service, which is free-to-air television, movies and internet access. He said that these are the rates for short-term patients, who are defined as patients staying for fewer than 10 days.

It might seem only trivial to the minister, but I remember when he showed us around the Albany Health Campus —

Dr K.D. Hames: Are you talking about Fiona Stanley Hospital?

Mr P.B. WATSON: No.

Dr K.D. Hames: But there is no Serco involvement in Albany.

Mr P.B. WATSON: He said he did not know where the money was going.

Dr K.D. Hames: It pays for the service. If you want Foxtel, you've got to pay for it.

Mr P.B. WATSON: But he said it is for free-to-air television.

Dr K.D. Hames: Yes, you get television for free.

Mr P.B. WATSON: No, it is not; it is $9.

Dr K.D. Hames: You may be right.

Mr P.B. WATSON: That is $63 per week for a pensioner or anyone else.

When the minister showed us around the Albany Health Campus—great hospital, and it is a shame the Premier is not here to hear me say it—he showed me the television on a computer. The doctor could put all the patient's information on it and it was also a TV. The computer is provided as an essential service, but it costs $9 a day to have free TV. I could understand a charge for Foxtel and movies. This chap was not a senior, but he is not in a great financial position, and he raised something that I did not know about. When I have been to hospital, I have probably been in the private system and people already pay for that service anyway. It is something that has come up—all these little things come up.

Dr K.D. Hames: It may be that when you go to Royal Perth or Charlie's, you probably have to pay to get a TV. I think it's been like that for a long time.

Mr P.B. WATSON: I am not saying that it is just there. I am saying that when there is a system there with a computer on one side that can be used as a TV —

Dr K.D. Hames: I am agreeing with you. You have to have the computer thing there anyway.

Mr P.B. WATSON: My next issue, minister, is about dialysis —

Dr K.D. Hames: You know none of this has anything to do with the bill we are debating, don't you?

Mr P.B. WATSON: It is about public health, is it not, minister?

Dr K.D. Hames: We are dealing with the Public Health Bill.

Mr P.B. WATSON: Public health, for my constituents, is going to a hospital. I did not realise that was not part of public health.

Dr K.D. Hames: No, it's not. Although, quite reasonably, you might expect that the Public Health Bill is about public health, it's actually not; it's about things like management —

Mr P.B. WATSON: The minister has his version; I have mine.

Several members interjected.

Mr P.B. WATSON: Members will have their opportunity to speak. Dialysis is another issue.

Dr K.D. Hames: No, that's not in the bill. You've got to talk about what's in the bill.

The ACTING SPEAKER (Mr P. Abetz): Members, the member for Albany has the floor.

Mr P.B. WATSON: Has the Minister for Health finished?

Dialysis is another issue. Val Crosby, a senior in my electorate, rang me just before I came up to Perth yesterday. Val's husband received a transplant but it did not work, so now he has to go down to the bottom of the list and he is waiting in Perth. Albany has the facilities to open extra beds, but there is no funding for staff. I rang the hospital CEO yesterday, who said that the hospital has the chairs but it does not have the staff. Government cost cutting or not enough funding being put into dialysis under the Public Health Bill means that my constituents have to live in Perth. The Minister for Health knows how much accommodation costs in Perth. When I first got this job, a hotel room cost maybe $100 or $150 a night; now it is $250 to $300 a night because of all the fly in, fly out workers needing accommodation in the city.

Dr K.D. Hames: Haven't I responded to you about that issue? You wrote to me.

Mr P.B. WATSON: This is another issue that has only just come up.

Dr K.D. Hames interjected.

Mr P.B. WATSON: I was told the beds are available.

Dr K.D. Hames: I think there was trouble getting staff.

Mr P.B. WATSON: The problem lies with staffing. I rang the hospital yesterday and I was told it has the chairs, but it would mean putting on another shift and the hospital cannot afford that. If the minister does not believe me, he can check with the CEO of the hospital.

I will raise another issue with the minister. Recently, a lady came into my office very distressed. I spoke about this the other night. Her husband had a collapsed lung. There is a word for it and the minister would probably know, as a doctor.

Dr K.D. Hames: Pneumothorax.

Mr P.B. WATSON: That is it. This lady's husband went to Albany Hospital. The specialist said that her husband would have to go to Sir Charles Gairdner Hospital the next day. He booked the Royal Flying Doctor Service plane. The wife went home and rang Sir Charles Gairdner, but was told that the hospital knew nothing

about admitting her husband; they told her that Albany people cannot go to Sir Charles Gairdner Hospital. The Department of Health denies that there are zones in Perth for people who go into hospital depending on where they live, but someone from Albany has to go to the new Fiona Stanley Hospital; they cannot go to Sir Charles Gairdner Hospital or Royal Perth Hospital. This gentleman's specialist did not know about these zones. I do not know whether it is a good system or a bad system, but communications have broken down when a specialist does not know about this system. When this woman found out that her husband was going to Sir Charles Gairdner Hospital, she rang the hospital to find out where she had to go, what would happen and when the visiting hours were, but she was told that her husband could not go to Sir Charles Gairdner Hospital.

Dr K.D. Hames: It generally depends on where the plane lands. If the plane goes to Jandakot, say, for an emergency, the patient would go to Fiona Stanley Hospital.

Mr P.B. WATSON: It was not an emergency.

Dr K.D. Hames: If they go to the main airport, which they would if it was the Royal Flying Doctor Service, they would go to the nearest hospital, which is Royal Perth.

Mr P.B. WATSON: The thing is that specialists are not told about this system; they do not know this, and because the specialist did not know, it was an extra day before this patient could get the flying doctor again. The systems are not talking to each other.

The lack of specialists is always an issue in regional areas. Albany has fly in, fly out doctors. Albany Hospital's emergency department doctors are all FIFO doctors. I know that is very hard for doctors and we are grateful that our emergency service has those FIFO doctors, but flying them in must be putting a tremendous cost on the health system.

Dr K.D. Hames: Getting them there is much more important than the cost.

Mr P.B. WATSON: I know that, minister, but would it not be better to encourage specialists to go to Albany? We have had these issues before in Albany. A mate of mine in Albany is a specialist. He said, "Why would I stay in Albany when I could be rostered on every second week or called in for the whole weekend?" He said that in Perth, whether it is a public or a private hospital, he has the weekend off. We have to offer incentives to specialists. In addition, if they stay in Albany, they feel that they are not able to keep up to date with any new procedures that are being done in Perth. It would be great if Albany Hospital could get a sister hospital and, say, for a month of the year, one of its doctors would go up to Perth and a specialist would go down to Albany to take their place, so the Albany doctor could keep their credentials up to date and see what the latest procedures are.

An oral surgeon, Dr Franc Henze, comes down Albany, but he cannot get theatre time. The hospital has cut the theatre time according to its budget. He sees people in Albany and they have to go to Perth to get treatment. It is a huge issue in my electorate.

Can I have an extension of time, please?

The ACTING SPEAKER: If you cannot fit it in in the remaining seven minutes, I will have to grant you an extension, but remember it is public health.

[Member's time extended.]

Mr P.B. WATSON: What am I talking about?

The ACTING SPEAKER: It is the Public Health Bill.

Mr P.B. WATSON: I am talking about the Public Health Bill, and all these things affect my constituents.

My next point is about a private hospital in Albany, which is very important. We have room available at the back of the hospital for a private hospital. I know that when the Labor Party was elected in 2001, St John of God Health Care was looking at this site, and it is very important that we get a private hospital in Albany. That will encourage more specialists to go to Albany. Our biggest problem at the moment is keeping the specialists. Albany Hospital is a great hospital with tremendous staff and good facilities. The staff are under real pressure. I know that all government services are being cut to the bone, but hospital services should be the last thing to be cut, especially in regional areas, where people have such a long way to travel if they have something wrong with them. We really, really have to look after our hospital staff, because if they get burnt out, they make mistakes. We have had a couple of issues in Albany over the last few years in which doctors have made mistakes because they were working long hours and were not able to concentrate. We have experienced all these sorts of issues. We cannot afford to lose doctors or staff.

Parking is a huge issue in Albany—that is on page 46 of the bill! Parking is horrendous. A lot of our seniors go to the hospital for treatment. They try to get a parking spot. They have to get out of their cars with their Zimmer frames about 800 or 900 metres away from the hospital and have to trundle up there. People who live nearby have had their driveways blocked.

Dr K.D. Hames: Page 46 says that the Chief Health Officer may give advice or make recommendations.

Mr P.B. WATSON: That is it, minister.

The patient assisted travel scheme is another huge issue. As I said before, accommodation in Perth used to cost $125 or $150 a night—I know there are some facilities at hospitals—but now it costs a lot more. A lot of seniors in my electorate have to come to Perth because specialists are not available in Albany. There are two issues with that. The first is the lack of understanding in the medical community about how far Albany is away from Perth. When people from Albany visit a specialist in Perth, sometimes that specialist will say, "Look, we can't fit you in today; come back tomorrow." I was told this by a little old lady who is a senior. She was told, "You'll just have to come back tomorrow as we can't fit you in today." She told them that she was flying back to Albany the following morning on a six o'clock flight. They said, "Oh, well, you'll have to cancel it." Some people have no idea of the distance involved. I do not know how many letters I have written to specialists and all the hospitals explaining that people in Albany cannot just go around the corner to their home; they have to go all the way back to Albany.

Albany does not have a lot of surgeons, obviously, because there is more work in Perth. A lot of seniors come up to Perth on the plane in wheelchairs. Virgin can accommodate only two wheelchairs on each plane. If people do not book early enough, they cannot travel with Virgin because it takes only two wheelchairs on each plane.

A lot of seniors hop into a car and then the husband or wife drives all the way to Perth. This issue has been around for a long time, but it is getting worse.

We have talked before about prevention. We spend billions of dollars on health, but we do not talk about what we are going to do in health prevention. Only the other day on ABC radio in Albany the topic of obesity was discussed, and apparently people aged between 25 and the 35 are the most obese in Australia. I was interviewed on the radio about the obesity problem and I said that we have to get to the kids first. The interviewer said, "Oh no, it is a problem for people who are 25 to 30 years of age." I said that that may be the case but those people were young once; they got into the wrong lifestyle and now they cannot get out of it, so by the time they are 25 or 35 they have picked up all the bad habits and they have continued them through.

Mr M.P. Murray: We need to shut McDonald's.

Mr P.B. WATSON: That is a good point. In society now we have latchkey kids because both husband and wife have to work not for anything special but just to pay the bills. Often mum and dad will pick up something to eat on the way home from work. We can talk about obesity in kids, but we need only look at some of the parents who are their role models, walking down the street with a McDonald's hamburger and chips in hand. Rolling behind them are children of the same ilk, and that will cost us dearly in health in the long run. The kids do not have any respect for themselves. They probably think that if mum and dad look like that, they can look like that, but they are losing their self-respect. They go to school where kids pick on them, calling them chubby or something like that, but it is not the kid's fault. I understand that in Scotland the sport and recreation portfolio is represented as a junior ministry within the health portfolio so that there is early intervention. I raised this matter with the former Minister for Health. He did not want to take out any money from health for sport and recreation, but it is a matter that we have to look at because what we are doing at the moment is just not working.

Dr K.D. Hames: We did give $5 million for the KidSport program.

Mr P.B. WATSON: That was tremendous, and I congratulate the minister for that.

Dr K.D. Hames: That came out of Health money.

Mr P.B. WATSON: Yes, but we need to do more of that, because kids follow their role models. If mum and dad go out and eat rubbish, they will too. We have to look at this issue because we will have these health issues for a long time; they will not go away. It is all right for us now, but I have noticed after going to school assemblies for 14 years that the children are getting bigger and bigger.

Dr K.D. Hames: A bit like ourselves, really, over the years.

Mr P.B. WATSON: My kids are all skinny.

We have to get people to realise that sport is good for us and it is fun. I met with some sporting groups recently and we were talking about why kids play sport. They play sport, firstly, because parents want to relive their past sporting abilities so they push their kids; secondly, kids want to play because they just love it; and, thirdly, some kids only play

sport and exercise because they have to lose weight. We see this particularly with young girls who want to lose weight and then they become anorexic. If every day they just exercised a little bit and watched their diets a little bit, they would not have to lose so much weight and then, the next thing we know, experience health problems. I know it is all right my saying this, and I realise how difficult it will be for the minister to get these things started, but we have to start somewhere, otherwise we will become like America and have an epidemic of obesity.

Dr A.D. Buti: We have it now!

Mr P.B. WATSON: It was that quick!

I know I may be pushing the barrow a little bit, but I now want to talk about mental health. I heard Professor Carol Perkins who works for the British government speak the other day about the issue surrounding mental health. She says that what we are doing in mental health is wrong and that we are hitting the target at the end of the line instead of getting it at the start of the line. She has said that coaches will teach young children about nutrition and the skills of the game, but coaches are not trained to look out for mental health problems in kids. If a coach of a footy or basketball team is hard on kids, some kids can take that away and carry that personal assault for a long time. During my running days I went to Little Athletics one day—I think it was a day before I went to the Commonwealth Games in New Zealand—and watched a race in which a little kid half the size of the rest of them ran his heart out. He ran right through the line but got beaten by just a touch. I congratulated the other guy first, but just as I was about to go up to congratulate this little boy his dad came up to him, grabbed him by the ear and said, "How dare you let so-and-so's son beat you!" I do not know what the dad thought, but that kid would carry that for years. I also remember seeing other big boys in Little Athletics winning the events because they were the biggest and strongest, who would then go up to compete in the senior athletics and suddenly lose because they were competing against people twice their size and think that they were losers. I saw it so many times. I have to be careful how I say this but when I went to Mexico City in 1968, I was ranked number 2 in the world and everyone thought I was going to do well, but I did not because I got sick over there. For probably 10 or 15 years I carried the idea that I was a failure. Herb Elliott said to me one day, "Look, mate, you're the best in Australia. You went away and you did your best." But when I came back and everyone was saying, "Bad luck", I did not want to hear it was bad luck; I just wanted to go away. I notice the same thing happen when young swimmers go away and do not do well. Swimmers like Karen Moras went away at 14 years of age to compete and did not do well. There is so much pressure on those people, and that pressure just builds over the years. I am sorry that I have got off the topic of the debate.

Mr M.P. Murray: What about Collingwood?

Mr P.B. WATSON: I have been barracking for Collingwood for over 65 years.

Mr M.P. Murray: No wonder you're depressed.

Mr P.B. WATSON: When a person barracks for Collingwood, they just barrack for Collingwood. We are not like some of the chardonnay-drinking Eagles' supporters who drop off when they do not play well.

I want to raise one small matter concerning Healthway. I did not always agree with the decisions of Healthway, but I think it is very important that Healthway still exists and I hope that the government does not interfere in the process. There were some good people working within Healthway. As I said, I did not agree with some of its decisions, but we have to have someone run it who is away from the action. Mr Acting Speaker, I thank you for allowing me to get right to the point of the bill! I support the bill.

Point of Order

Dr K.D. HAMES: Members will have an opportunity to debate general health matters during the budget, but I remind members that this legislation is specifically about public health. If members raise anything to do with hospitals or health services, it is not in the bill and I would ask you, Mr Acting Speaker, to call them to order. Members have spent a lot of time talking about many things that are legitimate public health matters and the like, so I ask you to keep an eye out for that in the contributions of those members who are yet to speak.

The ACTING SPEAKER (Mr P. Abetz): I take that point of order, and I urge all future speakers to address the Public Health Bill and to not speak about just anything to do with health.

Debate Resumed

DR A.D. BUTI (Armadale) [5.20 pm]: I also rise to contribute to the debate on the Public Health Bill and the Public Health (Consequential Provisions) Bill. In his second reading speech the minister states —

> The Public Health Bill 2014 is one of two bills being introduced to facilitate the comprehensive reform of public health regulation in Western Australia. The second bill is the Public Health (Consequential Provisions) Bill 2014. The introduction of these bills is a major step towards preventing illness and

> protecting and promoting the health of all Western Australians. The need to reform public health regulation in Western Australia has been widely acknowledged for many years. The Health Act 1911 was passed more than a century ago and it has been extensively amended in an ad hoc fashion on more than 100 occasions. The framework and content of the Health Act 1911 was itself substantially drawn from the Health Act 1898 and The Public Health Act 1886, the latter of which was the first stand-alone public health legislation in Western Australia.

I think we all agree that there is a desperate need for a major amendment to public health legislation in Western Australia. That is the purpose of the bills before the house. Many things have happened in society over the last 100 years in the medical world and in the regulatory world to necessitate the need for this comprehensive legislation. In adding the consequential provisions bill to the Public Health Bill, the legislation becomes quite substantial, and I am sure we will spend quite a deal of time in consideration in detail on the various clauses. One clause provides for the binding of the Crown. Clause 256 provides that the minister may exempt the Crown or crown authority from certain provisions. When we deal with issues as complex as health, we can understand why the government may seek to include a provision that will allow the Crown to be exempt from being legally bound. However, one must treat that with very careful consideration.

Before I forget, I believe the minister might be going to Zambia at the end of the month with a charity I have been involved in. If he is, well done.

Dr K.D. Hames: I am.

Dr A.D. BUTI: Thank you very much.

Mr R.H. Cook: Which part of the legislation is that in?

Dr A.D. BUTI: I am sure the minister would not take a point of order on that! It is an outstanding charity, so I am very pleased.

Dr K.D. Hames: I'm going to Tanzania first and then Zambia about an internal health program we have been running.

Dr A.D. BUTI: That is great.

On clause 256, the explanatory memorandum to the bill states —

> This clause authorises the Minister for Health to exempt, by way of notice published in the Gazette, the Crown or a Crown authority from compliance with the Bill and regulations made under the Bill.

It then refers to the duration and the content of the exemption et cetera. I have concerns that this could be used in the Aboriginal health area. Of course, there are difficulties in providing services in some areas. Unfortunately, I see this as an easy way out for government and we will need to scrutinise this very carefully during consideration in detail.

Mr R.H. Cook: One of the other dangers is, of course, that the government will say, "Well, we have so many exemptions from the Public Health Act, clearly the community is unsustainable", leading to discussions around closure and stuff, which is really down to a failure of government, not a failure of the community.

Dr A.D. BUTI: That is right; it is a bit like the Pygmalion effect: when one has a certain perception that X, Y, Z will happen, it happens because the perception leads one's behaviour to change to conform to one's perception.

Dr K.D. Hames: Remember that under your government the Crown was exempted. You could've got in there and fixed all those things, but didn't. I understand why, because we haven't been able to either. If suddenly you were required to fix all those things that probably need to be fixed, it would be an indeterminate and potentially massive cost.

Dr A.D. BUTI: I was not here when we were last in government, obviously, and maybe we should have.

Dr K.D. Hames: It's impossible to do; everyone has tried.

Dr A.D. BUTI: Under this bill, the government is taking that step of binding the Crown, but providing an exemption.

Dr K.D. Hames: It's a weak bind.

Dr A.D. BUTI: Yes, but all I am saying is that it has to be carefully considered.

Dr K.D. Hames: It's not a full bind; it's a weak bind.

Dr A.D. BUTI: Yes, but by providing an exemption, we have to seriously examine it; that is all I am saying.

Dr K.D. Hames: I agree with you.

Dr A.D. BUTI: That provision could easily be used in a way that may go against what is sought to be achieved by this comprehensive regulatory framework. The bill contains provisions regarding the Chief Health Officer and health plans. The explanatory memorandum states —

> The need to reform public health regulation in Western Australia has been widely acknowledged for many years.

The minister referred to that in his second reading speech. The explanatory memorandum refers to the need to be proactive rather than reactive, and that is quite important. The explanatory memorandum states on public health planning —

> The Bill requires both State and local governments to prepare public health plans. A long standing criticism of existing public health legislation is that it tends to be reactive. A problem is identified and a remedy is then sought to rectify the problem. Public health planning requires government to provide a strategic and forward-thinking approach that ensures that public health can be effectively promoted and protected.

It refers then to local government.

I think public health planning is incredibly important. That brings me to the issue of seeking to be proactive rather than reactive, and that relates to the issue of preventive health. The member for Albany discussed issues of obesity et cetera. I think it is really important that we do not seek to minimise within our health system the need to be proactive rather than reactive, as this bill provides. We can be proactive with preventive health. For instance, the minister's Department of Health released a report called the "WA Chronic Health Conditions Framework 2011–16". The report refers to a study that estimates that 65 000 Western Australians could avoid suffering chronic illness; 22 000 extra Western Australians could enter the workforce and generate $1 billion in extra earnings; and 8 000 fewer people would need to be admitted to hospital annually, which would result in savings of $300 million in hospital costs. They are incredible economic gains besides providing for the basic wellbeing of the individual. Yes, this government has been in power for only six and a bit years.

Dr K.D. Hames: Seven.

Dr A.D. BUTI: Yes; a Labor government was in for eight years previously, and not enough was done.

Dr K.D. Hames: Seven and a bit.

Dr A.D. BUTI: Yes; it was only seven and a bit. Much more needed to be done. I am hoping that this bill, which refers in its explanatory memorandum to public health planning and the need to be proactive rather than reactive, will look at the whole issue of being more focussed on preventive health. The lower house Education and Health Standing Committee—I think the member for Albany was a member of it during the last government and you, Mr Acting Speaker (Mr P. Abetz), were also a member, and I think it was chaired by the former member for Alfred Cove—released a report that referred to the level of obesity in our population and that the beds at Fiona Stanley Hospital would need to be larger. I am not sure whether that happened.

Dr K.D. Hames: I don't know whether all of them are but certainly a significant number of beds are made for bigger people. I know that much.

Dr A.D. BUTI: This issue has to be addressed. The health department has looked at this; it has produced a couple of excellent reports. I have some figures relating to what is known as the "disease burden" of Western Australia that I think are really important. They might be in the reports; I am not sure. They refer to chronic diseases that, in many respects, have preventive aspects. For instance, in 2011 over half of all Western Australians aged 16 years and over reported being diagnosed with at least one chronic health condition or having been injured in the past year. About 80 per cent of the mortality gap between Aboriginal people and other Australians aged 35 to 74 is due to potentially avoidable chronic diseases. Just over 40 per cent of hospitalisations in Western Australia are for preventable chronic conditions associated with alcohol.

[Member's time extended.]

Dr A.D. BUTI: Between 2005 and 2011, chronic diseases cost an estimated—we should now know how close these estimations were—$4.3 billion in hospitalisations in WA. A large proportion of these hospitalisations could be avoided. I know that the minister would be very keen about this. I am not talking about the current Minister for Health, but I am sure that ministers for health generally are the archenemy of Treasurers in any government because, as we all know, the health budget just sucks up the money.

Dr K.D. Hames: We get 28 per cent now. It was about 24.5 when we came to government.

Dr A.D. BUTI: We have an ageing population et cetera. The public health plans are referred to in the explanatory memorandum; they are part of the bill. I understand that a preventive health plan could not be put in the bill but I think it should be used as a trigger for us to look at this more closely.

Obesity has overtaken tobacco use as the largest contributor to sickness and death in Western Australia. The impact of obesity on population health is so substantial that without intervention it has the potential to reverse the improvements in life expectancy gained over recent years. Nearly one-third of the total burden of disease, including death, disability and loss of quality in life, in Western Australia in 2010 was due to preventable risk factors. Eighty per cent of the disease burden faced by Western Australians comprise four chronic and mostly preventable non-communicable diseases—that is, cardiovascular, cancers, chronic respiratory diseases and diabetes. Of course there is a genetic and environmental component. We always have to be careful when we talk about obesity, for instance. Although I think it is really important that we focus on obesity as a killer in Western Australia and Australia generally, we have to be sensitive about people who are obese. Obesity is not all due to environmental factors obviously—there is a genetic component—but the environmental aspect plays a very important role. We can reduce this burden of disease by a comprehensive public health plan that seeks to have preventive health as a major focus. It has not only a health and wellbeing benefit for society, but also a fantastic economic benefit. Maybe the Minister for Health can become a friend of the Treasurer. It may mean having greater expenditure in the health budget for a couple of years to put in place the preventive health strategies to see the benefits in the future. It is like a reinvestment-type issue.

Dr K.D. Hames: You're right but the benefits tend to be 10 to 20 years late.

Dr A.D. BUTI: That is right. The problem with governments is that we have a four-year election cycle et cetera. But of course being a courageous health minister, I am sure the member for Dawesville is not looking at the next election cycle, especially not the next election cycle. This is his chance.

The 2010 report of the WA Education and Health Standing Committee, of which the member for Albany and the Acting Speaker were members, stated —

> … obesity has now overtaken smoking as the main risk factor influencing disease … The other main risk factors include high blood pressure, physical inactivity, cholesterol and low intake of fruit and vegetables.

That relates to the issues of diet. It is really interesting to look at health and preventive health and the mix of diet and exercise. Personally, I think there is too much focus on diet and not enough focus on exercise. I think there are two reasons for that. One is the pressure of the diet industry. Many people have made a lot of money from the diet industry, with super diets and claims that people can lose X amount of weight in 10 days et cetera. People have a natural aversion to exercise. Even though people enjoy eating, they think it is probably easier to modify their diet than to engage in an exercise program. I think they are both complementary, and maybe more emphasis needs to be placed on exercise.

In 2011, the epidemiology branch of the WA Department of Health undertook a groundbreaking study and published a report entitled "The cost of excess body mass to the acute hospital system in Western Australia 2011". That report stated —

- There were 64,247 inpatient separations attributed to excess body mass … representing 6.8 per cent of all separations for the year. This resulted in a cost of $249.5 million or 5.9 per cent of all inpatient costs. The three most costly inpatient conditions attributed to excess body mass were osteoarthritis, ischaemic heart disease and type 2 diabetes.

…

- Males incurred more costs than females with a male to female ratio of 1.35 for inpatient costs and 1.2 for emergency department costs.
- The most costly age group was the 45 to 59 year old age group.
- The total acute hospital costs attributed to excess body mass was $253.2 million or 5.7 per cent of all acute hospital expenditure.
- Projections for the year 2021 predict costs of $530.2 million —

In 2011 dollars —

> with a 109.4 per cent increase in costs compared to 2011.

This is quite phenomenal. That report estimated that the costs attributed to excess body mass in the acute hospital system was $253.1 million.

That is an incredible burden on our health system and something that we need to address. Largely, we can address this issue by engaging in primary prevention strategies. Any public health planning should not just look at hospitalisation and the acute side of the health system; it should look at primary prevention. I think the Education and Health Standing Committee's 2010 report sought to address much of that. That is very important.

The government is aware of this because in 2011 and 2012, the Department of Health published two excellent future-oriented preventive health strategies and guidelines. The first was in 2011—the "WA Chronic Health Conditions Framework 2011–2016". That was followed up a year later by the "WA Health Promotion Strategic Framework 2012–2016". Both of these reports from the WA health department, for which Minister Hames is the responsible minister, advocated a multidepartment, multidisciplinary coordinated approach to developing a whole-of-life approach to chronic disease prevention. This requires funding. As the minister said, we may not see the benefit until 10 years down the track. If we had that money in 2011–12, when they do the figures in 2021, the hospitalisation cost would not be 5.9 per cent due to the burden of disease costs. It would be reduced but there would be a need to put in the money. I understand that we are under tight budgetary conditions at the moment, but we need to look at the future wellbeing of society, from not just a health perspective but also an economics perspective. There is no doubt that there are major economic benefits from having public health planning that has a very comprehensive preventative health plan.

A 2009 Victorian health report titled "The health and economic benefits of reducing disease risk factors" basically estimated that the health status and the economic and financial benefits of reducing the prevalence of the five behavioural risk factors that contribute to chronic diseases affecting millions of Australians would have substantial economic benefits. Those major risk factors are obesity, alcohol, smoking, exercise and general diet. That report states —

> Overall, large potential opportunity cost savings from the avoidable disease burden are possible if we achieve the 'feasible' reductions in the prevalence of the nominated risk factors.

The report then looked at Western Australia and stated that over the lifetime of the 2008 Western Australian adult population, cost savings were estimated to be $390 million. The total cost savings are the sum of the health sector offsets and the combined workforce, household and leisure production effects.

There was an issue also about Aboriginal health.

In 2009, as part of a planning process in the federal government's "National Preventative Health Strategy", there was an appraisal of the monetary benefits associated with effective chronic disease prevention programs. These figures are incredible and I am sure would make any government look at becoming quite serious about preventative health. For every dollar spent on a participant in poor health, it can be expected to yield $15 in societal benefits. This comprises $3 of projected direct healthcare savings, $3 of indirect economic benefits, including improved productivity, and $9 of quality-of-life benefits.

One of the challenges that any government and its health minister face is an ageing population. There are approximately 600 000 seniors aged 65-plus in Western Australia. If we examine the cost of a preventative health program for seniors that would cost about $500 for each senior participant, and if the program was scaled up statewide, the cost would yield a benefit of $4 billion in savings to the health budget over the rest of the life of those people.

Dr K.D. Hames: At what cost per year?

Dr A.D. BUTI: That is what I am not sure about, minister. It is about $500 per senior participant of 600 000 seniors. It is quite significant. I will let the minister do the maths while I continue.

Dr K.D. Hames: I am doing it. It is $300 million.

Dr A.D. BUTI: Yes, $300 million.

It is $300 million, with an estimated benefit of $4 billion. It is quite substantial, with the additional benefit of people feeling better. As I said, benefits from the program include things such as not having to spend additional money on hospitals and doctors, improved labour force productivity, and gain in wellbeing associated with changes in self-reported health. There would be indirect benefits such as not having to utilise emergency department visits or other healthcare professionals or pharmaceutical care, as well as reduced hospital utilisation and pressure to build more bed capacity; freeing up acute care beds to improve emergency department wait times; social gains from healthier work productivity; and reduced caregiver costs. They are phenomenal economic benefits.

At a more practical level, what can be done? We need to be imaginative and creative in what we seek to do. For instance, in the United Kingdom there is a free swimming program that is a partnership between the national government, local councils, Sport England and the Amateur Swimming Association. It aims to get people

exercising, in this case through swimming. That program is reducing the costs for people to attend swimming pools, providing swimming coaches to help people to swim and providing free lessons to non-swimmers.

The member for Kwinana mentioned the issue of fiscal education in primary schools. I think that is something that desperately needs to be addressed. The issue is probably even worse in high schools. We should start off in primary school, obviously, because that is where people develop lifetime habits. However, in our public high schools today, although there are physical education teachers and students have to do a certain amount of exercise, that is it. It might be two periods a week. The number of people doing additional sports, interschool sports or other sports has been going down severely since I was at school. When I was at school many moons ago, there was a very active interschool sports competition and program, but today many public schools have a very lukewarm response to children participating in sport. We have not just a double whammy, but many whammies in that children are more inactive because they spend more time in front of a computer. During playtime and lunchtime they do not run around as much as they used to. After school, students do not participate in as many sporting activities as they used to. That is increasing, and they are engaging in a lot more dietary junk food forms of behaviour. Although not exclusively confined to certain areas, there is no doubt at all that there is a socioeconomic basis for the problems that we have with chronic diseases. It is probably not for a state government to deal with, but we need to look at federal governments and the taxation arrangements in trying to assist people to move into a healthier eating and exercise regime. It is very difficult; I understand that.

Dr K.D. Hames: How do we do that?

Dr A.D. BUTI: Imposing a tax on junk food is a possibility. I know it is controversial.

Dr K.D. Hames interjected.

Dr A.D. BUTI: Does the Institute of Public Affairs not like that? It would not like that, would it?

There is an issue about junk food and taxation on junk food. There is the issue of providing tax incentives.

Dr K.D. Hames: Determining junk food is a tough call because there is more fat in a butter chicken than there is in McDonalds food.

Dr A.D. BUTI: I know it is not easy. The GST was not easy. I remember John Hewson got stumped over the birthday cake in the interview with Mike Willesee, which probably resulted in him losing the election. It is not easy, but just because it is not easy does not mean that we do not try to do it. The minister's own program in which he mentioned Tuck Waldron is a grant to try to encourage people to do sport. There is no reason why things cannot be done. The benefits to society and the economic benefits to this state and the nation will be significant if we engage in a comprehensive preventative health strategy, and this bill should stimulate some discussion and thinking by the government, particularly when there are very good reports by the Department of Health on preventative health. As the minister said, the budget has gone up to 28 per cent now, so I am not sure there would be any extra money that the minister could seek from the Treasurer, but if a preventative health strategy were put in place in future years, it may be possible to reduce the amount spent on health.

MR D.J. KELLY (Bassendean) [5.49 pm]: I rise to make a contribution to cognate debate on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. I understand that this legislation has been a very long time in the making. The promotion of public health is a very important issue for the community. All too often we put a lot of effort into the more sophisticated, expensive end of healthcare—the healthcare that is delivered in hospitals and the like. I fully support the approach of putting more resources into preventive health rather than dealing with health issues after people have already been admitted to hospitals. That is the area that inevitably chews up the public purse the quickest; unfortunately, it is also an area in which companies make a lot of profits, and it is often the profit motive that drives a lot of health spending in hospitals and the like. That being the case, any legislation that comes before the house that can help improve how we deal with health issues in a preventive way is worthy of our solid support, and that is why the opposition supports this legislation.

Although we are supporting it, I would like to make some comments. I understand that one of the key issues that delayed this bill being brought to the house was consideration of how it would apply to the Crown. One of the criticisms of the old legislation, the Health Act 1911, was that it did not cover the Crown. Although the previous legislation put a whole lot of prescriptive requirements on the general public, businesses and other layers of government, it did not apply to the Crown, which meant that the government had set a double standard—that is, one level of prescription for others in the community, while the Crown was left unrestricted.

Looking at this legislation, it is my understanding that there is unfortunately still a provision that allows an exemption for the Crown. The legislation allows the minister to make exemptions either with conditions or for a period of time. When I read the second reading speech, it seemed to indicate that the exemptions given by the minister to the Crown would be intended as temporary measures and that it was not envisaged that the Crown

would be exempted on a permanent basis, but for a period of time to allow it to get its house in order and to find the resources to make a transition to the new standards prescribed in this legislation.

I can see that there is a reasonable argument to say that it might be a bit difficult to require the Crown to meet all its obligations under the new legislation all at once as soon as the bill becomes law, in circumstances in which the Crown has not previously been bound by this type of legislation, but I am concerned that the exemption power given to the minister is extremely broad. The legislation could have been drafted in such a way as to give a definite time within which the Crown would become completely bound or that, when an exemption is given, the exemption could last for only a particular length of time. There is a whole range of ways in which the legislation could have been drafted to ensure that, at least by some specified end date, the Crown would, in fact, be bound by it.

On my reading of the legislation, that is not the way it was drafted. The exemptions that can be provided by the minister are, in effect, open-ended, and that worries me. It also worries me that we could end up with the Crown not bound by very significant parts of this legislation for an indefinite period because of the exemptions that the minister will be enabled to grant. I will be interested, when the minister makes his reply to the second reading debate, to hear him provide some explanation as to why the legislation is structured that way.

I am also concerned that under clause 282 enforcement orders cannot be given to the Crown. For example, even in situations in which the Crown is given an exemption with specific conditions that are not met, there is still no ability for an enforcement order to be applied against the Crown. To me, that does not seem to make a lot of sense. If enforcement orders are to be a useful tool against the broader community including, for example, local government, why can they not be an appropriate tool for the Crown? It creates a justifiable level of disquiet when this Parliament sets legislation which others have to abide by but which the Crown does not. I will be very interested to hear from the minister in his reply about the available exemptions and the absence of enforcement orders for the Crown, and why the legislation has been drafted in the way it has. If the Crown believed that requiring it to be subject to the legislation would immediately be unwieldy, onerous, impractical, overly expensive or whatever, it would have been possible to provide exemptions that had an absolute sunset clause or date from which everything would apply. That would give people a degree of assurance that the Crown was not ultimately going to weasel its way out of being subject to this legislation. But as I read it, that is not how the legislation applies, and that concerns me.

I want to now touch on the socioeconomic factors that influence preventive medicine and public health generally. It is all well and good to say that we hope and strive for a level of general health in the community that will prevent people ending up with chronic conditions that require hospitalisation, but economic factors are one of the major factors that influence the general health of the community. Inequality breeds ill health; I think that is without doubt a fact. It would be a mistake for the government to not have economic inequality in its sights when dealing with issues of public health. There are a number of broad factors that contribute to that economic inequality, such as education standards, job opportunities and unemployment.

Sitting suspended from 6.00 to 7.00 pm

Mr D.J. KELLY: I will continue my contribution to the cognate debate on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. Before I was interrupted by the dinner break, I was getting on to —

[Quorum formed.]

The ACTING SPEAKER: Members, keep the conversations down please. Thank you.

Mr D.J. KELLY: I would encourage members to stay because, as I said, this is going to be the best part of my speech. These are serious bills and I want to make some serious points. One of the important factors around public health outcomes is health education. If people are not aware of the issues that impact upon their health or how to access proper health services, it will inevitably have a detrimental impact on a range of public health outcomes. The bill requires the state to put in place state health plans, and local governments to put in place local government health plans. In those plans is a requirement for the identification of health outcomes and a strategy for how those health outcomes are delivered, not just in a theoretical sense but also on the ground.

In this regard, I would like to raise an issue that impacts directly on my electorate. My electorate of Bassendean is in the eastern suburbs of Perth. One of the new health facilities to be built in that region is the new Midland Health Campus, or the Midland public and private hospital, as it is called. I do not understand why this government decided to privatise that hospital when it seems to me that it has the real possibility of jeopardising some public health outcomes. As I said, information and health education is a key to public health outcomes. It is a key to getting good preventive health outcomes. The government decided to privatise the new

Midland Public Hospital and has entered into a contract with St John of God Health Care, a Catholic health provider. This means that the provider refuses to provide the full suite of health services in that area. I do not blame the provider for that decision. It was very up-front with the state government when it put in the bid that if it were successful, it would not provide a range of health services. I do not blame it for the situation, but I blame the state government, and particularly the minister. The restricted services that it will not provide at that facility go to things such as terminations, contraception advice and vasectomies; we understand that the government is in the process of negotiating with another provider in the Midland area to provide those services. But once the hospital is open, those restricted services might mean that if a teenage woman fronts up at the new hospital's emergency department with pain—she does not understand what it is—and discovers that she is having a miscarriage, and, in the course of being treated, says, "I did not know I was pregnant. What information can you give me so that I do not get in this situation again?", my understanding is that a contraceptive advice is not something that will be provided.

Point of Order

Dr K.D. HAMES: The speeches must be relevant to the Public Health Bill. The Public Health Bill has nothing to do with hospital or health services.

Mr D.J. KELLY: In response to that point of order —

The ACTING SPEAKER (Mr N.W. Morton): Further to the point of order.

Mr D.J. KELLY: The bill specifically talks about public health plans that are required to identify public health issues that then need to be put in place, including strategies around dealing with these public health issues. One of the public health issues in my electorate is unwanted pregnancies —

The ACTING SPEAKER: The bill being debated before us tonight states —

> An Act to protect, promote and improve the health of the public of Western Australia and to reduce the incidence of preventable illness, and for related purposes.

With regard to infrastructure and hospitals themselves, the long title of the bill makes no reference to that. The bill is more about public health, services, licensing and things of that nature—not necessarily the infrastructure and the hospitals themselves. I implore the member to keep his comments around those aspects and not necessarily about hospitals themselves.

Debate Resumed

Mr D.J. KELLY: I thank you for that direction, Mr Acting Speaker.

With those points in mind, I make clear the context in which I raise this issue. The bill specifically requires the state and local authorities to put in place public health plans, and to identify how those public health plans are to be delivered. The bill refers to public health plans in part 5, specifically state public health plans and local public health plans.

[Member's time extended.]

Mr D.J. KELLY: As part of the formulation of those public health plans, local authorities are to identify which issues they wish to deal with in the public health plan and how they will deliver them. I envisage that a local authority in my area will identify health education issues such as sexual health or reproductive health as issues it wants to deal with in its health plan. It is pretty obvious that, when coming up with a strategy, a local authority would look at resources in the area to assist in delivering the health plan to deliver the public health outcomes it wishes to. That may be the general practitioner network or it may be local groups. I would have thought that public hospitals in that context would be part of that plan. An example in that context would be if a local authority—for example, the City of Swan or the Town of Bassendean—decided that it wanted to deal with the issue of contraceptive education to prevent related medical outcomes as part of its local health plan, it would not be able to engage the operator of the Midland Health Campus to deliver that public health outcome because contraceptive advice is not something that the hospital will deliver under its contract with the state government. For the life of me, I cannot understand why the state government would put itself in a position in which the local governments in the eastern suburbs such as the City of Swan, the Town of Bassendean or the City of Belmont for that matter, could not engage with Midland Health Campus on issues identified in their state health plans. As I said, a young woman could present at the Midland Health Campus with a pregnancy that she did not know she had, and she could have a miscarriage in the emergency department. In the course of her being at the Midland Health Campus, she may then seek advice as to how she could prevent further unwanted pregnancies. If she was at Swan District Hospital, she would get advice straight up about contraception. If she was at Royal Perth Hospital, she would get advice about contraception. If she was at any other public hospital in

Western Australia, she would get straight-up advice about contraception. However, if she presents at the Midland Health Campus, under the terms of its contract, she will not be given that advice. The only response I have heard from the Minister for Health is, "Well, she will be referred to her GP for those restricted services." She is a young woman and her life is a bit chaotic. If the Midland Health Campus tells her that she should go to a GP to get that advice and education, she may not do that because her life is a bit chaotic. She therefore presents again 12 months later at the Midland Health Campus with another unwanted pregnancy. Who is really responsible for that? We might say, of course, that she is an adult—even if she is 16 years old—so it is her responsibility; she should have gone to get that advice and therefore not had another unwanted pregnancy. However, the responsibility that I lay at the foot of this government is that we all know that to prevent young people from having unwanted pregnancies we need to make it as easy as possible for them to get advice. By putting the major health facility in the eastern suburbs under the control of an operator that will not give that advice, we are in some way responsible for the negative public health outcomes that will result. I have never heard the Minister for Health give an adequate response for why he did that, or heard the minister's response to that specific scenario: if a woman comes to the Midland Health Campus with an unwanted pregnancy and seeks contraceptive advice to ensure that she does not have the same thing happen to her again, she does not get that advice and 12 months later she is back —

Dr K.D. Hames: Can the member explain why she would not get that advice? She would go to Marie Stopes, which does regular terminations. It is required under the act —

Mr D.J. KELLY: All right; I take that interjection. The minister is saying that she would go to the other clinic in Midland and she would get that advice.

Dr K.D. Hames: She goes there for her pregnancy.

Mr D.J. KELLY: That is right. So she is in the Midland Health Campus, she has had a miscarriage and she is seeking contraceptive advice on how not to get herself into this circumstance again.

Dr K.D. Hames: I missed the comment that she had had a miscarriage.

Mr D.J. KELLY: The minister missed the comment; he should listen because this is important. She had gone there because she did not know she was pregnant. She found out in the emergency department that she was pregnant and she has now had a miscarriage. She asks for advice about how she can prevent this from happening again. Instead of just being given contraceptive advice in the way she would if she were at any other public hospital, she will be told that she will have to go elsewhere because St John of God healthcare does not give contraceptive advice because to do so is against its beliefs. Maybe she will get that advice; maybe she will not. A percentage of young people, because life is chaotic, will never get that advice and they will turn up again in 12 months in the same circumstance. That is a scenario that I would like the Minister for Health to address. He has put a barrier between people in my electorate—young people in particular—and advice on issues such as contraception from an institution that we paid $400 million for. I refer to the institution right there in the electorate. The Minister for Health made the decision to privatise it and put in charge an operator that will not give that advice. The minister needs to take responsibility for what he has done. I have not heard the minister give any explanation for why that is the case.

In the context of this bill—a public health outcome—suicide prevention is a big issue, especially for young people in our community. Youth suicide is an issue that many people in our community grapple with. One of the factors that lead to youth suicide is people who are struggling with their own sexuality. We live in a community in which people who are same-sex attracted are often discriminated against and made to feel unwelcome and uncomfortable, and are told that there is something wrong with them. That is often a factor that leads to youth suicide. It strikes me that it is not the smartest thing to do because many people with those issues may present at a public hospital. If they present at the new Midland hospital, it is widely known that the operator is a Catholic public healthcare provider. I respect its views. We know that the Catholic Church has unwelcoming views about same-sex couples. A gay couple in my electorate have raised with me that they would not go to the new Midland Health Campus because of its attitude to their sexuality. They told me that the hospital can say that they will be treated like any other patient, but when the couple sign the admission forms and it is apparent that their partner is of the same sex, will the person on reception just raise their eyebrows over their glasses and look at them when they fill out the forms?

The minister's decision to privatise Midland Health Campus has put in place that sort of complication for gay and lesbian people who want to access health services in the eastern suburbs. I am sure the minister would agree that youth suicide is a pressing public health issue, and we should do everything that we possibly can to ensure that we do not make that situation worse by the way we conduct ourselves. When people are suffering from mental illness, they should feel they can access health services without fear or favour. The minister has raised

a whole bunch of issues for a section of the community because of the private provider he has chosen for Midland Health Campus. I would like the minister to address that in his response to the second reading debate on this bill. The minister will say that it is great that the government is doing loads of things to address youth suicide. He might even say that the government is doing things to ensure same-sex attracted people are welcomed in the way this government does business. Clearly, I do not think he can say that because of the decision he has made about Midland Health Campus. I would like the minister to address that in his response to the second reading debate.

I only have a few minutes to go, but I want to touch on housing, because it is one of the broader economic outcomes that affect public health outcomes. Not having a roof over their heads is a problem for people who want to manage their health. I urge the government to deal with its public housing waitlist. Last month, a 69-year-old pensioner in my electorate was evicted from his Department of Housing unit not because of bad behaviour, but because of some other matters. The government evicted one pensioner, presumably, so it could house another. In the future, that pensioner will struggle to keep a roof over his head because the government's public housing waitlists are way out of control.

MR C.J. TALLENTIRE (Gosnells) [7.22 pm]: I rise to make a contribution to the cognate debate on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. Although this is a cognate debate, I begin by looking at the consequential provisions bill. Interestingly, the explanatory memorandum for this bill is not terribly explanatory at all; it is very brief and many clauses have a very simple one-line explanation. I looked for an explanation for the changes and why a clause is included in the bill, and the standard comment is that this clause amends section X of XY Act. I do not find that an adequate explanation at all. I hope when the minister gives his second reading response, he is ready to provide the clarity that we need. It is a debate that we need to have before we get into consideration in detail, so we can have a more meaningful, genuine consideration in detail debate.

My observation is that consequential provisions bill does some fairly bland things, such as change references to Chief Health Officer so that there is a degree of consistency. That is fine; it replaces other references. I find concerning the deletion of a reference to environmental health officers and a switch to the use of the term "authorised officer". I understand that an environmental health officer in Western Australia is employed by local government and has a qualification. When I meet environmental health officers, I find it amazing that they have to be aware of and administer such a wide range legislative instruments. I am in admiration of environmental health officers. The minister is deleting their role in our health legislation and changing it to a reference to "authorised persons". I note, if I have understood this correctly, that authorised persons are those whom the minister has deemed to be authorised. They are not endorsed by a local government; they are people the minister has listed in the *Government Gazette*. I stand to be corrected on that.

Dr K.D. Hames: Environmental health officers will still continue, but currently where it is required under local government that an environmental health officer does everything, they will be able to get other officers to do some of those things that an environmental health officer may otherwise have done. They will be able to authorise someone to sit under the environmental health officer to do the water testing for them, for example. That helps the local government with its costs, but still leaves the environmental health officer as the pinnacle officer in managing environmental health. They continue as a profession and have a role, but they can have assistants, if you like, that do not have to have those qualifications to do simpler things.

Mr C.J. TALLENTIRE: I trust that is the case, but it does leave open the possibility of outsourcing a role that is held responsible to, say, a local government, as is the case with an environmental health officer, who is responsible to the mayor and councillors of a local government authority and there is that extra degree of scrutiny. Once things get outsourced to authorised persons, outsourcing is going on and there is the potential for things to be outsourced to the private sector and perhaps we could lose the accountability stream that we currently enjoy. That is a concern from my reading of the consequential provisions bill. Interestingly, the short title of the bill states —

> **An Act to amend the *Health Act 1911* and various other Acts as a consequence of the enactment of the *Public Health Act 2014*, and for related purposes.**

I was quite enthusiastic about the idea that the Public Health Bill 2014 would replace the Health Act 1911, but that does not seem to be the case at all. We will retain the Health Act 1911, and it will be an important part of our statutes relating to health in Western Australia. That is a curiosity in itself.

I turn to other aspects. I noticed, for example, that we have consequential amendments to the Blood Donation (Limitation of Liability) Act 1985. I recall that in 1985, a number of jurisdictions around the world had problems with donations of blood at the height of the AIDS epidemic, and there was a real concern about the quality and

safety of blood banks. I suspect that is why that legislation came into play but I note that we are amending that act to clarify where the responsibility lies for the donation of good clean blood. We are inserting into the Blood Donation (Limitation of Liability) Act—no doubt we will get into this further when we go into consideration in detail—a provision that states that transmittable diseases regulations are to —

> … consist of or include provisions that provide for or require a person donating blood to make a declaration.

It just seems to me that we are getting to the situation of taking that responsibility off the state and putting it onto the donor—in this case—to make a genuine declaration. We could say that the state is covering itself should someone not make a genuine declaration. I think there have been cases around the world, unfortunately, when people claimed that they did not present a risk, they donated blood and it turned out that they in fact did present a risk. That is, unfortunately, a possibility. I know that someone wanting to donate blood now has to make a declaration about something that strikes me as fairly banal. For instance, anyone who lived in the United Kingdom in the 1980s during the era of the BSE—bovine spongiform encephalopathy—scare and who may have eaten contaminated meat is prevented from donating blood to the Red Cross blood bank. That seems like a very cautious approach and perhaps a very sensible one, but the onus of liability seems to be resting with the donor. However, I will move on.

There is a curiosity here that I noted in passing—that is, amendments to the Cremation Act 1929. We are amending section 2 of the act. I then looked to see what section 3 of the act was about and I wondered why we are not amending it, because to me it does not sound like contemporary language. Section 3 is headed "Cremation without licence prohibited" and subsection (2) states —

> Nothing in this section prevents the dead body of any person of Asiatic race being cremated in accordance with the religion to which the deceased belonged, subject, always, to such regulations as may be prescribed in regard thereto.

I find it odd that we would make reference to a specific race in the licensing prohibitions around cremation, but that is more of a curiosity. It just seems odd that we will amend section 2 for some simple reason about the inclusion of the definition of the Chief Health Officer but we do not make another perhaps more important amendment; however, that is a relatively minor point.

I want to come to some more substantial issues about this bill. I am particularly concerned about the amendments to the Poisons Act 1964. The Poisons Act 1964 is to be amended. That is another case of getting rid of the role of environmental health officers and switching over to authorised officers. I have concerns about that, as I have mentioned. I want to move on, though, to something that relates to poisons but will actually be in the newly amended Health (Miscellaneous Provisions) Act 1911. I am referring to a change to the heading in division 9, part VIIA. Currently the heading reads "… disinfectants, therapeutic substances and pesticides" but we are changing it to just read "disinfectants and therapeutic substances". I know—I am sure the minister has had constituents approach him about this—that there is great concern in the community about the regulation of certain pesticides. Naturally, people are concerned. There is even some confusion about the terminology that a local government uses, which is an all-encompassing generic term for the various chemicals. Is "pesticide" being used as a term to catch all herbicides, insecticides and fungicides? I am not clear on that, but I am not going to find out any more either because we are deleting the term "pesticide" from the act. So we are saying that we do not have a concern about pesticides. I know, having done agricultural studies, that I am not a chemophobe. I am not someone who is scared of using herbicides; I know many in the community are. I know people who raise grave concerns about our reliance on glyphosate. I had understood from Monsanto when I was doing my studies in the 1990s that glyphosate was so safe that we could take a bath in it. I have never tried that and do not fancy doing it either, but that was the word that was put around. People are, however, increasingly asking questions, yet our local governments and certainly our agricultural community rely on glyphosate to an enormous extent. I think it is legitimate and easier for the local government to get someone to go in and occasionally spray sump land that has a weed infestation of some sort—it is often sump lands that are affected—rather than get a mowing contractor or the local government's own mower to go in there and do things. People get worried about the use of pesticides in that way. However, I do not see that we will have the capacity to control that through our public health legislation. I am therefore keen to know more about what is going on there. Have we just said that this is not a public health issue anymore, because I tell the minister what: it is not covered by the environmental legislation? That is not touched on at all. The only hope that people had for their concerns around pesticides to be addressed was public health legislation—and we are removing that. I am keen therefore to know more about that issue.

I want to turn a bit further to another consequential amendment; this time to the Country Areas Water Supply Act 1947. I note that there will be some substantial changes in that area, as the Minister for Water has

foreshadowed that she will be bringing into this place a water resources management bill in due course, and elements of that Country Areas Water Supply Act will be included in that bill. However, what concerns me are the changes to a section referring to the pollution of water. Section 12 of the Country Areas Water Supply Act is to be deleted and a new section 12 headed "Pollution of water" inserted. Currently, the section is headed "Pollution in catchment areas and water reserves, Minister's powers to prevent". Therefore, the Minister for Health has the power to prevent. The section states —

> For preventing the pollution of water within a catchment area or water reserve, the Minister shall have all the powers and authority of a local government within the meaning of and under the Health Act 1911, including power to make and enforce local laws under that Act, as if the catchment area or water reserve were a district for the purposes of that Act, and the Minister were the local government for that district.

That sounds to me as though the minister has substantial powers to control when there is the suspicion of pollution of a water resource going on. The amendment to insert a new section starts off reasonably strong but I am afraid it gets weak. It states —

> **12. Pollution of water**
>
> A person must not —
>
> (a) pollute any water within or under a water reserve or catchment area; or
>
> (b) allow or permit any water within or under a water reserve or catchment area to become polluted.

That sounds good. It goes on —

> Penalty: a fine of $10 000 and imprisonment for one year.

We have something that sounds robust, but the penalty to my mind is quite tiny. Many businesses would consider that the fine of $10 000 is quite small. Of course we have a huge debate going on in the community about the issue of shale gas fracking. People's primary concern there is whether the pollution of groundwater reserves would occur. I do not know how likely that is and I sometimes think that it is quite unlikely to occur. However, if it were to occur, the penalty is the payment of $10 000 and imprisonment for one year. Who would be imprisoned? It is so vague, I just do not think it would happen. Are we talking about the company CEO who would be imprisoned? It is just not explained. As I said before, the explanatory memorandum on this is just hopeless. It does not give us any detail at all. It is one of the briefest, most obscure explanatory memorandums I have seen in legislation.

[Member's time extended.]

Mr C.J. TALLENTIRE: I have some concerns about the consequential amendments. I look forward, though, to carefully going through this bill and having the minister, with his advisers, give us some detailed responses to those and many other issues that will, no doubt, be raised during the consideration in detail process.

I want to turn now to what I think we are referring to as the main bill—the Public Health Bill 2014—and look at some of the potential of that legislation. I have, of course, a great interest in the issue of climate change and the potential for that to be a very serious problem for the health of Western Australians. Associate Professor Brian Owler from the Australian Medical Association recently released a very good paper discussing this point. He was voicing the view of the Australian Medical Association that climate change is a very serious threat to public health. I was pleased to see that the AMA is thinking about this so seriously.

It is a threat in many ways, but one that particularly comes to mind is the threat that is posed by vector-borne diseases. We could face a situation in which there is an increased incidence of malaria. We know that around the world, malaria already kills about 800 000 people a year. Yes, it is possible to treat and prevent malaria. We can have campaigns—I understand that in some of the tropical parts of Australia, we already have this—whereby local government is engaged in making sure that there is nowhere for mosquitoes to breed. But there is still that potential. Another vector-borne disease that is often spoken of is, of course, dengue fever. There is a fear that as we have this shifting of climate bands—this heating up that goes on—there is the potential for vector-borne diseases to shift southwards. Although dengue fever might be occurring at more equatorial latitudes, there is the potential for it to shift southwards towards Australia. That would be a very serious health concern, and I think it is one that would then require us to look at the provisions in this bill about the capacity for the minister to make a public health state-of-emergency declaration. So I am pleased to see that the legislation includes the capacity for the declaration of a state of emergency. That would perhaps empower the necessary local government authorities and state authorities to do things such as making sure that a particular species of mosquito is

controlled and even eradicated. We need to have those powers in our legislation so that we can eventually achieve the necessary outcome.

In Europe, it has been necessary in the last decade to declare a state of emergency simply because of the temperature. Older people are particularly vulnerable to high temperatures and a period of extended hot weather. The reason that is said to be more common in Europe is that they do not have structures in place such as air-conditioning, fans and other cooling devices, so they were not as ready for the sorts of heatwaves that they have experienced. We can quantify how many people have died because of the increased duration and intensity of heatwaves during some of the European summers in past years. That is another occasion on which the minister may need to declare a public health state of emergency; therefore, it is good to see that those powers are in the bill.

I want to say a bit more about the situation facing the elderly in our community. I heard a statistic recently that the number one reason that people occupy a hospital bed is that they have osteoporosis. I thought it would perhaps have been because they have cancer. But, no, it seems that for people with cancer, they have either been treated or they die. So that is not the number one reason for people being in hospital; it is things such as fractures that are caused by osteoporosis. People injure themselves. Sometimes it is as banal as they get up for a glass of water and they slip over and fracture a hip. That is the sort of public health issue that we need to tackle. I hope that the legislation before us will empower us to do that. I have heard discussion already from other members about the need for our health system to focus on preventative health. That is especially the case when it comes to helping the elderly. We need to make sure that homes are designed with minimal objects in place that could cause a person to fall over. I know that elderly people talk about gathering up the rugs in the house and making sure there are no other things around that may cause them to slip and fall over. Those sorts of public health issues need to be incorporated in a range of areas, not least of which is the design codes that are used, and making sure that people are provided with the right kind of accommodation that suits their age group.

These sorts of discussions are ones that we on this side of the house often get into when we talk about public health policy. Only a few weeks ago, the Deputy Leader of the Opposition and shadow Minister for Health and I were doing the Five Dams ride, and we were riding up a rather steep gradient, I think somewhere near Wungong Dam, of eight per cent, and we were chatting away about public health policy, and one of the things that we got onto was the need for greater effort to be made around preventative health measures.

Mr P.B. Watson interjected.

Mr C.J. TALLENTIRE: We were doing quite well, I can assure the member for Albany, and it only dawned on us as we were well engaged in the conversation that, hey, we were doing an eight per cent climb. So, yes, we impressed ourselves there, and we managed to, of course, complete the ride—235 kilometres and nearly 3 000 metres of climbing—and in fairly good time as well.

That is an example of preventative health. This is what we need people to be engaged in. Some might consider that something like the Five Dams ride is getting towards the extreme end of the spectrum. But what I think we really need to encourage is active commuting. Public health needs to be driving this. Reference was made to a group that was set up by the previous Minister for Sport and Recreation, the member for Wagin, in the area of active commuting. We need to make sure that people's daily trip to work is active rather than passive and that they are able to walk or ride or do something that will elevate their heart rate for perhaps half an hour each day. The health benefits that would come from that would be manyfold. We would see a reduction in type 2 diabetes; people would actually feel better; we would, of course, see fewer cars on the roads; and we would actually see people connecting more with their communities. So, it is very sensible for us to encourage people to make this move towards active commuting. There are all kinds of ways in which people can achieve that. I know people who say that they struggle to find a car parking space right next to their primary school so that they can drop off their kids. I suggest to them that perhaps they could park a little further away and then walk, and that that would do them good and they would not have a stressful time trying to find a car park right next to the school gate. Those are the kinds of initiatives that I think a public health policy needs to include.

It is stated that this legislation will pick up on a risk-based approach. It has been suggested that has worked very well in the environmental sphere; that we are switching all kinds of environmental decision-making to this risk-based approach. I caution members not to be overly optimistic because it is essential, when taking a risk-based approach, to set limits. One has to say, "We're prepared to let this go. We're prepared to say that we're not going to treat some people with certain illnesses." That is what it comes down to in the end; some very hard decisions have to be made. I hope that we will have the opportunity during further debate to go into the whole issue of public health and public health investment in the care of the elderly.

I commend to members the latest *Quarterly Essay* "Dear Life: On caring for the elderly" by Karen Hitchcock, who is a physician in a major inner-city hospital. She talks about the sorts of life and death issues that she faces on a daily basis. I have no doubt that the Minister for Health has been in a situation in which he has had to work

out whether it is really necessary to put someone through an arduous, painful treatment that they are not really committed to and the likelihood of them recovering from it is not high. There are all sorts of very complicated issues. It is an issue we need to discuss much more than I have heard in recent times. That raises the whole question of how we approach the elderly. There is some discussion in the *Quarterly Essay* about how younger people are a bit inclined to categorise older people as either being a cute older person—they just say nice things and they are not too argumentative—or a difficult older person; they come into the hospital or to the retirement or nursing home and straightaway say they want their tea hot and they want their bedpan within half an hour of asking for it. Those sorts of things get somebody labelled —

Mr P.B. Watson: It sounds like the Minister for Health on Mother's Day going crook about something.

Mr C.J. TALLENTIRE: Yes, possibly. That will have someone labelled as difficult. Or someone may go into a nursing home and remain mute. They are shell-shocked perhaps by the ambulance ride in and the night-time arrival. Their thinking is already a little confused. These are really complex issues to deal with and they are ones that we need to tackle. I conclude there.

MS J.M. FREEMAN (Mirrabooka) [7.52 pm]: I would like to congratulate the Minister for Health on introducing to Parliament the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. The minister knows that on repetitive occasions I have raised with him the delays and the need for these bills. The bills are well received, although I think the minister has not shown enough ticker and courage. Many aspects of the 2008 bill have been removed from the principal bill, the Public Health Bill. I will go through that here.

Dr K.D. Hames: That is a bit harsh.

Ms J.M. FREEMAN: It gets harsher but we will get to that bit!

I was very appreciative of the YouTube video put out by WA's Chief Health Officer, Professor Tarun Weeramanthri. For anyone who wants to find out what this Public Health Bill is about, the Department of Health's Chief Health Officer has actually stood in front of the camera and welcomed these bills. The bills are about risk-based processes. We should also ensure they are outcomes based. Some issues are not outcomes based. But of all things, the bills need to be community based. They need to place the government at the forefront of building a healthy and thriving community.

I picked up the book *Origins* by Susan Prescott from the Deputy Leader of the Opposition's office this afternoon. She is a practising Western Australian paediatrician. Her experience and research has compelled her to seek a healthier community by focusing on early life, but she also says that should not exclude a life course approach to promoting health and preventing disease. She challenges us to deliver a future healthy community by focusing on wellbeing. She says the challenges we face go well beyond the health sector and that we can address this only in the much broader context of the social, political, cultural and economic determinants of health.

It is with that in mind that I remind the minister that in the December 2014 Small Area Labour Markets data from the federal Department of Employment, Balga and Mirrabooka sit at 18.9 per cent unemployment. If public health is about structural change, not individual blame, and the most powerful influences on health are education, work and exposure to hazards, an urgent public health response is needed in Mirrabooka–Balga. As detailed in Susan Prescott's book, poverty is a major risk factor for coronary heart disease and many other non-communicative diseases, even in developing countries.

In the *Medical Journal of Australia* article titled "Reducing the impact of unemployment on health: revisiting the agenda for primary health care", Elizabeth Harris and Mark F. Harris summarised seven research studies in 2009 and concluded —

> People who are unemployed have poorer physical and mental health than those who are employed.
>
> …
>
> The association between unemployment and poor physical and mental health is well described, and our understanding of the pathways through which these associations occur has increased. Unemployment is consistently associated with poor mental health, anxiety, depression, suicide and parasuicide, —

I had never heard of parasuicide before, but I am happy to read out what it says here —

> and less consistently associated with cardiovascular disease, respiratory disease and musculoskeletal problems.

It is a great pointer to us that this is a public health issue. If nothing more, it is stated at the bottom of the first page of the *Medical Journal of Australia* article —

> The 2004–05 National Health Survey revealed that … unemployed people were more likely to visit emergency departments; …

Minister, for no other than economic reasons of emergency departments, my electorate has an unemployment situation. It is a public health issue and it requires focus.

Given that clause 3(1)(i) of the Public Health Bill, "Objects and principles", is "to reduce the inequalities in public health of disadvantaged communities", the sustainability principle that outlines economic factors should be considered to benefit future generations, so there is a public health imperative in the community that I represent.

If we look to similar urban environments and the impact of unemployment, we can look no further than and with distress at Baltimore, which, in the zip code 21217—where riots have raged—in 2011 had unemployment of 19.1 per cent, and less than 60 per cent of the students of Baltimore graduate. I remind the minister again: the unemployment rate in Balga–Mirrabooka is at 18.9 per cent.

The Public Health Bill moves government's role from capturing "nuisance" issues such as insanitary earth closets, open manure pits and venereal diseases to a structured public health system with a focus on preventative health and health plans that identify community health issues. The new Health Act needs to be not only risk based but also outcomes based. The Minister for Health said by way of interjection during the member for Kwinana's contribution about health, obesity and exercise, "You can lead a horse to water but you can't make it drink." That is often said about occupational health and safety, which is also a systems-based approach to the issues, but I can easily respond to that, minister: if you walk the horse, you will make it thirsty! Certainly, that is what occurred with the campaign in Western Australia as a leader in the public health campaign, and reinforced through legislation, against tobacco. Western Australia absolutely championed the national campaign against smoking. Public health structure should and must be a sharp tool to improve the health and wellbeing of the community. Effectively, hospitals and doctors sew up individuals but these bills should foster sewing together the many aspects of our society to deliver wellbeing and prevent illness in our community.

The history of public health came about in the days of the outbreak of cholera in Britain in 1848. Health was seen as an individual issue, not as a public issue, and cholera, a waterborne disease, killed thousands of people who had been driven into squalid circumstances through the industrialisation of the eighteenth century. The introduction of the Public Health Act in Britain in 1848 provided for sewers and regulated food distribution. It was revised in 1875 to bring together a range of acts covering sewerage, drains, water supply, housing, disease and preventing food contamination. It delivered a community that today enjoys substantial environmental health—at least in our urban centres if not in our remote communities—because we adopted that same process of formulating a public health act as Britain did all those years ago as a response to a terrible disease. Contemporary thinking now argues that that nineteenth century approach taken by the Health Act 1911 that focused on those sanitary preoccupations, driven by those sorts of diseases and poor living conditions and poor environment no longer serves the community. It is, of course, a concern that Aboriginal remote communities in Western Australia have not been served by the 1911 act because it was found not to cover those communities, and the recent Auditor General's report found that sanitary hazards and issues around water and disease are still prominent in those communities.

It is, therefore, extremely concerning that under this new legislation the Crown will not be held to account under clause 281—proposed part 17—of the legislation, and there will be no capacity to enforce basic sanitary conditions under that clause. I think incorporating clause 281 in this bill, which provides the exemption, borders on criminal, minister. The previous act could not deliver to those people who were such an important aspect of why we had public health legislation, and now we say that we are in a contemporary, healthy society in an urban setting that does not need that legislation anymore; we need risk-based legislation, but we do not apply that to the communities that have never been served by our Health Act. We certainly have not done our job.

It is quite interesting that the discussion paper on the Public Health Bill in 2005 stated quite stridently —

> Good public policy should require the Crown to be bound by its legislation. In effect this means that the state government and its instrumentalities ought to be subject to the same legislation that affects ordinary citizens. There are strong reasons for example, why a statutory authority ought to be subject to pollution controls or requirements relating to occupational health and safety. Similarly, there are good reasons why a state agency (for example the Education Department) ought to be subject to provisions of public health legislation.

The discussion paper never contemplated the exemption. In fact, clause 6 of the draft Public Health Bill 2008 stated —

> This Act binds the State and, so far as the legislative power of the State permits, the Crown in all its other capacities.

One line! We now have in clause 5 three lines, including —

(2) Nothing in this Act makes the Crown in any capacity liable to be prosecuted for an offence.

These additions seem purposefully and pointedly aimed at the communities that can least afford this proposed act not to apply to them. What is worse is what happens after a notice of failure to comply with the act has been issued. Under clause 259(2)(c), the failure to comply with a condition of exemption "does not of itself give rise to any right or remedy". A department cannot be made to accept that it is putting public health at risk.

But what is much more concerning to me—I would like the minister to clarify this—is that clause 259(2)(b) states that a failure to comply does not give rise to any criminal or civil liability. Not only can these people not come to government and say, "You're putting my health at risk; the public health of my community is at risk and you're not responding to this", but also they have, as I read that provision, no capacity for any other recourse in any court of law. Although we are happy to stand and say that public health and community health is important to us, we are not willing to put our money where our mouth is. That really does concern me.

It is a shame that the minister says that it is Treasury that would not let this go through as it was in the 2008 bill and discussion paper. I remind the minister that that same Treasury did not have such an influence on the minister during the Fiona Stanley Hospital process. If it had, and if the minister had listened to Treasury at that point in time, we may not have entered into a contract that has lost millions of dollars for state taxpayers. I remind the minister of the Under Treasurer's evidence to the Education and Health Standing Committee on 13 February 2014 about Treasury concerns not being taken into account —

> I am pretty sure they were not, and that has been borne out by the additional funding that has had to be put in place to deal with that contract in a delay-in-phase environment. Those risks were not adequately mitigated in the formulation of the contract. I have to say that Treasury had extremely limited visibility of that contract.

If the minister can say to us that he brings some major issue of public policy that we have been waiting on for so long but he could not fight Treasury on it, although he did not listen to Treasury before, I have to say that he cannot convince me that he has not been asleep at the wheel with the delivery of Fiona Stanley Hospital, and the minister is not delivering on this now because he is not delivering to all the people in Western Australia!

Several members interjected.

Ms J.M. FREEMAN: The minister is not delivering! I am just yelling over the top of him, and I will keep doing it. It is interesting that our place as a national leader —

Dr K.D. Hames: That's very domineering.

Ms J.M. FREEMAN: Oh, minister! Minister, I am a domineering, cranky, loud female. The Premier might call me "shrill", but I am happy with who I am and I will keep going—thank you very much.

It is interesting that our place as the national leader in stopping smoking has never seen us be so bold —

Several members interjected.

Ms J.M. FREEMAN: Minister, I have the floor. As I recall, when someone yells in this place, as we heard today when we all stood and talked about a former member, that seems to be a great character trait in men, so why can it not be a great character trait in women?

Several members interjected.

Ms J.M. FREEMAN: Minister, I have the floor!

It is interesting that our place as a national leader in stopping smoking has never seen us be so bold in other public health concerns, such as alcohol consumption. When, for instance, I have raised the issue of alcohol advertising at sporting events funded by the government, the then Minister for Sport and Recreation would take the soft view that, "Education is better, and it's better if you're on the sports field to be able to talk to people." Further, when it got really heated, as it sometimes can with me, he would say, "You can't do anything about it because advertising is a federal issue." It is really interesting to me that if these major public health issues are federal issues, why is it that the commonwealth government has such limited influence on public health? With the exception of quarantine, states take the responsibility for public health management, including of communicable diseases. That does not seem to deliver on public health, and it causes problems, especially for critical issues and health concerns such as alcohol that have been raised in debate in this and the other place and through the 2011 Education and Health Standing Committee report entitled "Alcohol: Reducing the Harm and Curbing the Culture of Excess". What is concerning is that this bill will remove the public health policy provisions of the 2008 bill. If this is not a federal issue, why have we removed the capacity for public health

policy? The minister knows about the public health discussion paper of June 2005 and that the 2008 bill was drafted after a lot of public consultation. On the matter of policy, the discussion paper stated —

> While the areas covered by policies could also be dealt with by regulations it should be noted that policies are a relatively new way of providing controls and standards that are subordinate to the main Act. They are also different to regulations insofar as there is a process of community consultation which is spelt out in the Act and has to occur prior to their coming into force. As indicated, they are now used extensively.

The 2008 bill did not come to this house, and the 2014 bill has many omissions compared with the 2008 bill. Clause 33(1)(d) of the Public Health Bill 2008 would have ensured that public health policies could disclose specified activities.

[Member's time extended.]

Dr K.D. Hames interjected.

Ms J.M. FREEMAN: Is the minister mocking me? I cannot believe he is mocking me. I would just like it recorded in *Hansard* that the minister made a shrill noise!

Clause 33 of the Public Health Bill 2008 is headed "Content of public policies" and clause 33(1)(i) states —

> without limiting paragraph (h), provide that any activity or thing, or the supply of any goods or service, is required to meet a specified standard, or comply with specified conditions, to prevent a public health risk;

I would think that is a health policy, which would then become subordinate legislation that could address the issue that the member for Kwinana raised of liquor stores being placed near schools. It seems to me an absolutely pertinent way of ensuring that policies reflect what the community wants, because that policy could be done with the involvement of stakeholders and the community. The legislation becomes subordinate—that is what frames our public health policies and framework under the act and that is what is delivered to the community. Those provisions have been removed from the current bill. A really important tool for and aspect of public health has been removed from this bill. It is not because it will cost anything and it is not because the government did not want to deliver public health to remote Aboriginal communities; it is because the government wants to control public health. It is not public health if the government controls it; it is public health when people can be included and that is made part of the policy. My question to the minister is: why is there not a standard national approach to public health? Given that there will not be a community policy approach, it might as well be done as a broadbrush public health policy. Would that not be a more cost efficient way to deal with non-communicable and communicable diseases more effectively?

The federal report, "A Healthier Future for all Australians: Final Report of the National Health and Hospitals Reform Commission" of June 2009 tanked, to be realistic, but it had a really good vision. It had a vision of a sustainable, high-quality, responsive health system for all Australians now and in the future. It is easy to say that—I suppose it is a global statement—but the point is that the report discussed how that would be delivered. I would like to know in the minister's response to the second reading debate what the health department and the minister have done in the discussion about public health and federalism. It amazes me that we can have national consumer laws and national practitioner laws for nurses, but we cannot have national laws for public health. I thought maybe the various state legislations looked the same, so I looked at the New South Wales law, which is the Public Health Act 2010, and the principles are different. I looked at the Victorian Public Health and Wellbeing Act 2008 and the principles are also different, as are some of its objects. They certainly all have policy provisions and bind the Crown. It seems to me that it has taken a long time to deliver an important piece of public policy and legislation, and it has not been done in a cohesive manner that has a capacity to deliver to the Australian community as a whole.

I congratulate Wanneroo council for its health plan. A number of councils have done a health plan and I was at the launch of that at Wanneroo council. At the time, the council raised the fact that it was looking forward to this bill with anticipation. That was about a year ago now, so the council will be very pleased that this bill is before us.

With respect to health plans and public health, as the minister will know, I have been submitting petitions regarding the care of patients at the WA Cancer Centre focusing particularly on the facilities for patients. The Deputy Leader of the Opposition and I went to look at the cancer centre and although it has all the machines that go "ping" and it is a very, very impressive piece of architecture for the practitioners, it does not overly deliver to patients. I have to say that the radiotherapy section has a lot of places to sit and it has a nice environment, but the waiting rooms for those patients undergoing chemotherapy or seeing a doctor are not patient-centred. If we are going to talk about public health, let us talk about what is most important.

Dr K.D. Hames: You guys designed it, not us.

Ms J.M. FREEMAN: On that basis, I would still like the minister —

Dr K.D. Hames: It is much better than you thought!

Ms J.M. FREEMAN: No—it brought in eight facilities—I would say to the minister that, on that basis, the Labor government did not institute a patient-centred design. I was not a member at that time, but if I had been, I would have gone to the health minister, who might one day be called Roger Cook, and said that we needed do something about it. People who are waiting for treatment cannot be sitting in chairs that, frankly, would not be found in a shopping centre. Sick people waiting to see a doctor should not be sitting in uncomfortable chairs and they should not be crammed in. People who are ill and dealing with the traumatic effects of being ill should not have to do that. People waiting for chemotherapy who can barely hold themselves up should not be taken downstairs to wait for a couple of hours sitting in uncomfortable chairs because there are not enough nurses and other staff. When we were taken around the centre, the doctors were great. They can be really impressed by the facilities they show when they are treating people. When people are rolled in and hooked up to machines, that is good, but people have to wait a long time, and unfortunately that is not very good. People with cancer now want to keep working and have other lives, and we have to look at it in that way. We were in the waiting room and all these patients were duly waiting, as they do, because the doctors were up in the wards. I mentioned the state of the chairs to one of the doctors showing us around and he just dismissed it out of hand. I pointed to a woman who was sitting in a chair trying to put her head on her hand and the chair was too uncomfortable even to do that. It is perfectly reasonable that a person witnessing that happening to someone they care for, his wife, would find that really difficult to deal with. A person dealing with a sick family member does not want to have to deal with the distress of that person not even being able to make themselves comfortable while they wait for treatment. What is worse is we know that cancer is on the increase. On 21 January 2015, the director of education and research at the Cancer Council of WA, Terry Slavin, said that almost 12 000 new cases of cancer were diagnosed in 2012 and that 87 159 people living in WA at some time have had cancer. This data tells us that more people are getting cancer and it suggests that more work is needed on prevention, as work is needed in assisting people. Cancer is now something that many people survive—it is not the "big C" any longer—and we need to make it something that does not have an impact on their wellbeing and mental health.

I would just like to say that a very important part of public health is women's health and the minister has recently tendered out women's health services throughout the state. I am very, very blessed to have a great women's health service in my electorate. The Ishar Multicultural Women's Health Centre provides a great service to women in our community. It is active in the community and it does preventive work. All the women's health centres I have dealt with are of great benefit in what they deliver. I think it is a great public health model to have a community-based, not-for-profit organisation run by members of the community. It would be a great shame for a tender process to allow a private company bent on profit taking over a unique and worthwhile system. That system should be prized in the tender process for the fact that it is not for profit and community based and it is grounded and founded in the community.

Dr K.D. Hames: I agree with you, but I do not have anything to do with tenders. The director general does the tenders.

Ms J.M. FREEMAN: I just wanted to put that on the record.

I will finish by telling the minister that I am doing Mindful in May. It has been a great process. I am 12 days into Mindful in May. It is a fundraiser for water quality projects in developing nations. Every day I get an email with a link to a 10-minute meditation, which can take 20 minutes, and a number of videos showing people around the world being interviewed about mindfulness. I first became aware of mindfulness when I was involved in workers' compensation issues and I talked to a woman at St John of God Bunbury Hospital who works with people with chronic pain. It has been shown that it has great capacity to help people deal with chronic pain. Everyone thinks it is a hippy thing, so I want to show members that it is not. A study in the November 2014 edition of *Scientific American*, a very well respected journal, states —

> A comparison of the brain scans of meditators with tens of thousands of hours of practice with those of neophytes and non-meditators has started to explain why this set of techniques for training the mind holds great potential for supplying cognitive and emotional benefits.

Further, a research article on relapse in people with depression by Teasdale in 2000 in the *Journal of Consulting and Clinical Psychology* has shown that 37 per cent of people with depression who undertook an eight-week mindfulness program relapsed compared with 66 per cent of people with depression who did not do the eight-week mindfulness program relapsing. Much of the information shows that the capacity to focus, to be mindful and to be present is an important aspect that we have lost in our busy lives, as we flick on our computers and do all those things. It has been a great grounding practice for me over the past 12 days. I cannot think of the

name of the woman who has organised it, but I congratulate her. She is from Victoria and runs this program across Australia. She tries to show people the benefits of mindfulness training. Those benefits have been recognised by public health professionals. When we are discussing public health, we need to be innovative, we need to think about the health of our community and we need to consider wellbeing, not just —

Dr K.D. Hames: Does it make you calm?

Ms J.M. FREEMAN: Not when the minister interjects, but it makes me pointed and capable of thinking clearly about why what he said annoyed me. I suppose that is what it gives me the capacity to do. It certainly has been shown in many studies to be a really effective way of reducing relapse in people with depression.

MR W.J. JOHNSTON (Cannington) [8.22 pm]: I rise to contribute to the debate on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. I was impressed with the member for Mirrabooka's contribution, because, as usual, she has made a proper analysis of the issues in the legislation and she has made a very strong contribution. It reflects very positively on her. She is up to her usual high standard. It is sad, of course, that the Minister for Health does not reflect that same high standard. The way that the minister cannot help but interject and try to intimidate the member for Mirrabooka reflects very badly on him. Given the incredible length of service that he has given to this chamber, both before his defeat in 2001 and after his re-election in a different seat in 2005, I would have thought he would know not to try to intimidate a woman of the quality of the member for Mirrabooka. I have known the member for a long time and I know that she is not someone who can be intimidated. I was very pleased to work with the member for Mirrabooka at what is now UnionsWA when it was the Trades and Labor Council of WA. That is when I first met her.

Several members interjected.

The ACTING SPEAKER: Thank you, members. The member for Cannington has the floor.

Mr W.J. JOHNSTON: I was not seeking any interjections from the Minister for Health; I was just outlining the qualities of the member for Mirrabooka and the fact that she cannot be intimidated by a person with a weak personality such as the minister's. I think the minister's performance in his portfolio has been very poor.

I want to address one of those issues that I think are related here—that is, the management of outsourcing in the Department of Health. I point out that there are many aspects of this bill that go to —

Point of Order

Dr K.D. HAMES: I think this bears no relationship whatsoever to what is in the bill.

Mr W.J. JOHNSTON: The bill, in fact, authorises outsourcing. It is, in fact, cogent to the bill. It sets out the provisions that allow outsourcing, so I do not see how the minister can say that my comments do not relate to the bill. For example, the bill allows for authorities to councils and gives a process for those authorities to be carried out by outsourcing.

The ACTING SPEAKER (Mr I.M. Britza): Member, I will give you leeway but I am listening in that area.

Debate Resumed

Mr W.J. JOHNSTON: Of course; I look forward to your careful guidance, Mr Acting Speaker. I very much look forward to it, because I know that you will give me a clear direction to stay within the path of the standing orders, and I attempt to do no more than that.

Ms R. Saffioti: He's walked out.

Mr P. Papalia: He's stormed out.

The ACTING SPEAKER: Members!

Mr W.J. JOHNSTON: He has stormed out.

Mr J.R. Quigley: Retreated.

Mr W.J. JOHNSTON: He has retreated.

Several members interjected.

The ACTING SPEAKER: We all know exactly what happened.

Mr W.J. JOHNSTON: I am sure that the minister is attending to urgent parliamentary business elsewhere in the building and I am sure that we do not have to speculate where he has gone for 120 seconds.

We have to be very careful about managing outsourcing. One of the things that councils need to think about when they go through their outsourcing process to use non-employees to carry out functions under the

Public Health Bill is how successful and unsuccessful outsourcing models are. I make the observation that one of the things that companies that outsource services want to do is retain control of the quality of the service that is being outsourced. One of the ways that business does that is to make sure that the outsourcing arrangements are for only a short time. If a business outsources for a long time, it runs the risk of losing control over the quality of the outsourced service. If it has a very long contract for those outsourced services, it can end up having great expense in renegotiating or bringing the contracts back inside. Before councils use the opportunities to allow people who are not direct employees to conduct the affairs of councils under the powers provided in this bill, they should be careful that they retain that quality. If they are going to look at an outsourcing model, they should not look at the outsourcing model that the government used for the non-clinical services at Fiona Stanley Hospital. If they enter into an outsourcing arrangement with a very long contract period, they will lose control of the service.

Point of Order

Dr K.D. HAMES: The outsourcing that the member is referring to is about councils having the ability to authorise someone to be an environmental officer under the bill. It refers in no way to outsourcing in public hospitals. The bill does not refer to public hospitals.

Mr W.J. JOHNSTON: I was not referring to outsourcing in public hospitals; I was referring to outsourcing models that councils should look at in making decisions. I was referring to that fact that, in looking at those models, they should identify the ones that have failed.

The ACTING SPEAKER: Member for Cannington, I want you to continue, but I will be looking for where that is in the bill. Normally, I would have my attention on exactly what you are saying but I am just looking for it.

Debate Resumed

Mr W.J. JOHNSTON: The minister identified exactly what I was referring to—the power under the bill for a council to outsource its environmental health functions.

The ACTING SPEAKER: Yes. That is correct.

Mr W.J. JOHNSTON: That is the exact issue that I was addressing. I am pointing out that councils making the decision about outsourcing arrangements will need to look at models for how they will manage their outsourcing. There are various models all around the world and I was making the observation about what occurs in the private sector. I was contrasting that with the poor model that had been used for the outsourcing of the activities at Fiona Stanley Hospital, whereby the government outsourced over a long time and it lost control of the functioning that it had outsourced. Indeed, it had to pay $118 million to the outsourcing provider not to provide services. One could imagine that when the councils are looking at outsourcing, they do not want to make the same mistakes that the government has made in outsourcing. They need to be careful and pay careful attention to value for money, because that was not done in the model that the minister was responsible for. That is why I am raising this issue. It is very important that councils, in using the authorities that the minister is proposing under the Public Health Bill, not use the minister's practices because they will lose control and they will have to spend more money than they should. It will be a whole series of negative outcomes. That is a very critical issue that councils will need to examine. As I am sure you know, Mr Acting Speaker, there is some concern amongst councils that this bill allows cost shifting from state government to local government. That will be an issue that everybody will be watching if this legislation is to become law.

The member for Mirrabooka went through in very great detail the history of public health acts. She explained what happened in England in contrast with Australia, and how those concentrations on public health overcame disease outcomes in the United Kingdom. Most of the increase in life expectancy in our nation has come not from medical achievements, but in fact from work on public health. I want to illustrate this with some statistics from the Central Intelligence Agency's World Factbook, comparing Australia with Indonesia. For example, the CIA's Factbook states that there are 190 maternal deaths per 100 000 women in Indonesia compared with six in Australia. There are 25.16 deaths per 1 000 births in Indonesia compared with just 4.43 in Australia. Life expectancy at birth in Indonesia is 72.17 years—the World Factbook goes to that second decimal place—compared with 82.07 years in Australia. Health expenditure in Indonesia is three per cent of the gross domestic product, whereas in Australia it is 9.1 per cent. Interestingly, the Factbook states that 84.9 per cent of Indonesians have access to what they describe as "improved water", but 25.6 per cent of rural people do not have access to improved water in Indonesia. Only 58.8 per cent of Indonesians have access to what the CIA describes as "improved sanitation". In rural areas, 54.5 per cent are said to have unimproved sanitation. The figures for Australia in all of those categories is 100 per cent. Therefore, according to the CIA, 100 per cent of Australians in country and metropolitan areas have access to so-called improved water—in other words, water with treatment to remove potential microbes et cetera—and 100 per cent of Australians have access to some form of

sanitation. That access to improved water and sanitation is the major driver of the much more outstanding health and life outcomes in Australia compared with Indonesia. If we went back and looked at Australia of 100 years ago, or 150 years ago, we would see statistics that looked much more like Indonesia today because we had not then got to the level of improvements in our public health structures that we have today.

I am sure you would remember, because I think you are about the same age as me, Mr Acting Speaker, that when the Australian government engaged Paul Hogan as our tourist ambassador back in the 1980s, one of the points he made when he was promoting Australia in America was the fact that we can drink out of any tap in the country. It was one of those great things about Australia. We are a place that people can trust. I have been to plenty of places in the world where people cannot drink out of a tap, whereas we know in Australia that unless there is a sign, we can, generally speaking, drink out of a tap. Interestingly, there was a sign in Adelaide —

Ms J.M. Freeman interjected.

Mr W.J. JOHNSTON: Yes, indeed. There was a sign that I am sure the member for Churchlands would be very familiar with from when the Public Accounts Committee went to the biennial Australasian Council of Public Accounts Committees conference in Adelaide a couple of weeks ago. The conference was held at the newly refurbished Adelaide Oval. There was a sign on the way into the toilet that stated, "Untreated recycled water used to flush" —

Mr S.K. L'Estrange: It didn't even say that. It just said, "Don't drink the water."

Mr W.J. JOHNSTON: No, no. I have the photo! It stated, "Recycled water in use for toilet flushing. Do not drink." We Western Australians were all confident that we were not going to drink the water in the toilet that was used for flushing, but perhaps in South Australia this is news to them! I have many good friends in South Australia and I do not want to reflect on any of their qualities, but I was actually a bit surprised to see that sign in that form. If it had said, "Recycled water, aren't we pretty good?" I would have understood that, but then the urging not to drink it out of the toilet bowl was a bit beyond me, I must tell members that.

Mr S.K. L'Estrange: I sent it to my seven-year-old son. He was very concerned.

Mr W.J. JOHNSTON: My 17-year-old son liked it too.

It is perhaps not that long ago that these things were much more important to us than they are today. When I say important to us, I mean in our thinking; of course, it is the success of the process that we have now.

There is a very small non-government organisation that is run by a guy in my electorate. His name is Peter Johnston—same spelling as my surname, but he is of absolutely no relation to me. He runs an organisation called Bamboo Micro Credit that support projects, particularly microcredit, in a couple of different places in Indonesia. Last January, I and a number of colleagues on this side of the chamber, including the member for Mirrabooka and the member for Kwinana, went to Indonesia and we visited one of the projects supported by Bamboo Micro Credit. It provides fresh water for villages in Indonesia in particular circumstances.

The arrangement is that it puts in a simple water supply system where there is a naturally occurring spring above the village and the village is currently drawing water from the river. The organisation explained to us that the rivers are the worst places to get water because that is where most of the diseases flow, as well as sediment and other chemical residues et cetera. Part of that system involves capping the supply so that no dead animals or other things can fall into the well or water source used by the village. That is quite important. Of course, they want the water source to be above the village, because that way there is no need for pumping. That is a Bamboo Micro Credit project, which is one of the many non-government organisations in the Australian community that is trying to help people to improve their circumstances. If the Central Intelligence Agency is right—I take on board the member for Mirrabooka's interjection about remote Indigenous communities—and we take its comments at face value that we supposedly have 100 per cent improved water and proper sanitation, that is the biggest contributor to the enormous lift in Australian life expectancy. If one went back 100 years in Australia to about my grandparents' generation—I imagine it is the same for the Acting Speaker—my grandmother was one of 13 children. Her oldest and youngest brothers actually had the same name, because the oldest son had died before the youngest son was born. They were both named Arthur John.

[Member's time extended.]

Mr W.J. JOHNSTON: The oldest was called Arthur and the youngest was called Jack John. That was not uncommon in families in the first quarter of the twentieth century. Fortunately, that is not the situation now. We have such high life expectancy not so much due to medical interventions, but to improved public health processes.

I was telling the Leader of the Opposition a story earlier today about when as a high school student I lived in Indonesia. After being at sport or whatever, I would walk home along the verge of a very busy road and the drainage ditch—obviously, Indonesia has a very high amount of rainfall—at night had rats running up and down it. I live in Victoria Park and there are plenty of rats there—perhaps that is East Victoria Park! The cats drag in the occasional rat. In Australia, if anyone saw a rat in the front yard, they would be aghast.

Mr P. Papalia: What about the party room?

Mr W.J. JOHNSTON: Not in our party room.

Mr R.H. Cook: Not anymore.

Mr W.J. JOHNSTON: No, not anymore.

Controlling sanitation and ensuring bins are collected every week and waste disposal is done away from populations are examples of improved public health processes.

I looked up the report "Health outcomes and cost: A 166-country comparison" by the Economist Intelligence Unit, which is a sister organisation of *The Economist*. I think it is a yearly report. It states that our expenditure on health care is actually a lot lower than many other countries. We are about one-third lower than the United States, for example, but our health outcomes are actually much higher because we use our resources much more efficiently. Calls for changes to the Australian health system should always be looked at through the prism of effectiveness, not just who pays. Just as there is the potential for cost shifting here to councils, there is always a fear about cost shifting from governments to low-income earners in the community who have to pay more for health services that are demanded by us all.

I know that the Premier is very concerned about amendments to the Constitution. I look forward to the Minister for Health explaining in his second reading reply how we are amending the Constitution Acts Amendment Act 1899 without taking it to the people. I am surprised. I see that clauses 115 and 116 of the Public Health (Consequential Provisions) Bill 2014 amend the Constitution Acts Amendment Act.

Ms R. Saffioti: Has there been much consultation?

Mr W.J. JOHNSTON: Those are the sorts of issues the minister is going to have to tell us about.

Mr P. Papalia interjected.

Mr W.J. JOHNSTON: That is right. I really think this is an important issue for the minister to talk about. Schedule V will be amended. I am sure the minister will outline the community consultation that has gone ahead about clause 116 of Public Health (Consequential Provisions) Bill 2014. For the minister's benefit, it is lines 10 to 22 on page 86 of the bill. I know the Premier is very concerned about amending the Constitution Acts Amendment Act 1899 without consulting the community.

Dr K.D. Hames: Aren't we about to amend the Constitution without consultation?

Mr W.J. JOHNSTON: Yes, and the Premier said that we were being outrageous to attempt to amend the Constitution without any —

Dr K.D. Hames: He supported it.

Mr W.J. JOHNSTON: No, he has not. I read his speech. Does the Minister for Health want me to get out his speech and read it for him? I understand that the Premier has effectively endorsed the outcome of the committee, but he has not spoken in the chamber on this. His words in the chamber were that he was very concerned about amending the Constitution without taking it to the people.

Dr K.D. Hames interjected.

Mr W.J. JOHNSTON: Is he no longer concerned?

Several members interjected.

Mr W.J. JOHNSTON: I do not know because he has not told us that in this chamber.

The ACTING SPEAKER: Members, I cannot see the relevance of this. Can you just come back to the bill, member.

Mr W.J. JOHNSTON: I am talking about clause 116.

Mr R.H. Cook interjected.

Mr W.J. JOHNSTON: I am always relevant; otherwise Mr Acting Speaker would not let me speak.

Several members interjected.

The ACTING SPEAKER: Thank you, members. I am simply trying to connect the dots. You all have them connected, but I am still trying to connect them.

Mr W.J. JOHNSTON: If Mr Acting Speaker cares to turn to page 86 of the Public Health (Consequential Provisions) Bill 2014, lines 10 to 22, he will see schedule V is headed —

Division 7 — *Constitution Acts Amendment Act 1899* amended

I am just going through the fact that I expect the Minister for Health to explain what consultation there has been about the amendment to the Constitution. I know that this is an issue of deep concern. Perhaps, the minister would like to tell us what happened in the cabinet discussions. Was someone being prevailed upon to overcome his natural reticence to amend the Constitution without having had widespread community consultation? The Minister for Health must be one of the few ministers who can get the Premier to agree with something that he does not like. Clearly, getting this legislation before us to amend the Constitution without any consultation with the community —

Dr K.D. Hames: It has been a great highlight!

Mr W.J. JOHNSTON: I am sure that it is.

Several members interjected.

Mr W.J. JOHNSTON: I loved it when the minister used to say only two things in the chamber. One was, "Why are you complaining? This was your policy", and the other was, "Why are you complaining? Jim McGinty was going to do this." They were the two lines. We then did word bingo in question time once and the minister has moved on to a different set of words.

Dr K.D. Hames: Point of order!

Mr W.J. JOHNSTON: Sorry!

The ACTING SPEAKER: He is coming back!

Ms R. Saffioti interjected.

Mr W.J. JOHNSTON: I will also be entertained to have a look at what is happening with the Cat Act. I had a look through that. The Cat Act is one of my favourites. The Cat Act is being amended in fact just before the —

The ACTING SPEAKER: Help me again, member.

Mr W.J. JOHNSTON: It is on page 84 under the heading "Division 6 — *Cat Act 2011* amended." This is one of the provisions that deals with outsourcing, as it happens, because a person is able to be an authorised officer and not just an employee.

Dr K.D. Hames: That doesn't mean outsourcing.

Mr W.J. JOHNSTON: No, I am saying it authorises outsourcing. The bill does not say that it requires outsourcing; it is one of the many provisions throughout the bill that allows outsourcing, as it happens. I think there were 17 amendments to the Cat Act —

Mr P. Papalia interjected.

Mr W.J. JOHNSTON: No, I am referring in particular to some exchanges between me and the former Minister for Local Government, the member for Bunbury. I think I suggested 17 amendments to him and I think he accepted 13 of those 17. The member for Warnbro and I worked very closely, because although the Cat Act had been written by people who liked dogs, some of us in the chamber like cats. I am one of those strange cat people.

Mr P. Papalia: We were representing people who like cats regardless!

Mr J.H.D. Day: Me too!

Mr W.J. JOHNSTON: There we go! The Leader of the House is a cat person.

Mr R.H. Cook: What's wrong with cat people?

Mr W.J. JOHNSTON: Nothing is wrong with cat people! I was just making the point that —

Ms R. Saffioti: Some of my best friends are cat people!

Mr W.J. JOHNSTON: Ha, ha!

The ACTING SPEAKER: Excuse me, members of the house; let us come back to the bill.

Mr W.J. JOHNSTON: I was. I am here on pages 84 and 85 of the bill

The ACTING SPEAKER: I am with you.

Mr W.J. JOHNSTON: Excellent! I am just saying that an authorised person —

Dr K.D. Hames: We have a rag doll.

Mr W.J. JOHNSTON: The minister has a rare dog?

Dr K.D. Hames: A rag doll cat.

Mr W.J. JOHNSTON: A rag doll! We have what is called a domestic medium-hair cat. If members ever hear of a domestic medium-hair cat, that means a moggy. It has to be called something, so it is called a domestic medium-hair cat. That is what we have. We also have the dumbest dog in the world. It is a labradoodle, a cross between a labrador and a poodle. It is an eight-year-old puppy! It still thinks it is a puppy and it is eight years old.

I note that we are amending the Cat Act, which, as I say, is one of my favourite pieces of legislation from the last term.

Mr P. Papalia: I have great warmth for the Cat Act too.

Mr W.J. JOHNSTON: Yes, I am sure the member for Warnbro does. It was one of those interesting occasions when the chamber worked well. We actually had the opposition talking and the government listening. So often in this place that does not happen, and I often use that as an example. Sometimes when schoolkids are doing their session on Parliament, they have the Cat Act as their reference work. They give out all the different roles to the kids. There are a couple of acts. There is one about hoons and one about the Cat Act. I always make the point that the Cat Act is a good one to have a look at because it was actually an example of the Parliament not necessarily at its best, but doing its job properly. There was proper consideration —

Mr P. Papalia: Ask for an extension.

Mr W.J. JOHNSTON: I have had my extension, otherwise I would ask for one.

We are all looking forward to the further debate on these cognate bills and we are waiting with bated breath for the minister's second reading reply, as I am sure he will have lots of things to tell us.

MS R. SAFFIOTI (West Swan) [8.54 pm]: I rise to speak on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. I appreciated the contributions made by my colleagues before me, particularly the member for Cannington, as he was the only one I heard in the chamber.

I want to make some comments about the Public Health Bill and I want to focus on two key areas. Part 2 of the bill refers to the continuation of the longstanding arrangements whereby responsibility for public health is shared between state and local governments. Basically, on behalf of the state, the Minister for Health and the Chief Health Officer delegate many roles to local governments and they appoint environmental health officers to undertake particular roles. I have some legitimate issues relating to my electorate that I have raised in this chamber on a number of occasions. One is the failure of some of our environmental health assessments and the operations that occur between state and local governments in the regulation of particular public health matters. My issue relates particularly to chicken farms. Although everyone in this house goes back to some of their pet topics, the chicken farm on Cheltenham Street is one of the key issues that I have raised constantly in this house. As many are aware, the chicken farm, the Swan Valley Egg Farm, has been operating on Cheltenham Street, in what was West Swan but is now Bennett Springs, for a number of years. More recently, it was operating outside its approved licence, running approximately 150 000 birds on a property that was licensed for only 24 000 birds.

Mr P.B. Watson: Double-bunked!

Ms R. SAFFIOTI: More than double-bunked, member for Albany. Even worse, the eggs were being passed off as free range. That is an issue that is in front of the Australian Competition and Consumer Commission at the moment, so I will not comment further on that. However, in relation to the whole issue, I want to demonstrate the complete failure of our system to regulate and to understand what is happening on some issues.

As I said, from about 2004 this farm was operating well above its licence. Can members imagine the environmental impact on its neighbours of a farm licensed for 24 000 birds that is carrying up to 150 000 birds? It must be remembered that this farm started operating before the neighbours had setbacks and buffers from the sheds. In this particular instance, the sheds were approximately 30 to 40 metres—if that—from the neighbours and were running 150 000 birds. The environmental health impact and the public health impact of this were

significant. The local residents complained to the City of Swan on numerous occasions. I have read the documents supplied through a freedom of information application and noted the numerous complaints made to the City of Swan year upon year, and nothing actually happened until a crisis point came. Finally, the City of Swan went to the owner and basically said that they were operating outside their previous licence. The owner of the chicken farm sought retrospective approval. There was, of course, a public consultation phase. Finally, it went right through to the State Administrative Tribunal, and the application for the extension of the chicken farm to up to 80 000 chickens, which is what the owners sought, was rejected, and it is now meant to be operating at 24 000 chickens. Still, the operation of 24 000 chickens in a property that is very, very close to homes and has enormous environmental impacts should be of great concern.

Whenever we raise these issues, there is always the comment, "Who was there first?" But we need to take into consideration a number of issues, such as what type of farm was being operated when the initial approval was given, and where has it been allowed to go over the years, and also the fact that the world has moved on and people are not accepting polluters living right next door to their property.

I have raised this issue numerous times in this place. I have raised it with the Minister for Water, the Minister for Planning in some aspects, the Minister for Environment and the Minister for Local Government. We have tried to demonstrate the enormous public health risks and some of the impacts on neighbouring properties in relation to water quality and dust. Across a number of areas, we have tried to have this issue considered seriously. Another issue is how dead birds are being dealt with. We have basically received little or no response from the state government. As late as October last year, we asked the minister representing the Minister for Health questions about what is happening with the operations of the egg farm not only in West Swan but also in Carabooda. At that time, the minister said it is all up to the local government. This is why I really have a problem. When a local government fails to act, and the responsibility really should rest on the state government, what can people do? I see that the Minister for Environment is looking up. I have written to him as well, and he came back and said the issue is with the City of Swan. But if the City of Swan fails to act, as it has in this case, what can we do?

I want to contrast this with what has been done by the City of Wanneroo. I am not saying that the City of Wanneroo is a perfect example in all cases, but back in October or November last year a local journalist took some photos of the Carabooda egg farm, and the City of Wanneroo found that there were complaints and it started an investigation straightaway. I am not sure what the result of the investigation has been. But it actually launched a formal investigation into what is happening. This is in stark contrast with what is happening in the City of Swan. Can I say that on a number of occasions when we have raised this issue, there seems to be a gap in regulation. This is the case particularly in relation to some agricultural practices that are being conducted in urban areas. The state is saying that it is the council's responsibility, and the council is saying that it is not equipped and it is not able to investigate properly, and we also have the role of the Department of Agriculture and Food, which I am really not sure about.

We have raised this issue on numerous occasions. I believe there are strong public health concerns about the regulation of particularly the West Swan chicken farm, which is adjacent to properties. As I have said, I do not think we can just say, "Who was there first?", because this farm has been allowed to operate well beyond its initial set-up. We actually have to say, "What is the public health risk, and what is happening?" That is particularly the case when we are dealing with, basically, loads of chicken manure and the public health problems that can arise from that.

The Minister for Planning, the Minister for Environment and the Minister for Health are in the chamber at the moment. I hope some work can be done on this issue. I do not think the buck-passing between the state and the local government on this issue is good enough. If we do not believe the local government is doing its job, we have to go through some sort of complaints procedure against the local government authority, and sometimes that is a lengthy process that does not achieve any result. But if we go to the state government, the state government says that we have to go back to the local government authority. There has been a lot of buck-passing. I have raised this issue with numerous ministers. I am still waiting for the meeting that the Minister for Local Government promised me about six months ago on this particular issue. It is a massive issue in my electorate. A similar issue in my electorate is also coming to a head. It is an issue for a lot of people around the place. I think there has been a gap in regulation and a gap in investigation. Basically, even if we delegate some authority to a local government, the state government still has some primary responsibility to make sure that it is protecting public health. I have tried on numerous occasions to get the state government to take this issue seriously and to investigate water quality and general environmental issues; for example, the immediate impacts on the neighbours of the manure and the dust that the farm creates. However, I do not think it is taking this issue seriously.

We can talk about changing legislation all we like. But if we are not—I do not use this term very often—fair dinkum about ensuring that we are minimising the risks to public health, legislation means nothing. It is about

what we are doing on the ground to make sure we are protecting public health. I have found it staggering that no minister has been able or keen to put up their hand and say, "This seems to be a legitimate issue. It has been going on for years. We will take some action on it." That should be the case particularly given that this is occurring in an area that is now urban deferred and because of the proximity of this farm to local residents. It is completely different from new farms that are being operated and that have setbacks of at least 100 metres, 200 metres or 300 metres. There is no setback whatsoever for this farm. It is causing people to sell up and move out, because they have no future in an area where they are living next to a farm that is basically impacting their everyday life.

I believe this issue is quite serious. I am not confident that a standard procedural process is being applied by environmental health officers across councils. I still do not understand who regulates chicken farms and who does not, because, honestly, it has been put to me that everyone else is regulating them, when no-one actually is. I still have buck-passing between the state government and local government, and the Department of Agriculture and Food, possibly—it is saying it does not regulate chicken farms —

Mr P. Papalia interjected.

Ms R. SAFFIOTI: No. There is basically a massive gap in regulation. This is a real issue, particularly as the urban front continues to expand and we have this continuous confrontation between agriculture and urbanisation. We need to be far more proactive on this. I believe in supporting local agriculture. I do not believe in shutting people down just because the urban front is approaching. But I do believe in assisting people to relocate. I believe in having local producers. As people know, I grew up on an orchard in Roleystone. I believe we should have local producers helping to feed our local market. But I think the confrontations that are occurring in relation to the urban front are not being sorted out by this government and we need to have a proper plan and a proper strategy, because we cannot continually have this issue and this confrontation. Local residents get fed up; they cannot live their lifestyle because of the pollution, and, basically, things drag on and it creates an unbearable outcome for everyone involved.

I want to put that point on the record. I do not have all the letters and all correspondence that I sent. But I have sent about four or five letters to government. I have approached ministers, I have grieved and I have asked questions on notice. We have raised it in the local paper. We have sought explanations from the City of Swan. It is now being played out through the State Administrative Tribunal and the Australian Competition and Consumer Commission. But, ultimately, the significant public health risks that existed and continue to exist have not been taken seriously by this government. That is one key issue that I wanted to raise.

Mr I.M. Britza: Member, will you take an interjection?

Ms R. SAFFIOTI: Sure.

Mr I.M. Britza: There are two things. Number one, you have accurately presented that issue; and, number two, I have been a witness to those things that you have questioned, and it is a disastrous situation, and you have accurately presented it.

Ms R. SAFFIOTI: Thank you, member for Morley. I know the member also has been working on this issue. It is an issue that, to put it bluntly, any Minister for Environment who was worth their salt would take seriously and not just read out a pre-prepared media statement. That is my criticism. Any minister can stand and read a prepared statement. Programmed robots can do that. Ministers have a responsibility to try to get to the bottom of it. People do not like them because of the smug looks on their faces. They show contempt and arrogance to people on this side and people from the public who raise proper concerns. You guys think, "Unless you donate to the Liberal Party or unless you have them for dinner, you don't care about them." That is the approach. I have heard about the bullying that you guys do, too. I hear it again and again. If someone challenges them, they ring people and try to bully them out of it. It is a disgrace.

Mr F.M. Logan: The former member for Vasse never did that!

Ms R. SAFFIOTI: There are plenty of examples. They do not take issues seriously. Ministers actually get paid to sort out problems.

[Member's time extended.]

Ms R. SAFFIOTI: They do not get paid to read out a prepared briefing or a ministerial statement or answer a dorothy dixer with an arrogant tone, because anyone can do that. As I said, any programmed robot can be sent in to do that. I know that is how people on the government side are treated and operate. When presented with a real problem and real evidence of pollution, one would think the Minister for Environment would take it seriously; that he would possibly send one of the many thousands of bureaucrats to see if there is any legitimacy to the claim—but no. That is my biggest criticism. Ultimately, governments make decisions and are held to

account but it is also about the approach that they take to the public of Western Australia and to the opposition at any time. We raise serious issues.

Mr P. Papalia: Oppositions do.

Ms R. SAFFIOTI: Oppositions do, because we represent the public. The government may not like the public, but we represent them.

As I said, I was disappointed. I hope this triggers some work done by somebody on that side to try to address the issue. I am surprised the Minister for Health has not taken this seriously.

Dr K.D. Hames: Have not taken what seriously?

Ms R. SAFFIOTI: I am surprised he has not taken the issue about the chicken farm seriously.

Dr K.D. Hames: Why do you think I have not taken it seriously? I have been sitting here immobile, not interjecting on you, because you criticised me for interjecting before. I have been sitting here very quietly and patiently.

Ms R. SAFFIOTI: It is a key public health issue.

Another key issue I want to touch upon is how we plan our suburbs and our cities, particularly active open space. Is the shadow Minister for Sport and Recreation yet to make a speech or has he done his?

Mr P.B. Watson: I have done mine.

Mr B.S. Wyatt: He smashed it!

Ms R. SAFFIOTI: He smashed it.

Another key issue relates to active open space in our suburbs. The constant tension between development costs and making sure we have enough active open space in our suburbs is a massive issue. It is basically growing as a major costing issue, but also a public health and lifestyle issue. I will quote extensively from a report that was co-commissioned by the Department of Sport and Recreation and Curtin University entitled "Active Open Space (playing fields) in a growing Perth–Peel". It was released in January 2013. It tries to differentiate between public open space and active open space. There has been a lot of contention about this over time. Different theories have changed over time. This report looks at active open space; that is, space that can be readily used to run around on, to kick any type of ball on, or to play netball or basketball on. It looked at how we have changed over time the amount of space we allocate for active open space as it relates to public health. It has probably been stated before that our community faces a number of public health threats. Of course, there is the issue of getting our kids active. Getting older people active is also a major issue. It is something that not only the government, but also the Parliament, should aspire to. It is something that the opposition is also trying to achieve. To do that, I do not think there can be conflicting messages from government. I remember last year a statement made by the Minister for Water about water allocation in new areas for playing fields and the minister saying that the new playing fields will all be giant sandpits with some monkey bars. For toddlers and preschoolers, that is fair enough, but as we get older we need more space. We need more space to let our younger and older children, and older people, participate in our community.

The main author of the study published in January 2013 was Garry Middle. The report states that the average percentage of active open space by suburb has dropped dramatically over time. In old inner suburbs, 1.85 per cent was the average percentage of active open space by suburb category. The middle ring of suburbs dropped to 1.59 per cent. It then dropped to 0.74 per cent to what was called "water and bush 'constrained' suburbs". Then 0.77 per cent is for "new 'urban designed' suburbs".

Mr V.A. Catania: Member, over what period of time?

Ms R. SAFFIOTI: Since about the 1950s. It has changed over time. One just needs to drive around our suburbs to understand that. Driving up Alexander Drive, one can see Yokine Reserve and massive areas of open space that were dedicated for active open space. We have moved to being far more environmentally conscious, which is fine, but we replaced some of that active open space with other public open space but did not allow enough active open space to compensate. As a result, we have more wetlands, bushland and drainage areas but we are not creating enough active open space to compensate for that.

I have spoken extensively with the member for Albany about this issue. It is something that needs to be addressed. There is no use talking about how to get young children fit. KidSport was a good initiative; we all accept that. The reality is that organised sport is only a portion of what our children do every week. As parents get busier, it is harder and harder to get kids to organised sport. Some of the distances required, nowadays in particular, are quite significant. We need active open space in our suburbs. The real problem we have is that the

growing suburbs are not getting the active space needed. On top of that, block sizes are much smaller in many new suburbs. There is not actually a backyard. If we compare some of the older suburbs, let us say Mt Hawthorn, it has good proximity to good playing fields but larger blocks. In comparison, Ellenbrook has 300-square-metre cottage blocks with very limited playing space. Ellenbrook has a lot of public open space, but the question is whether there is enough active open space for kids to enjoy and play some sort of sport. We also need to look at the greater use of netball and basketball courts in subdivisions. We quite often see on American shows everyone shooting hoops all the time. Can we incorporate in our constrained spaces more netball and basketball courts as active open space for our new growing suburbs? The issue of active open space is a real one.

The other key point is the lag in the delivery of sporting fields. Even where new sporting fields have been designated for a growing metropolitan area, there is a significant lag between communities moving in and the infrastructure being developed. People are sometimes waiting 10, 15 or 20 years before the regional sporting fields or district sporting fields are built. There is a massive time delay, and the children need those sporting fields when they are going through that phase. That is another significant issue that I, again, do not think is being addressed. The metropolitan regional improvement tax is being underused. It is collected by the government, but the government is not spending the amount it is collecting. There is now more than $200 million sitting in that fund. Part of that funding is to help purchase active open space and regional playing fields, but it is just not being used.

The DEPUTY SPEAKER: Member for West Swan, can you assist me by just referring to the bill? It is a big bill and I have had a flick through it but I cannot find any reference to public open space and recreation areas. If you can just refer to the bill, that would be good. Thank you.

Ms R. SAFFIOTI: We are talking about the public health plans that have been required by the councils. I was talking about councils and state government in relation to developing public health plans, and one of the key points there is about trying to ensure there is a lot of activity in the area.

The DEPUTY SPEAKER: Thank you.

Ms R. SAFFIOTI: It is a key part. If anyone does not think activity is related to public health, we might as well go home.

The document goes on to state that the total predicted shortfall of active open space in the north west by 2031 will be about 143 hectares; in the north east, between 60 and 65 hectares, in the south west, 60 to 65 hectares; in the south east, 128 to 134 hectares; and in the Pilbara, between 89 and 92 hectares.

As I said, I think we keep being sent conflicting messages. For example, we recently raised the issue of the government not building Caversham south primary school in south Caversham. Even though it bought the land for it, it said the kids could go to another school. The government will not build a local primary school and it wants kids to walk to school. How are these kids going to walk to school if their closest school is across Reid Highway and about four or five kilometres away? There are conflicting messages all the time.

We have heard issues about water restrictions for public open space, but, as I said, we need to be smarter about how we deliver our active open space because we are getting more and more time-poor—I know I am. As parents we are becoming more and more time-poor, and we basically need to have local active space so that our children can go and play in a safe, local environment with the local community. This all contributes to how active and healthy our community is.

Lastly, I want to touch upon a very, very general issue—support for new mothers. The member for Cannington raised it, and I apologise that I am running out of time. I think we need to be far smarter about how we provide support for new mothers in our community. I am not sure whether it can be achieved by working with local councils but we are not providing the support needed by new mothers, particularly in a modern environment that is completely different from 50 years ago, frankly. People can talk about 50 years ago, but the world has changed and the stresses on new mothers are completely different. I believe we need to be far more supportive of new mothers in the community, particularly with postnatal support. Postnatal depression is something that occurs a lot more than we think, and I think we need to be far smarter about how we target our resources and help support new mothers.

MR B.S. WYATT (Victoria Park) [9.24 pm]: I rise to make a contribution to the cognate debate on the Public Health Bill 2014 and the Public Health (Consequential Provisions) Bill 2014. I confirm that the opposition will support the passage of the bills. The principal bill is indeed a large bill, and, reading through the minister's second reading speech, it has been some time in the making, along with the regulations that will follow.

The principal bill is an interesting bill that takes me back a little. In 2001–02 I lived in London. I was lucky enough to be a student there, so I was not working the sorts of hours some of my friends were. One of the things

we got to do, and I did a lot of, was running. I would run down from the halls of residence at Russell Square, down to the River Thames and then, depending on how vigorous I was feeling, I would run from bridge to bridge to bridge, across the bridge, back, and across the other side.

Mr R.H. Cook: You said you studied really hard.

Mr B.S. WYATT: Oh, incredibly hard! I thank the member for Kwinana.

As I was running along I would see some amazing architecture. I would run past the houses of Parliament, obviously, and at the time the Salvador Dali exhibition was on near the London Eye—it was on for most of the time I was there—and there were lots of statues and memorials along the way that I would generally run past and note without stopping to read. But there was one on, I think, Victoria Embankment—with the Northern Hemisphere I am all ends up whether it is north or south; I think the north is right—which was a memorial that was almost Romanesque. It was written in Latin and there was a bust of a guy named Joseph Bazalgette. I did not know at the time, but, member for Cockburn, Joseph Bazalgette designed the London sewer system. He saved more lives than anyone else from the Victorian era. In the time of Sir Joseph Bazalgette—I think he became a knight in the end, and quite rightly for what he did for London and England—in the 1850s there was the Great Stink of the Thames. Effectively, everything was deposited in the Thames. The sewers ran into the Thames, and bodies, offal, carcasses and sewage were floating in the Thames—everything went into the Thames. Over a period of time it built up, and after a particularly hot spell in London, the Great Stink occurred. Regular breakouts of cholera were killing thousands and thousands and thousands.

Mr I.C. Blayney: There was a doctor—I can't remember his name—who discovered the connection between sewage and cholera, because they were not connecting them.

Mr B.S. WYATT: Either way, lots of English people were dying as a result of the cholera that was coming out of the Thames at the time. Bazalgette was an engineer by trade—I am very impressed that the member for Cockburn picked that—and he basically designed a system of sewers that, effectively, turned the sewage around and took it outside the metropolitan area. It was that contribution that saved more lives than any other Englishman of the Victorian era. Indeed, when I was living in London and travelling around rural England and parts of Europe et cetera, I would regularly come across towns that had the ruins of the Roman Empire still there. Of course, it is generally considered that the Roman Empire effectively conquered the world on the back of a sophisticated sewerage system, with the movement of fresh water and the expelling of contaminated water. Ultimately, as the member for Cannington stated, the sanitation of communities allowed for the removal of diseases such as cholera, and for people to live longer lives. I had no idea who Bazalgette was. I ran past his bust on Victoria Embankment for the better part of 18 months, but during that time I finally worked out who that person was; he was the person who designed, around the 1850s, the English sewerage system. It is interesting to note as well the reflections at the time on the state of the Thames. The Thames is not drinkable water by any stretch of the imagination, but there are certainly no outbreaks of cholera anymore. I know the member for Cockburn will like this. In his novel *Little Dorrit*, Dickens wrote that the Thames was —

> … a deadly sewer ... in the place of a fine, fresh river.

In a letter to a friend, he said —

> I can certify that the offensive smells, even in that short whiff, have been of a most head-and-stomach-distending nature.

That is the Thames described in a way that perhaps only Dickens could!

Mr F.M. Logan: It's better now.

Mr B.S. WYATT: It is better now, but I recall that when I was in England, I thought I would take up a sport that I did not do in Australia and I took up rowing for my college. I am not a particularly good rower, but it was fun while it lasted. One afternoon, it was a bit rough and in we all went. One of the crew swallowed a bit of water and was quite crook for a short spell. However, he did not catch cholera and cark it, so ultimately things have improved. The story of Bazalgette is an interesting historical aside on the importance of sanitation. It is interesting that we now find ourselves updating a bill that probably made its way through Parliament not long after Bazalgette had finished the English sewerage system in the 1850s or 1860s. In the minister's second reading speech, the current 1911 act replaced the old 1800-and-something act. Perhaps there was some overlap. I will have to look at the time of Mr Bazalgette's death and whether there was any overlap between his life and the passage of that legislation.

I will now make some broader comments relating to the bill, you will be pleased to know, Madam Deputy Speaker.

The DEPUTY SPEAKER: Thank you, member for Victoria Park.

Mr B.S. WYATT: I guess the place to start is really the general public health duty at clause 34 in part 3, which will effectively be established by the passage of the Public Health Bill. I would have thought that the general public health duty might have been in part 1 of the bill and an explanation of how it would be delivered would follow. I quote clause 34(1) —

> A person must take all reasonable and practicable steps to prevent or minimise any harm to public health that might foreseeably result from anything done or omitted to be done by the person.

That is subclause (1), and there are a few other subclauses.

I thank the member for Kwinana for pointing out the following at clause 35, "Consequences of failure to comply with general public health duty", which states —

> (1) A failure to comply with the general public health duty does not of itself —
>
> (a) give rise to any right or remedy; or
>
> (b) constitute an offence.
>
> (2) However, a failure to comply with the general public health duty may constitute grounds for action to be taken under this Act, including the issue of an improvement notice or enforcement order.

A very hefty bill is being created and passed to deliver a very important service to Western Australia, but ultimately there is no right or remedy if the legislation is breached, because there is no offence created as a result. All that is being created is the capacity for the issuing of an improvement notice or enforcement order. That is curious because I noted that the minister's second reading speech made the following point —

> Amongst other things, part 1 of the bill provides for the binding of the Crown. The bill thereby gives effect to the principle that all persons are entitled to the same public health standards irrespective of whether the land or buildings that affect them are owned, managed or controlled by the Crown.

But not really; the next paragraph of the minister's second reading speech makes the following point —

> The bill does not, however, authorise enforcement action to be taken in respect of the Crown.

I am interested in that because I assume that this will apply to Aboriginal Lands Trust lands. For the benefit of Hansard, the minister has nodded back to me in the affirmative. However, no capacity is being created to force the Crown to deliver a service or, to be more precise, to force the Crown to deliver on its general public health duty being created by this legislation. There is the ability to issue an improvement notice or enforcement order. The part of the bill that refers to the enforcement order, being clause 282, states —

> An enforcement order cannot be given under this Act to the Crown in any of its capacities.

People living on crown land are not being given the capacity to force the government to implement its general public health duty, which is curious. The member for Kwinana brought my attention to clause 256, "Minister may exempt the Crown or Crown authority from certain provisions", and here we see the fingerprints of Treasury, which the member for Kwinana no doubt mentioned. Clause 256 states —

> (1) The Minister may, by notice published in the *Gazette*, exempt the Crown or a Crown authority from the application of —
>
> (a) one or more provisions of this Act; or
>
> (b) one or more provisions of the regulations; or
>
> (c) a combination of those things.
>
> (2) An exemption cannot exempt the Crown or a Crown authority from the application of any of the following —

The bill then lists paragraphs (a) to (g), which are areas in which the Crown cannot be given an exemption. Interestingly, subclause (3) states —

> The Minister can exempt the Crown or a Crown authority from the application of a provision of this Act or of the regulations only if the Minister is satisfied that the Crown or, as the case requires, the Crown authority is unable to take the steps necessary to comply with the provision, whether because of a lack of financial or other resources or for any other reason.

Despite the fact that in the second reading speech the minister said that, among other things, part 1 of the bill provides for the binding of the Crown, it does not really. It creates vast opportunities for the Crown to get out of its general health duty to citizens, particularly those citizens living on land that is effectively owned or controlled by the government, which is why I asked the minister whether it would apply to Aboriginal Lands Trust land—and he answered yes. Let us take the example that the budget of the day does not provide sufficient resourcing to provide clean water to a remote Aboriginal community. Under clause 256(3) that is a basis upon which the minister can exempt the Crown from doing that—simply because there is nothing in the budget for it to do so. Because there is no capacity to issue an enforcement order against the Crown, the bill is almost meaningless for those people. I say that because, for a number of years, I pursued the government over the provision of drinking water to the community of Jigalong. That has since been resolved and clean water is now available there, but it took a long time. For a long time that community had to drink water from bottles trucked in, despite the fact that there was a $10 million allocation in the budget that kept getting rolled over and not spent. This provision gives the government an easy way out of its general public health duty—it just does not put the money in the budget. Therefore, under clause 256(3), the minister can exempt the Crown because it does not have the financial or other resources to deliver on that particular duty.

The reason I started my speech tonight with the reference to England is simply that these services must be provided. There are serious repercussions if there is inadequate sanitation; the flow-on effect is disease and death if those services are not provided. It is curious that we are debating an important bill that will update an act in dire need of updating—the current one is from 1911—but pressure is not really being put on the Crown to honour its general public health duty —

Mr F.M. Logan: To all citizens of WA.

Mr B.S. WYATT: — to all citizens of WA. However—I know that the member for Cockburn will make some comments about this—it will not give those people living in remote Aboriginal communities any capacity to demand that the government provide service delivery in the area of public health, which I find surprising. I find it surprising that the government is being given such an easy way out of its obligations under the general public health duty.

I have a couple of points that I want to quickly deal with. There have been a lot of conversations in this place and in the public about the success or failure, or otherwise, of remote Aboriginal communities. I know, Madam Deputy Speaker, that you have been a keen observer of and participant in that debate. General comments have been made about health outcomes, violence, drug abuse and alcohol abuse. We are all familiar with the discussion.

[Member's time extended.]

Mr B.S. WYATT: Interestingly, I want to make a couple of comments about the health outcomes for Aboriginal people living in major cities and how that compares with the health outcomes for Aboriginal people living in regional, outer regional, remote and very remote communities. This is an Australian Bureau of Statistics analysis. Members can have a look. There are standards of error, of course. It is an interesting analysis. It goes through a number of different health outcomes, not just self-reporting, for Aboriginal people living in these areas. We do not have to go far to find reports and analyses that suggest that Aboriginal people living in remote communities generally—we have had conversations in this place about sexually transmitted diseases—have better health outcomes than Aboriginal people living in the larger centres. That is certainly what the Australian Bureau of Statistics suggests in this analysis. I will not go through them all. As members can see, I am not very good at printing Excel documents. I had to use a stapler and some sticky tape to get it all here.

Ms R. Saffioti interjected.

Mr B.S. WYATT: I do not want to hear from the member for West Swan! Can you call her to order, please, Madam Deputy Speaker? I do not want any interjections from my own side at the moment.

The DEPUTY SPEAKER: Member for West Swan!

Mr B.S. WYATT: I want to refer to a couple of points, particularly obesity, and therefore diabetes, and cigarette use and alcohol consumption within Aboriginal communities in the major cities all the way through to very remote communities. For the benefit of those listening at home, the bigger the figure, the bigger the problem. The figures for overweight people are 32.4 people per 1 000 in major cities, 20.4 in inner regional communities, and 21.6 in outer regional communities. But the figures decline dramatically to nine people per 1 000 in remote communities and 13 in very remote communities. There are similar figures for obesity, although they are more stark. The bigger the population that Aboriginal people live in, the more obese they are. If we think about it, that should not be a surprise. Generally, people living in remote and very remote communities tend to have a more traditional diet than perhaps those living in larger centres. The figures for a current daily smoker are 52.5 people

per 1 000 in the major cities, 35.6 in regional communities and 34.4 in outer regional communities, and they decline dramatically to 15.4 people per 1 000 in remote communities and 29.9 in very remote communities, which is a bit higher. I will not go through them all, as there are heaps of them, but they all show the same trend. The more remote the place that people live in, the better their health outcomes will be. I want to put on the record the figures for alcohol consumption. Basically, the figures for those with a long-term risk of high consumption are 16.5 people per 1 000 in the major cities, nine in inner regional communities and 10.7 in outer regional communities. The figures decline to 5.3 people per 1 000 in remote communities and 5.8 in very remote communities. Those figures are based on the 2001 National Health and Medical Research Council guidelines, but, based on the 2009 NHMRC guidelines, the figures for those exceeding the lifetime risk guidelines again decline from 26 people per 1 000 in the major cities to 7.3 in remote communities. I have been critiqued for perhaps being obsessed with statistics and reports of statistics and figures and facts —

Ms M.M. Quirk: As opposed to the bigger picture.

Mr B.S. WYATT: Yes, as opposed to the bigger picture. The reason I do that is maybe, as a lawyer, I am a bit obsessive and I look at the facts in these debates. I accept, as does everybody in this place, that remote communities have significant problems. We all accept that. One of those problems is, of course, the delivery of services by government. Government is not very good at that. Let us not blame it all on the Aboriginal people. I dare say that one of the reasons the government is being given the big out in the Public Health Bill 2014 is that it is not very good at that.

This is the Australian Bureau of Statistics analysis. I accept that we can probably critique the statistics on their size, and the standard of error et cetera, but it shows a very clear trend across a number of different areas. We hear it. People say that the reason they moved to a remote community is that they had to get out of town; they are getting away from the alcohol and the abuse or the dysfunction. The ABS analysis proves that point. We need to be a bit careful in the debate. Some have simply said that all those communities have failed and are delivering terrible outcomes, but we have to understand that if they are shut, some of these statistics will start to change—for the worse. This has been the point that I have tried to get into the Premier's head. It is not as simple as saying that these homeland communities have failed and they have to be closed. I was pleased with the change in rhetoric last week. But the ABS makes the point that there are also positives in these communities that we want to capture. We want to make sure that, if people are being moved and services are being cut, we capture those positives as well so that those trends are not then reversed. It would not take much, Madam Deputy Speaker. You know better than most in this house that it would not take much for those trends to go the other way.

Mr F.M. Logan: Can I suggest, member for Victoria Park, that you email them to the police commissioner as well?

Mr B.S. WYATT: For anyone who is interested, the ABS does incredible research and it is always useful to look at what it puts out. The ABS, the Productivity Commission and our own economic regulator put out brilliant, interesting and informative pieces of research that I sometimes think are perhaps ignored in places such as the Parliaments of Australia.

I want to conclude by re-emphasising a couple of points. It is an important bill, and the member for Kwinana has gone through it in greater detail than I have done or intend to do. We are not really putting any bite on the government to honour its general public health duty, and let us not pretend otherwise. We have given the government a big way out—that is, to simply move money around in the budget to make sure the resources are not there and the minister can make sure it is not provided. I do not think that is what people expected. I think the minister said it took 10 years to get this legislation here —

Dr K.D. Hames: I think it is longer than that—20 years.

Mr B.S. WYATT: It took 20 years to get to this bill. It is a complicated bill, I understand that, but we are giving the government an easy out in terms of its obligations to deliver on that duty. I make that point particularly with people who live on Aboriginal Lands Trust lands in mind who will not have the capacity to force the government to deliver on a very, very important duty.

MR F.M. LOGAN (Cockburn) [9.50 pm]: I would like to continue on the theme that has just been enunciated by the member for Victoria Park in his discussion about the Public Health Bill 2014, which we are debating here tonight. Part 1, clause 3 refers to the objects and principles of the act. Clause 3(1)(i) states quite clearly that one of the objects of the act is —

> to reduce the inequalities in public health of disadvantaged communities …

We could not get any more a disadvantaged community than those 84 communities that were referred to in the Western Australian Auditor General's report released last Thursday on the ineffectiveness of the government in

delivering essential services to remote Aboriginal communities. Those 84 communities are listed at the back of that report, and I will come back to that in a second. This legislation binds the Crown specifically for the purposes of the enforcement of the provisions of this bill. Although clause 3 deals with only the objects and principles of the act, in part 13, division 3, "Enforcement orders", clause 205(1) deals with —

> An enforcement agency may give an enforcement order to a person if the agency reasonably believes that —
>
> …
>
> (b) the issue of the order is necessary to prevent or mitigate a serious public health risk.

Therefore, clause 5 binds the Crown and clause 3(1)(i) sets out to deal with the reduction in the equalities of public health in disadvantaged communities. But if we see in those disadvantaged communities a serious public health risk, and that was identified in the Auditor General's report that was released on Thursday, is it then possible for any remote community that receives services from the state government to use this legislation to bring a change to its position by seeking to have the Department of Health and the minister bring an order for that change to ensure that a serious public health risk is averted? It is possible for that to occur unless, of course, the minister, as pointed out by the member for Victoria Park, gives an exemption for the Crown to be bound by that provision. That exemption referred to by the shadow Minister for Health and also the member for Victoria Park is contained in clause 256(3). The member for Victoria Park read it out and I will do the same —

> The Minister can exempt the Crown or a Crown authority from the application of a provision of this Act or of the regulations only if the Minister is satisfied that the Crown or, as the case requires, the Crown authority is unable to take the steps necessary to comply with the provision, whether because of a lack of financial or other resources or for any other reason.

That is the get-out clause for the minister of the day to refuse any action being brought by a remote Aboriginal community that would require the Department of Health to enforce orders to mitigate serious health outbreaks. If we then go to the likelihood of a serious health outbreak, we could not get a better example of that than the work done by the Auditor General in his overview of the services to remote communities, which I referred to and was released in this house last Thursday. The summary in the Auditor General's report referred to water quality and states that 80 per cent of the communities assessed did not meet Escherichia coli and Naegleria levels at least once—not that I know what Naegleria is but I am sure when the minister comes back he will tell me. I certainly know what E. coli does to children having had a friend who lost his firstborn daughter to an E. coli outbreak on a remote outback station here in Western Australia, which was a horrendous and long lingering death for this poor young child. The report states that some communities repeatedly failed to meet water standards, that one in five communities exceeded safe levels for nitrates or uranium in their water, and that the inadequate testing of wastewater systems is creating health risks. That was simply the overview of what the Auditor General referred to. In the briefing that the Auditor General provided to members of the house, he went into more detail and said that the Pilbara over the two-year period in which the Auditor General's staff reviewed the issue of water quality in those remote communities, had seven fails in the testing. In one community the testing failed three times during that two-year period. The goldfields had eight fails in terms of water quality, and the Kimberley had 13 fails over that two-year period in water quality. In one community the testing of water quality failed 11 times in that two-year period. Because of that, many communities have to rely on bottled water, but that still provides a serious risk of exposure to serious diseases, particularly for young children and elderly people. Minister for Health, I referred earlier to E. coli but I am not too sure about Naegleria. Perhaps the minister can tell me exactly what that is. For the sake of Hansard, it is N-a-e-g-l-e-r-i-a.

Dr K.D. Hames: I have not heard of it. The Minister for Planning says it is a bacterium.

Mr F.M. LOGAN: It is a bacterial disease.

Mr J.H.D. Day: If I remember rightly it caused a major problem in Sydney about 10 years ago.

Ms M.M. Quirk: That was cryptosporidium, was it not?

Mr F.M. LOGAN: Yes. I am sure, given the concerns raised by the Auditor General, that whatever it is, it will be no good for anybody whatsoever. I will just spell it again for the minister so that he can google it. It is N-a-e-g-l-e-r-i-a.

Those are some of the issues relating to the water quality of the 84 communities assessed by the Auditor General. Remember, there were only 84.

Dr K.D. Hames: It is a protozoa, not a bacteria.

Mr F.M. LOGAN: Protozoic. I am sure Dr Hames, once he is finished reading his research on Google, will present an overview of Naegleria to the house and its protozoic qualities.

Dr K.D. Hames: It's also known as a brain-eating amoeba.

Mr F.M. LOGAN: Charming! That goes to the point I am talking about—it is a serious health outbreak. The Minister for Health has just advised us that it is also called a brain-eating disorder.

Ms M.M. Quirk: Amoeba.

Mr F.M. LOGAN: A brain-eating amoeba.

The issue I am bringing to the house is that the Auditor General of Western Australia found that that brain-eating amoeba and E. coli bacteria are present in 60 per cent of the communities that receive services from the Western Australian government. If that is not a public health risk, what is it?

I ask the Leader of the House whether we are rising at 10.00 pm.

Mr J.H.D. Day: It is when you are finished.

Mr F.M. LOGAN: The reason I raise those issues is that the exposure of young and elderly people in remote communities to those protozoics and microbial diseases is not only horrendous, but also preventable. The only organisation that has not prevented them is the government of Western Australia, which is being paid by the federal government to provide services to ensure there is clean drinking water and an appropriate sewerage system in these remote communities. We have heard from the Auditor General that those services have failed completely—failed completely! In referring to the sewerage systems, the Auditor General's report states —

> The lack of testing means that Housing could not always know if wastewater systems were effective. Ineffective systems can result in blockages and even sewage overflows, which can directly impact on community health.

The report further refers to Jigalong. The member for Victoria Park quite rightly informed the house that the water quality for drinking is now safe in Jigalong because of the purification system that has been put in place courtesy, I believe after many commitments, of royalties for regions. However, member for Victoria Park, the problem is that the sewerage system is not working properly. Photographs are provided by the Auditor General to prove the point. Jigalong's extensive wastewater ponds, including two overflow ponds, are attractive to both wild birds and animals, but also to children. The Auditor General's report states —

> Large animals such as camels may damage fences to get at the water. Stakeholders told us that children have been known to climb the fences to hunt the ducks that frequent them.

That is, the ducks frequent the sewerage ponds. Over a number of days when the inspection was undertaken, the Auditor General found that the fence was intact but the gate was open, making it easier for the kids to get the ducks that go onto the sewerage ponds. By way of verbal explanation of that, the people involved in the inspection said in the briefing that in their discussion with some kids and adults at Jigalong they found that the kids regularly run into the sewerage ponds to try to capture the ducks, which they then proceed to eat. How can that not be an infectious diseases issue and a serious health risk? The sewage ponds have an open gate that allows the children to go in there. How is that not a serious health risk? It certainly would not happen in Perth but it happens in quite a number of remote communities in Western Australia. Who caused that problem? It is the very organisations that are there to provide services to them—the government of Western Australian and the Department of Housing. The report handed down by the Auditor General refers to how that contract for the provision of services to those remote communities, which has been in place for quite a number of years, has not worked. Even though it states that in the Auditor General's report, we found out, by asking the Auditor General who was responsible for managing this program, that it was none other than Parsons Brinckerhoff. Parsons Brinckerhoff is a very large maintenance contracting company, which, I think, is based quite close to Parliament House, in West Perth. It is normally involved in project management on major resource projects—mining and oil and gas projects—but for some reason it also has the $1 million a year project with the Department of Housing to program manage the delivery of those services to those remote Aboriginal communities.

[Member's time extended.]

Mr F.M. LOGAN: The Auditor General's report found that although under the contract Parsons Brinckerhoff was paid $1 million a year by the state government, it hardly ever properly managed the contract. Also, the service providers that Parsons Brinckerhoff had contracted to undertake the work were left to communicate with the Department of Health. Therefore, the program manager was cut out of the loop completely and did not know what was and what was not being done. When Parsons Brinckerhoff put to the department that it should do some

inspections in various remote communities, Parsons Brinckerhoff was told by the Department of Housing that it did not have the money to do that, so nothing was overseen and none of the contract was properly audited by the program manager to see whether those services were actually carried out in the first place. It is no wonder that the water systems do not work and that the Auditor General made such criticisms about the wastewater systems and their likely impact on the public health of people living in those remote communities.

The money paid totals $14.7 million per year for the delivery of these services. In many of the cases identified by the Auditor General, many of the services to remote communities were not carried out. Some were poorly carried out, and in a number of cases, because there was confusion in the Department of Housing about who was supposed to be on the list for essential services and who was not, the Department of Housing was not even sure that the right communities were receiving the right services. Even after the audit undertaken by the Auditor General, nobody is really quite sure whether some communities were serviced when they should not have been serviced and other communities were not serviced when they should have been serviced. It is no wonder there are public health issues in remote Aboriginal communities.

I have been told personally about a number of contractors working under the Parsons Brinkerhoff project but I am yet to find out more about the way in which they failed to carry out their work on behalf of the Department of Housing and Parsons Brinkerhoff. When I do, I will bring that information to the house as well. However, there is certainly enough in the Auditor General's report to highlight the disgraceful way in which public moneys were wasted and that fraud may well have occurred because bills were put in for work that was not done. The only people who have suffered as a result of that are the very inhabitants of the remote communities that the Barnett government wants to close down.

When we come back to the relationship between the Auditor General's report and the Public Health Bill 2014, surely there is enough in the Auditor General's report to highlight that there have been risks to public health due to the failure of the state government and the Department of Housing to properly provide services to remote communities. Therefore, under this legislation, would those communities not be able to seek redress or seek an order from the government to ensure that they and their health are protected while living in those remote communities? It should be remembered that their health has been undermined because of a lack of servicing by the state government. Do they have the capacity for redress under this bill? The member for Victoria Park and I have referred earlier to the exemptions that would probably allow the minister to exempt the Department of Health from being bound by the issuance of any order or penalty as a result of the health issues that have been created in those remote Aboriginal communities.

I would like the minister to respond to my comments and the comments of the member for Victoria Park about the relationship between the binding of the Crown and the section to which I referred on the nature of very serious health risks, and about the exemption provision. In particular, I would like the minister to explain how those provisions of the act can be read in light of the disgraceful situation that has occurred, and the health risks that have been created and that the Auditor General has notified this house of, as a result of the failure of the Department of Housing to properly manage its contracts for essential services to the remote communities of Western Australia.

Debate adjourned, on motion by **Mr J.H.D. Day (Leader of the House)**.

House adjourned at 10.14 pm