HEALTH SERVICES BILL 2016

Third Reading

MR J.H.D. DAY (Kalamunda — Minister for Health) [4.24 pm]: I move —

That the bill be now read a third time.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4.24 pm]: Mr Acting Speaker, before I start, can I clarify how long I can speak on this bill? It is 30 minutes.

The ACTING SPEAKER (Mr N.W. Morton): It is 30 minutes, yes.

Mr R.H. COOK: I would therefore like to thank the opposition Whip, as I have prepared a speech of about 15 minutes!

Mr J.H.D. Day: That is fine!

Mr R.H. COOK: I could speak slowly.

Mr J.H.D. Day: Quality is better than quantity!

Mr R.H. COOK: You never know your luck, minister; it could be!

I am very pleased to rise to speak on the Health Services Bill 2016, which we had the opportunity to discuss in great detail. Obviously, one of the reasons we got that opportunity was that, once again, we utilised the second chamber, which allowed members on this side of the chamber to cross-examine at length the former Minister for Health and his advisers about the provisions of the bill. I take the opportunity to thank the former Minister for Health—although I am not reflecting on the current Minister for Health—for the way he handled the bill. I think I can speak for all members of the Legislation Committee when I say that he provided ample opportunity for us to discuss each of the clauses that we were concerned about and, in doing so, he was also prepared to back the judgement of the committee in the face of contrary advice from the advisers and make some changes to the bill. It was very pleasing that the minister had the confidence to take some of those changes on board and, as a result, we have made some changes to the bill. I think the member for Mirrabooka in particular was most effective in getting some of her amendments up. It is pleasing that we were able to influence the legislation in that way. In discussing the process in the second chamber, I should say that it puts a lot of pressure on the advisers because it means that we can ask about detail directly of the advisers and engage in that manner rather than, as you would be familiar with, Mr Acting Speaker, in the consideration in detail process in this place whereby there is a more stilted debate because all answers have to go through the minister. In engaging in that way, we were able to get into a great deal more useful, constructive and detailed debate.

I also put on record my appreciation to the director general of the Department of Health, Dr Russell-Weisz, and his staff, Ms Rebecca Brown and Ms Robyn Daniels, and others from the Parliamentary Counsel's Office. I mention those advisers in particular because they always made themselves available to give advice on this bill, including having one meeting on a Sunday afternoon, which I thought was well and truly above and beyond the call of duty. It was good to get that detailed advice.

It is true that we have some significant concerns about the timing and manner of this legislation. What we were able to ascertain in the Legislation Committee is that this legislation will add extra administrative costs to the department. If that came at a time when the department was not under extreme budgetary duress, perhaps we could say that we could afford the extra fat to spend the extra half a million or million dollars on a governance model and governance principles and that that would be a good investment for the smooth running of the department. However, of course, at this time in the debate, the department is not only under extreme budgetary stress, but also subject to savage cuts by this government to not only services, but also staff, which has been confirmed by departmental spokespeople in the media and by the minister's advice to this place during question time today. In fact, 717 full-time equivalents will be removed from the Department of Health in the coming months. Of those, 359 alone will be at Fiona Stanley Hospital. We therefore ask ourselves: Is it the right time for the minister to be spending money on sitting fees for board members and extra administrative staff to look after these boards? Is it the time for the minister to be making this sort of gesture? I know we are not talking about the same sort of numbers, but how these things are perceived is very much a matter of politics. I do not care whether he believes that telling someone their contract has expired and their services are no longer required is technically speaking not sacking. I think it is. We know there is still work to be done but because of the way many employment arrangements are made nowadays, many staff are on contracts. Because these people are being sacked, as we claim they are, two events are occurring: firstly, a department is stripping itself of over 700 staff

and, secondly, a minister is putting through this house of Parliament the Health Services Bill, which will increase the financial burden upon the Department of Health. We are quite rightly questioning the government's motives, timing and intent concerning that because it must be galling to the staff in our wards who see their colleagues being removed from their positions. It must be galling to nurses who look around and see no ward clerk because they are not allowed to replace their ward clerks during the day. It must be galling to staff who have to explain to patients that the paediatrician they normally expect to see on roster at five o'clock on a weekday is not there and cannot be replaced. It must be galling to staff to see a government act in this manner, ripping as it is into the fabric of the health department and its services while at the same time furnishing itself with a nice piece of legislation that will allow the minister to appoint some friends to some boards and, essentially, bulk out the department's administrative costs. The minister will say that the numbers are not of great consequence.

Are you feeling lonely, as I am, minister?

Mr D.T. Redman interjected.

[Quorum formed.]

Mr R.H. COOK: It is good to have everyone back. I am sure the Leader of the Nationals is pleased to have everyone come and join us.

As I was saying, it must be galling to people who see what this government is doing to the health services and the health workers of this state in passing legislation that will impose extra costs on the department. These extra costs will not pay for additional staffing, improved equipment, extended clinic times or extra operations. The money associated with this bill will quite simply pay for the department's administrative overheads. That will build in fixed costs to the department, and that means the department will have to cut even more deeply into the health workforce to achieve the budgetary restraint the government so desperately craves now that it has wrecked the state's finances. As I said in my second reading contribution, this sign that says "Due to staff shortages, the ward will not have a ward clerk available to cover today", has been issued to all ward clerks at Fiona Stanley Hospital because they know that if a ward clerk is sick, on leave or cannot for some reason staff the ward on the day, there will be no-one to replace them. On the one hand, the minister is furnishing himself with these luxurious boards while on the other hand a department is being cut to the bone. The Australian Medical Association says that the department's resources, leanness and budgetary performance are already drum tight.

It is not surprising that we come to the third reading debate in this place with some significant concerns about this legislation. Of course, in the Legislation Committee stage, and via some briefings, we learned—we were all a bit confused about why it took so long for this legislation to come to this place—that the minister has already appointed interim board members and interim board chairs because it was anticipated that this legislation would be in place much earlier. It is anticipated that those interim board chairs and members will be appointed to their substantive positions once this legislation has been passed, which is expected to be by 30 June. However, this legislation took a long time to come to this place and now we understand why. It is because the previous Minister for Health was obsessed with establishing the East Metropolitan Health Service Board and the East Metropolitan Health Service division as part of this legislative process. That is fine; we can do that but there is an implication from that; namely, that we build in further fixed costs, further cost overheads—further administrative burdens on a department when, as I said, this current minister wants to sack over 700 staff. Further administrative burdens will be put on the department while, in a budgetary sense, the department is itself under attack from the current minister. What a great parting gift from the former minister, Minister Hames, to Minister Day in saying, "Okay, Minister Day, here's the portfolio. By the way, I've wrecked the budget and built in a few fiscal booby traps for you, so we've now increased the fixed-cost element of this department, and congratulations you'll have to cut more staff. Anyway I have to go fishing. Thanks for your time and thanks for your patience; I'm out of here." In sporting parlance, what an extraordinary hospital pass to send across to Minister Day and what a debacle of a portfolio for him to inherit. We know Minister Day was a reluctant recruit to the health portfolio. I do not know why; it is a great policy area.

Mr J.H.D. Day: I was neither actively seeking the role nor reluctant.

Mr R.H. COOK: If he was agnostic, as he claims he was prior to his initial briefing, I can imagine that after his initial briefing from the outgoing minister from his senior departmental official, he said, "What? We're creating a whole new board and you want me to sack how many staff? You want me to create another board and we are what over budget?" He would have said, "Let me get this straight, Kim; you want me to employ a whole lot of new board members while at the same time you want me to sack a whole bunch of ward clerks, a whole bunch of nursing staff and a whole bunch of cleaners and other people, but, hang on, you want me to appoint and to pay a whole new board in the system." Kim would have said, "Yes, that's right, John; it's a great idea, isn't it?"

Minister Day would have said, "I bet part of your harebrained idea is that this whole new health services board has its own tertiary hospital, its own cancer services, its own trauma centre." Minister Hames would have said, "Yes, that's right, John." Minister Day would have said, "Kim you're mad." But this is the department the minister has inherited. I understand that it is the government's prerogative to establish a new framework of governance for the Department of Health. I can understand that it looked at a map and saw that Royal Perth Hospital sits there, Sir Charles Gairdner Hospital sits there and Fiona Stanley Hospital sits there. Three hospitals and the Child and Adolescent Health Service board and the WA Country Health Service board—it is a lot of boards, but it makes sense; on the map it kind of makes sense.

Let us be acutely aware throughout this debate that there are costs associated with these decisions. We understand that the extra costs are in the order of $500 000 to $1 million. On Thursday, we will see the budget brought down. Hopefully, part of that budget will redress one of the two big blights on our health services—that is, Graylands Hospital and the Quadriplegic Centre. We know that the government through successive decisions has forgone the opportunity to rescue the poor patients stuck in Graylands Hospital and for year after year the opportunity to redevelop Osborne Park Hospital, which has now disappeared out of the forward estimates. The government has wrecked the finances and spent $500 million on Elizabeth Quay. That is $500 million this minister cannot spend on patients in substandard facilities at Graylands Hospital. The minister has forgone the opportunity to redevelop that hospital. Although this minister was responsible for spending half a billion dollars on Elizabeth Quay, we know that he will not spend a brass razoo to rebuild the Quadriplegic Centre.

Mr J.H.D. Day: You're being very economical with the truth on a number of aspects.

Mr R.H. COOK: No, I am not. Although the minister is fresh to this portfolio in this term of government, I have been there year after year. I asked the honourable Graham Jacobs those same questions when I was shadow Minister for Mental Health, and I have asked Hon Kim Hames those question every year. Why has the government deferred upgrading Osborne Park Hospital to improve mental health facilities and to create the capacity to close wards, such as Smith and Murchison, at Graylands Hospital? Why not pull those patients out of Graylands Hospital so that there is a redevelopment opportunity there? I asked ministers why they continually deferred that decision and they said that it was not their priority yet. They would push out that decision year after year. Towards the end of his time in the role, the acting director general of Health, Professor Stokes, would wring his hands and say that what we were doing to those patients was dreadful and the facility should be retired. The retirement of that facility was entirely in government members' hands. The government decided not to retire that facility. The government decided that it had other priorities. On Thursday, the government will demonstrate again that it has priorities other than the Quadriplegic Centre. We know from the previous Minister for Health's public utterances that he has presented multiple business cases to the current minister and other cabinet colleagues about redeveloping the Quadriplegic Centre, which have been ignored or rejected. We know that the previous Minister for Health went about undertaking an extensive review of the Quadriplegic Centre in 2015 and that that report is before the minister at the moment, and that the minister will take the opportunity on Thursday to do yet another report.

It is interesting that the only money the government can afford to spend on the Quadriplegic Centre is pretty much the same cost that with a stroke of a pen today we will provide the Department of Health to construct these new boards. Does that not speak volumes about the morality and the priorities of this government? Minister Hames had known for some time that the Quadriplegic Centre was in need of upgrade. He said, on the record, to the media, that failure to upgrade or rebuild the Quadriplegic Centre would mean that he had failed as a minister. In October 2015, he said that he would be taking a business case to and responding to that business case in the 2015–16 budget. Clearly, the previous minister was under a very apparent expectation that this would be the year that the government would actually do the right thing and redevelop the Quadriplegic Centre. Something has gone dreadfully wrong in the exchange of the health portfolio between ministers, because we have yet another consultant's report under the new Minister for Health. The new minister has sort of learnt from the old minister that if there is a political problem, he should get Professor Bryant Stokes to do a consultant report. If there is a crisis, such as there is in the mental health portfolio, the government gets Professor Stokes to do a report. If there is a crisis in the management of a public hospital, such as the Peel Health Campus, the government gets Professor Stokes to do a report. Now that we have a crisis in the Quadriplegic Centre, the minister has gone back to the old Barnett government health portfolio trick of getting Professor Stokes to do a report. We know that the time for reports is over. This government has considered multiple business cases and we know that it is in possession of a report undertaken last year that provides extensive planning and recommendations about what is required in a new Quadriplegic Centre. This area of the health portfolio does not need another report; it needs a minister who is prepared to take action. We have seen that this minister is prepared to bring legislation into this place that will create a new board and new costs associated with the

Department of Health, but he is not prepared to take action on the Quadriplegic Centre. This issue is about priorities.

Mr J.H.D. Day: That is clearly not what I said.

Mr R.H. COOK: The minister has made it quite clear in the media and in question time today that he would be seeking further reports on the Quadriplegic Centre. The minister has made it quite clear through his dampening of public expectations that there will be no money in the budget for the redevelopment of the Quadriplegic Centre other than for the engagement of further reports.

I know that the minister is new to the portfolio, but this is not a new policy issue. This issue has been brewing for a number of years, and, perhaps, we are to blame. I think the Quadriplegic Centre first put up its hand in 2004 and said that this is an issue, but it is no longer an issue; it is a crisis that the government has had front and centre of its cabinet deliberations. I think the minister agrees with me that the time is over for further consultant reports. It is now time to put substantial dollars into capital works at this centre to bring it up to standards that meet modern-day expectations in terms of caring for those people.

I say this by way of background, because we said at the beginning of this debate that we oppose legislation that does little more than create a board coming into this place at a time when we are under such fiscal demand. The legislation does little more than create an extra metropolitan health service area and its financial impact will be an extra cost burden on the department. We had an opportunity to go through the legislation in detail, and, by and large, I agree with the framework the government has put in place. It is unrealistic to expect that a department with a budget of $8 billion can be driven from a single policy point of leadership; that is, to expect a single director general of Health to be able to control this behemoth of a department with its multiple cost centres is simply unrealistic into the future. We have to find a new way to move forward.

The Health Services Bill 2016 mirrors legislation in other states, and many of the reforms around hospital trusts in the United Kingdom's National Health Service. I think a fairly good balance has been struck by not going to the bizarre lengths that Victoria has, where something like 28 boards manage its hospitals. Nevertheless, extra boards will be created that will result in extra cost burdens on the department.

Mr J.H.D. Day: How many do you think there should be, if any?

Mr R.H. COOK: I would have started with two—north and south.

Mrs G.J. Godfrey: We need one in the east.

Mr R.H. COOK: I think that is probably correct, member, but I suspect we are between five and 10 years ahead of needing one in the east. But if there is one now, we can grow into that and that is fair enough. The member for Belmont was in this place when I said that the implications of extra boards are the building of extra cost structures. Sure as eggs are eggs, the east will say, "The south and north have these services and we should have them in the east." The challenge for the government and department leaders will be to say, "Hang on; it's probably true that they have this service at Joondalup and at Fiona Stanley Hospital, but that doesn't mean that you need that service at Royal Perth Hospital." We have seen how empires are created inside the health system. It will be a huge challenge to stop the duplication of services that will inevitably happen. The clinical services framework process will now be even more crucial and have to be even more tightly managed to make sure that we do not get that service creep—that might be a way to describe it. Managing the expectations of the boards in that process will be a very difficult task indeed.

Mr J.H.D. Day: It sounds like you are very supportive of reform; that is good to hear.

Mr R.H. COOK: I am absolutely supportive of reform. I have said that a lot of elements of this legislation are commonsense, and if we could do that outside the political prism of cuts to literally hundreds of staff, that would be a very much better situation in which to find ourselves during the reform agenda.

There will also be some challenges around the activity-based funding model for hospitals. Before, there was perhaps an incentive for hospitals to manage activity inside their facilities. There will now be an element of them being encouraged to create activity to maintain their budgets.

Alas—I am sure the minister will be disappointed to hear this—I am running out of time. This legislation comes at a time of vicious budget cuts. The people paying that price will not be board members or the minister constructing the boards under this legislation; they will be the staff now being sacked and the patients who will experience a consequential decline in the services offered to them. It is unfortunate that the government has seen fit to increase the financial administrative burden on the department at a time of cutting services and staff in the health department.

MS L.L. BAKER (Maylands) [4.54 pm]: The debate on the Health Services Bill 2016 has been, I think, very productive. I greatly enjoyed the committee room stage, during which we drilled down into the aspects of the bill that concerned us. I will speak about one concern around the Health Services Bill 2016 and reiterate some of what I said in my second reading contribution. I agree that a decentralised model looks like it is the best way to pursue funding the sector, but of great concern to me are the problems or challenges around how policy outcomes will be driven down through the whole network.

I particularly want to talk about children, because of the five boards proposed to be established that we heard referred to in a previous debate—including the North Metropolitan Health Service, the East Metropolitan Health Service, the South Metropolitan Health Service and the WA Country Health Service—of particular interest to me is the Child and Adolescent Health Service. I raise the issue of children's health because I think we have all recently been recipients of the foundation paper titled "The Valuing Children Initiative". I will use the reference material provided in that paper in referring to the state of children's health in Western Australia.

Where did the Valuing Children Initiative come from? The author of the foundation paper is Linda Savage, who, until last year, was a member of the upper house. She has probably been one of the most formidable advocates of early childhood education that I have seen in this Parliament in my eight years as a member. She is a truly remarkable woman with a very large intellect and a very large passion for and commitment to seeing the benefits of early childhood education realised.

Mr J.H.D. Day: It's a pity she's not a member of the Legislative Council still.

Ms L.L. BAKER: It is indeed.

Mrs G.J. Godfrey: Hear, hear! She was very good.

Ms L.L. BAKER: I miss her; she is a good friend as well as a valued expert.

I turn to the Valuing Children Initiative foundation paper to cite some of its information. I am sure some members have had the chance to read this paper on child health and wellbeing. The initiative was created by two people, the friendship and support of whom over my years in the sector I reflect on dearly. One is the wonderful Tony Pietropiccolo, who I think now uses a calculator to work out how long he has run Centrecare—I think it was 30 years some time ago. He has run Centrecare, on behalf of the Catholic Church in Western Australia, with remarkable efficiency and great love from his staff. When he was president of the Western Australian Council of Social Service and I was CEO, he would spend many hours explaining the ins and outs of the Catholic Church. In answer to my somewhat naive questions about why we do not have nuns anymore, he would embark on a three-hour lecture, over lots of very good strong short black and espresso coffees, and give me his take on that. He always said to me that until we were prepared as a society to lift the carpet and look underneath it, we would never be able to confront some of the more distasteful and, indeed, quite horrific aspects of child wellbeing in this country. I know his commitment has been very deep and very ongoing. Basil Hanna, who runs the Parkerville Children and Youth Care facility, has done remarkable work in this state. I am probably stretching it to say that the George Jones Child Advocacy Centre at Gosnells is particularly Basil's model because child advocacy centres using that model have been rolled out all over the developed world. They have proved to be invaluable in tackling the reporting of child abuse and strengthening the health and wellbeing of children through the bringing together of multidisciplinary services. They provide a friendly environment where children can feel confident that they are welcome and will be heard. Basil's commitment through Parkerville Children and Youth Care and his boards, and Tony Pietropiccolo's commitment through Centrecare and his long investment in the health and wellbeing of children came together to form the Valuing Children Initiative. The initiative reflects the growing concern in our community that, despite compelling evidence about what a child needs to flourish, this has not always successfully translated into action, into resources and, indeed, into even better outcomes for children.

It is important to recognise the positives and the capacity for progress. The marked improvements in the rates of survival at birth and in infancy and the decrease in cancer-related deaths amongst children is also notable. There has been a significant decline in the number of accidents and deaths in childhood, and life expectancy has improved for most children overall. Australia is ranked in the top third by the Organisation for Economic Co-operation and Development for approximately one-quarter of indicators for child and youth health and wellbeing. It leads the world in low youth smoking rates, some educational and employment outcomes and environmental conditions at home.

Despite these achievements, there are significant areas of concern for the health and wellbeing of children. The latest Australian Research Alliance for Children and Youth report card, "The Wellbeing of Young Australians", was published in 2013. Based on empirical data from a range of organisations, and input from more than

37 000 children and young people about their hopes, needs and desires, it reported that despite many positive steps being taken, there is evidence to suggest Australian children and youth are not faring as well as they could. In an international context, Australia could best be described as middle-of-the-road, and that is pretty sad, really. In relation to the health services framework that we move forward under, I think it underwrites why I am so concerned that the policy directions of this government and future governments can be appropriately relayed out through a decentralised system and guide the work that is being done at a local level through our health system.

Comparative indicators across OECD countries show that Australia is not doing so well in the areas of child poverty; infant mortality for certain groups of newborns; youth participation in education and employment; the incidence of diabetes, obesity and mental illness; the sexualisation of children; and a lack of school readiness. One in four Australian children are overweight or obese. Those figures should be of grave concern to our health system, and, indeed, to our whole society; it is not just the health system that should be concerned. In Australia, almost one-fifth of children live below the poverty line and Aboriginal and Torres Strait Islander children continue to bear a far greater burden of our failure to protect children and to provide them with a good childhood. We have only to open the newspaper or turn on the radio to hear the dreadful consequences of some of the trauma that our Aboriginal children face every day.

In the last two decades we have seen reports on the revealing and shocking extent of the sexual abuse of children in institutions and in their own homes. Indeed, Peter Blaxell's report into St Andrew's Hostel, Katanning, which was brought into this Parliament some eight years ago, was scathing in its view of the abuse that had taken place in that hostel and went a long way towards saying how we could avoid this happening in the future. My concern is that we are still not in a position to unequivocally say that things are better for children in Western Australia. We really cannot hold our hand on our heart and say that children will be listened to and given any more credibility now than they were 20 years ago when the dreadful abuses that we read so much about were being perpetrated in St Andrew's Hostel against those children by trusted members of the community.

The Royal Commission into Institutional Responses to Child Sexual Abuse commenced in 2013 and is due to report in 2017. The level of abuse that is being reported would probably be shocking to most adult Australians. The National Children's Commissioner, in her "Children's Rights Report 2015", estimated that one in 28 children first experience sexual abuse by a family member before the age of 15 years. Notifications to child protection services in Australia have increased in the last three years, as well as the number of substantiated cases. Of the more than 40 000 substantiated cases of neglect and emotional, physical and sexual abuse, more than 5 000 were cases of sexual abuse. The commissioner commented that it was likely that these figures were an underestimation of the number of children abused and neglected. She is quoted in the Valuing Children Initiative's "Foundation Paper April 2015" as saying —

> *'Australia is a wealthy nation that ranks well in comparison with other developed countries on many measures of health and wellbeing. However, evidence indicates that many children and young people face a range of issues including behavioural and emotional problems and mental health issues, living in jobless families, witnessing or experiencing violence in their family, starting school poorly equipped to learn and being homeless.'*

The Valuing Children Initiative points to a number of issues. The modelling of the long-term economic benefits of investing in children to give them a good start in life and the support they require while growing up provides more evidence that enhancing the lives of children and helping them reach their potential benefits not only children but also the whole community. Social and wellbeing outcomes are increasingly recognised alongside economic indicators as a measure of a nation's success. I say again that children and young people's health is critical to the overall success of the community. Therefore, the kinds of policies we see coming out must be well managed throughout the community. We currently do not have a system in place in Western Australia for looking at our legislation through the lens of how it impacts on children. That is how the human rights legislation in Victoria works, for example; it is also how human rights legislation works in other countries. It provides a framework for viewing legislation. It does not necessarily mean that governments do not pass legislation because it does not comply with human rights legislation; it means that when legislation is brought to Parliament, we can tell Parliament why it is that the legislation sits outside what would normally be acceptable human rights standards. I think that is a good model to think about in this state.

Over the last decade, states and territories have legislated to establish statutory bodies headed by commissioners and guardians for children and young people. Our inaugural Commissioner for Children and Young People, Michelle Scott, was appointed in 2007, and the new commissioner was appointed only recently. We very much look forward to seeing how he influences the health and wellbeing of children in Western Australia into the future.

People working at the coalface of child health and wellbeing understand that in tackling the most basic responsibility to protect children, they cannot do it alone. They cannot simply on their own provide all the support required by families in need and reduce the risk of child abuse and neglect if they act as an island. Child protection approaches now recognise that protecting children is, indeed, everyone's business, and that parents, communities, governments, non-government organisations and businesses all have a role to play. The question we need to ask is, as I said earlier: have attitudes to children evolved to keep pace with what the community expects for children, what it believes they deserve, and what children have a right to expect? It is not an easy question but, as Linda Savage points out, it is a question that must be asked if we are to move closer to the goal of ensuring that all children have a caring, safe and supportive childhood. It is a question made even more urgent in the face of the stark knowledge of our failure in many areas to protect children from abuse.

What we need to consider with regard to the Health Services Bill 2016 is how we make sure that the policy environment going forward with devolved boards will include very strong links back towards the kind of community that we want to live in, how we want children to be raised and cared for, and how we want to protect them in their journey to adulthood. In my contribution to the second reading debate, I specifically mentioned how we can influence the boards to make sure that they cover Aboriginal child health and that the kinds of programs and services that are being rolled out are effective at addressing the diversity in our community, whether that be Aboriginal health, migrant health or whatever it is. These new six to 10-member committees must be able to respond to the overall needs of health services in our state.

As I said, it was a very good experience to be involved in the debates around the Health Services Bill 2016. My colleagues raised issues, including relating to staffing and the appointment of staff to these boards and to some of the regulations that have come in to manage the chief executive officer's appointment. The former minister approved some changes during these debates and I think he accepted several amendments, which he seemed to be quite comfortable with. He seemed to be very accepting of the need for the boards to reflect not only a good diversity of Australians but also strong employment standards, and to be able to put in place very good systems to manage a devolved health service in our state. I do not want to add a lot more to my final comments about the Health Services Bill. In my contribution to the second reading debate, I spoke about making sure that the governance of health recognises and responds to the kinds of experiences that particular groups and individuals in our community have. I also spoke about the impact of the over-consumption of alcohol, the use of illicit drugs, eating disorders and the need to make sure that we have a strong women's health plan in the state and how that will be managed across these new boards and across the service providers. Because I do not know enough about the health system and the way that it intends to do this, I will be very interested to hear how that might happen in the future. Thanks for the opportunity to contribute to this debate. I look forward to hearing how the needs of children in this state will be met under this new deregulated system.

MR D.A. TEMPLEMAN (Mandurah) [5.12 pm]: I cannot let the opportunity of the third reading of the Health Services Bill 2016 pass without reflecting on the debate that took place both during the second reading stage and what was a comprehensive consideration in detail process. It is important that we reflect on what this bill does.

As highlighted in the second reading speech by the former Minister for Health, a number of the clauses relate to defining a range of responsibilities and entities like the ministerial body and the establishment and oversight of that ministerial body; the minister's delegation powers; the administration of the act by the department of the chief executive officer; the issues associated with health service providers, their role and function; service agreements, which are made between the department CEO and the commission CEO; the issues associated with fees and charges for health services and other matters; and accountability and financial provisions that appear under part 7 of the bill. Elements within this bill that were borne out by debate during the consideration in detail stage also highlight a number of matters that concern criminal misconduct of employees of the department, or of the health sector; disciplinary matters associated with that; and controls of conduct and traffic on health service provider land, which is something that I will focus on shortly. The bill also includes a range of miscellaneous and transitional measures.

I have said in this place before, and it is my firm belief, that there is now a need for a concise and visionary health plan for Peel as it exists as a regional entity within Western Australia. I premise that call with the following facts. The Peel region continues to be seen by government as an area that will have population growth. As highlighted in the Perth and Peel@3.5 million document and also the subsequent growth plans or green growth plans and other planning processes, including the Peel region blueprint that comes under the Minister for Regional Development's jurisdiction, there is now a very clear need for a plan that determines and outlines to the population who live in the Peel catchment area the current scope of services in public health; the role and future role of Peel Health Campus in delivering services for the growth of the region; and the current and future role of

Murray District Hospital, which, of course, is the other major health facility in the Peel. Boddington has its own health facility as well. For some time now, my questioning in this place has always been: in the clinical services framework, where does the Peel region fit in terms of delivery? As we know, particularly the western part of the Peel region that encompasses Mandurah and the Shire of Murray, services are delivered predominantly through the South Metropolitan Health Service under its clinical framework. That framework was guided, of course, by the Reid report, which was the overarching plan for the state's delivery of health services. No Minister for Health in this place, particularly recent Ministers for Health, has been able to answer the question for me of what is the overall plan as Mandurah and the Peel region grow to the populations that are projected in the next 20 years. Bear in mind that the growth in the Peel region will not only continue in the City of Mandurah and the Shire of Murray, but will also be in the Shire of Waroona and, of course, in the Shires of Boddington and Serpentine–Jarrahdale. Most of Serpentine–Jarrahdale's health services are delivered via its immediate health facility, the closest hospital being Armadale–Kelmscott Memorial Hospital. However, the need for clarification of the plans is important because the answer we keep getting back from a local perspective—whether it is a person seeking localised services in Mandurah, Dawesville, or the Shire of Murray—is the constant fallback position that because we are part of the South Metropolitan Health Service area, we will need to look to the resources to the north of the region for many of the services that people expect to be delivered locally.

There is no argument about Fiona Stanley Hospital being the key tertiary hospital for the population that lives there—that is, for my family who live there and for the many families who call the Peel region home. There is no argument that those services of a tertiary nature will be delivered from Fiona Stanley. However, as I have said in this place before, that is not an excuse for services to be lost from the region to Fiona Stanley to the detriment of a localised service provision. One of the problems that many people unfortunately do not understand is that there are assumptions that many of the services that should be delivered to the Peel can be delivered centrally from Perth or from Perth-based and metropolitan-based services. The fact is that people do not expect that. The expectation is that services, many of them simple and basic, should still be delivered locally.

I will give the minister an example in mental health. I might be drawing a short straw, but I want to give this example of health service provision. A big issue locally in Mandurah and Peel in the last month has been a serious number of young people taking their own lives. It has caused great consternation in the community. I know for a member such as the member for Kimberley this is a massive tragedy, because even our tragic numbers in the last month do not compare to the appalling statistics that come out of the Kimberley. However, as the member for Kimberley would know, the devastation of the suicide of a young person, or any person, but particularly a young person, is far reaching, and the impact is immeasurable on family, friends, peers and the wider community. One of the problems is the presumption that many of the services currently provided in mental health can be provided from Perth. That is simply not the real story. Indeed, there are programs, one in particular, that need some funding to help deliver and coordinate services locally where they are needed—and where they are timely. I want to give members an example. In a population of Mandurah of 80 000-plus, with a wider regional population of over 120 000, and expected to grow to around 200 000 within five years, there are no mental health beds in the Peel region at all. That was borne out by my question to the Minister for Mental Health on 28 April this year. In asking about the "Western Australian Mental Health Alcohol and Other Drugs Services Plan 2015–2025", I asked specifically: how many of the 10 mental health beds announced in the plan for Peel will actually be located in the Peel region at the Peel Health Campus? The answer was none. The 10 beds will be provided in Rockingham, and they will be operational in the second half of this year. People say, "Okay; Rockingham is only up the road", but they miss the fact that the population centre is in Mandurah and will grow to the east. We will have growth through to Pinjarra. That growth is occurring in that eastern corridor between Mandurah and Pinjarra, and the population projections are 90 000-plus people living there within the Perth and Peel@3.5 million plan.

It makes sense to begin to have a health plan for Peel that is about localised services, and not just provide the excuse or the standard answer: "You will have to travel. You will have to go to Perth. You will have to go to Fiona Stanley. You will have to go to Rockingham." That is not what people in Peel expect, and indeed it is not what they deserve. These people deserve quality health services delivered locally. I have mentioned this point in this place a number of times. For example, if a person breaks their arm in Mandurah and goes to the Peel Health Campus, the likelihood is that they will not have their arm set and follow-up appointments in Mandurah. The treatments will occur most likely in Fremantle with the fracture team and/or sometimes in Royal Perth Hospital. They say, "You're good; you've got a fracture team up the road." But the expectation is that that service will be delivered locally. It is a basic fundamental service when a person breaks their wrist or arm. If it is a compact fracture needing higher level treatment, absolutely go elsewhere. But the likelihood under the current system with a basic cracking or breaking of an arm is that they will be transferred from Peel to another institution, and any follow-up appointments will not take place locally, but wherever they have been sent.

I remember when I grieved about this matter some time ago to the former Minister for Health the member for Eyre, he could not believe it. As a general practitioner, he told me he used to set a broken arm if he was doing his Saturday morning clinics. They were rudimentary. But why are they not rudimentary in a hospital like Peel? This is not a criticism of the Peel Health Campus, by the way, because I am very happy and pleased with the way that Ramsay Health Care has been operating that facility since the contract changed. Ramsay has demonstrated its capacity to deliver quality. I am not blaming Ramsay, but it is an example of a service that is expected and should be delivered locally, and is not.

The reality is that even through the government's "Better Choices. Better Lives. Mental Health Alcohol and Other Drug Services Plan 2015–2025" something like the provision of mental health beds at the Peel Health Campus for local people in the Peel will not happen under this government's plan. I do not think that that is right. That is just one example of why under the auspices of the Health Services Bill 2016, we must get our heads around the delivery of services into the Peel. What will be delivered, what can be delivered and what should be delivered, and when is that likely to happen must be considered, because the approach is very piecemeal at the moment. This is despite some tremendous work done by health providers, GPs, and those in the nursing and allied health services; these are very good and dedicated people. The fact is there may be a clinical services plan, but there is not an overall plan for health delivery into the future. I understand as much as anybody the cost issue. I understand the state's health budget continues to grow rapidly, and there is an issue of how to ensure that a quality service is delivered at an efficient rate for the taxpayer. The growing population of the Peel should certainly not miss out and have their service delivery jettisoned mainly to the hierarchical systems further to the north. That is why another look at the Peel region is needed regarding what role it will play into the future, because, as I am sure the Premier would have had put to him when cabinet recently visited the region, there is a very strong will and sense by the five local government authorities that the Peel region must maintain regional identity. This is based upon reflecting and understanding that there is a proximity to Perth, but using that proximity to Perth as an opportunity rather than a dependency. That is something that government and political parties need to get their heads around.

We will continue to deliver to the state a place to live in Mandurah and the wider Peel region for a greater number of seniors, for example, than found in any other place in the state. As members would know, 25 per cent of the population of Mandurah is aged over 65 years, and so the associated health needs and future health needs as someone ages will be a key consideration with health provision into the future. A large proportion of not only the current but also the projected population for Peel continues to be aged 65 and older but at the other end of the demographic bell curve is the zero to 15-year age bracket in which we have a disproportionate number of younger people in comparison. Our population flattens or dips in that 25 to 45-year age group as people in that demographic leave the region and do not figure as highly as those other two bumps in the bell curve.

This bill puts a range of frameworks in place. I do not want to rake over old ground but the problem with our major hospital in the region relates to some of the residual issues associated with the former contractor. I do not want to rake over those issues but I think the relationship and understanding of the minister's department of the current and future delivery of services through the Peel Health Campus should be focused on. I think we need to acknowledge the good progress made by Ramsay Health Care when it took over from the former contractor. We need to continue to push for the provision of the services that are required. What services does Peel Health Campus require in the future? We know that Peel Health Campus needs to increase its number of beds. The hospital is quite often full when people present at the emergency department. Finding a bed can sometimes be difficult. We know that the ED is not able to cope with the number of presentations that occur there. When we were in government we doubled the number of beds in the emergency department at Peel Health Campus but we have outgrown that very quickly. We also expanded dialysis and oncology services. I am sure members would be aware that there is nothing like being able to have chemotherapy or dialysis sessions delivered locally. As I mentioned earlier, what we consider to be rudimentary and some would say are basic services, such as fractures, should be able to be treated locally, along with ongoing treatment. I think that is a reasonable expectation for people.

One of the effects of somebody breaking their arm or fracturing a limb, for example, is the economic cost to their household when they have to attend follow-up appointments. People have to understand this. If someone based in Mandurah, Pinjarra, Yunderup or Dawesville is required to either go to the fracture clinic in Rockingham for a follow-up appointment or to Perth, that takes at least half a day and sometimes a full day. That is a major imposition for a working person, both economically and logistically, especially if they need someone to take them to the appointment. If someone is older and too sick to use public transport and they cannot get on the health buses that leave Mandurah daily for people seeking cancer treatment or heart specialist attention et cetera, it is not as simple as being told to get on the train. That is what a lot of people have been told. The patient assisted travel scheme is no longer available to most people in Mandurah, Yunderup and the Peel region. It is

available to people living in Pinjarra or south of the Dawesville Channel. These are important health services that are delivered to local communities. I appreciate the Acting Speaker (Ms J.M. Freeman) gesticulating to ensure that I speak to the bill. I hope that I have been but she is gesticulating and indicating that perhaps that is not the case.

I will conclude my contribution by asking that as this bill passes and becomes law, as ministerial bodies are established, as there are clearly defined roles for the CEO and as entities are created that will be tasked with overseeing how we provide for services now and into the future, they will not just look at Peel, as many people in this place do, as being just a tacked-on part of the metropolitan area. The fact is that it is not. Therefore, it needs to be looked at as having special circumstances. I ask that the Peel region be considered and given the special status that it deserves in terms of demographics, future growth, logistical issues for access to health services in the future and the fact that the population of the region will be as big as the south west, as projected. The south west and Peel regions will have a population of up to 200 000-odd within a very few short years and we need to plan properly for that in health services.

MR P.B. WATSON (Albany) [5.37 pm]: I would like to fully support the Health Services Bill 2016. I congratulate the health services that we have in our region. We have a great hospital at the moment. We have tremendous people working there, including doctors. Right throughout our region, we are very lucky in Albany to have the services that are provided. Things can change pretty quickly in a regional town such as Albany. If I can have the house's indulgence, I would like to read a letter from a Perth surgeon who has been coming down to Albany for a long time. It states —

> I am writing to advise you of the impact that the new Airline carrier to Albany is having on the continued provision of medical services to the Great Southern Region.
>
> Previous to the change in carrier, I would visit Albany for a full-day once a month and two days every second month, providing consultation and clinical review for all patients in the Great Southern Region. Due to the lack of a vascular ultrasound service in Albany, over the last 4 years I sent my own specialist vascular sonographers and ultrasound machine on a fortnightly basis to provide local patients with reliable, non-invasive imaging (avoiding the need for excess radiation and IV contrast and greatly reduce the need for patients to repeatedly travel to Perth) to enable diagnosis and ongoing management of vascular disorders.
>
> The change in flight times since Rex became the sole carrier to Albany resulted in it no longer being feasible for either myself or my sonographers to travel to Albany in the morning and return the same day. The earliest flight from Perth results in the loss of three hours of a possible eight hours of clinic time in Albany. At considerable extra cost financially and personally, my Vascular Sonographers and I now have no option but to stay in Albany for two consecutive nights in order to maintain the same level of service provision required in the Great Southern Region. This is particularly difficult given that we all have young families in Perth.
>
> To add insult to injury, Rex has now advised us that they will not guarantee transport of our portable ultrasound machine with us when we fly due to its weight (approximately 20kg and fits in a medium sized suitcase). Rex does not allow purchase of an extra baggage allowance at the time of the booking and extra baggage is subject to a "first come first served" basis at the time of check-in at the airport, without any guarantee that once it has been accepted, it will actually travel on the plane! I understand that for air travel safety reasons the plane can only carry a certain weight, however the transport of this ultrasound machine was always appropriately prioritised by Skywest and Virgin.
>
> As you can appreciate, we cannot provide a vascular service without the medical equipment required to do so. It is not feasible for us to operate with the risk that our clinics in Albany have to be cancelled at the last minute as a result of equipment not able to be transported; for us to fly to Albany only to find that the ultrasound machine has been held in Perth; or have this expensive medical equipment remain in Albany upon departure.
>
> As the major hub for the Great Southern Region, can Albany really entertain this risk to its Perth-based primary healthcare providers? I am sure that our vascular service is not the only one impacted upon.

The point about this is that it is not only about the people in Albany. This is one of three letters that I have received. I have spoken to the minister. Regional Express Holdings Ltd asked the Albany community which way it wanted to go and the Albany Chamber of Commerce and Industry said that it wanted to get its businesspeople to Perth, but when an essential service such as this is affected, there must be a rethink. We must have these specialists because Albany is an ageing community. We need a proper service for not only aged people, but also the school kids who have to go to Perth for essential services. Surgeons are businesspeople; they do not just do

it. Obviously, they care and they want to do it for the community, but they have to run a business. Three people now have to stay in Albany for two nights whereas previously they did not have to stay at all. It is championed by the Chamber of Commerce and Industry that three people stay overnight, but that is three people. With the previous service, a lot of people would come down on the morning flight at 6.15 am and I would be sitting next to them and they would ask me about a good place to have breakfast in Albany and we would talk about where they could go. It will be very hard to work out, but we have to look at it.

Another issue that affects people in the regions is the patient assisted travel scheme. I think PATS is a tremendous service, but I know of some instances in which seniors have been halfway to Perth—probably between Kojonup and Williams—and the receptionist at the surgeon's office has rung and said that they cannot fit them in today and has asked whether they could come in the next day. Those seniors have said, "Hold on a minute; I got up at four o'clock this morning and I'm halfway to Perth." The people in the surgeon's office do not realise that Albany is 450 kilometres away. I am talking about PATS and services for people in the regions, Madam Acting Speaker. This relates to health services in the regions. I am narrowing it down. I thought very hard about the bill and I looked at all the speeches and this is what I have got out of it. It is an issue. I have sent a letter to the surgeon of every person who has come to me to tell them that Albany is four and a half hours away and they cannot just ask these patients to come back the next day, so surely they could get a patient in the city to change their appointment, but it does not have any effect.

Albany Hospital is tremendous but parking is still an issue. People continually park in the driveways of the people in my electorate who live very close to the hospital. I know that there are plans to put in a new parking area at the back of the hospital, but at the moment, it is very hard to get a parking space. As I say, I cannot say enough about the people there. I had to go to the hospital emergency service at half past two the other morning and the service that my family and I got was tremendous. I have nothing but praise for the service at Albany Hospital.

Another issue that affects our region is the ambulance service. We are losing people. I have been to Wellstead, Jerramungup and a lot of other little towns and not enough young people are getting involved. I was told that the other day in Jerramungup, people had to go to the footy club and grab some guys to drive the ambulance. There are so many different things people have to do to drive an ambulance; there is so much red tape. It is an issue in our region. I went to a road safety forum in Albany a couple of weeks ago and I found out that the total number of deaths in the Albany police district last year was 15 but there have been more than 21 this year and it is only May. We are losing people on a regular basis. Ambulances in those in-between towns are important. A person's life can be saved if they get to hospital quickly, but people in the regions have to hunt around for someone to drive the ambulance. We had a tragic accident at Jerramungup involving a young boy who was driving and those people were all over the road, but there was only one ambulance there and people had to go into town to get another ambulance. It is something that we have to look at in regional areas. I do not know how we are going to prevent people from running off the road, not paying attention or not wearing a seatbelt. It is a health issue because it puts a lot of pressure on our health system.

I note that in the federal budget, the Albany region will get $156 million less over 10 years. That is $15.6 million less a year from the federal government, which is very disturbing. We want people to stay in regional areas, but we have to provide services for them. I know that royalties for regions has done a great job in that area, but I think that more can be done.

Mental health beds are an issue. It is the elephant in the room. I was at the police station the other day and I know that the police spend a lot of time taking mental health patients to hospital. The police do not have the facilities to look after those people, so the police have to stay at the hospital until those people settle down.

All in all, I think it is a good bill. I think the minister has done a great job with his first health bill. As the member for Mandurah said, we have to look at regional areas a little differently. There are different issues. Regional areas have issues that the metropolitan area does not have. The member for Mandurah said that the people in Mandurah travel to Perth on a bus. People from Albany can drive for four and a half or five hours or they can take the bus, which is about a six or seven-hour trip, or they can fly to Perth. Some of our oldies do not want to fly, so they go on the bus, but it is a very long trip for them. Most of them have suggested to me that we should have a train service to Perth, as we used to. They used to get on the train in Albany and travel overnight to Perth, go to the doctor and then hop on the train and go back to Albany again.

The health industry in Albany is going very strongly. We have some great surgeons at our hospital, so a lot of people do not have to go to Perth, but a lot of people still have to do that. One of the major issues is that young children with attention deficit hyperactivity disorder and young people with other issues are slipping through the cracks. There is a waitlist time of 18 months to see the specialist when they come to Albany.

Unless people have a bit of money and can afford to go to Perth or have time off to go to Perth, it is a big problem. Sometimes kids in the lower socioeconomic areas such as Spencer Park undergo speech therapy and are examined for ADHD. They get missed and the parents cannot do anything about it so other issues arise as they go through life.

Things are going really well in Albany and I fully support the Health Services Bill.

MR D.J. KELLY (Bassendean) [5.49 pm]: I rise to make a contribution to the third reading of this Health Services Bill. On reading through this new bill I saw how it will provide some new structures around how the government manages the public health system. However, a basic point is almost completely ignored in the way the bill is structured and in the minister's second reading speech; that is, there is an assumption that we have almost a unitary system in which virtually all services are provided by the public sector. The minister and the chief executive officer of the health department have the role of sitting over the top, managing the system and making sure outcomes are in the best interests of the patients, the public purse and the like. However, it is not until we drill down into the terms of the bill that we realise that the bill tries to deal also with the other thing that is happening here in Western Australia; that is, that this and successive conservative governments are fragmenting the public health system. They are privatising health providers, whether it be at Peel Health Campus, Joondalup Health Campus, the Serco contract or the new hospital at Midland. This government is fragmenting the public health system. We have to dig down into the bill to the definition of a health service provider and a public health service provider at page 5 of the bill and public health service at page 7. They include private entities that are contracted to the government to provide health services.

At the first look, the bill reads as though its objective is to accommodate a minister with the health department managing our system. But we have to dig down to see how it relates to all the private entities that are now running such big chunks of our health system. It is a pity the new minister was not in some of the Legislation Committee sessions. We had some very interesting discussions with the previous health minister about how this bill will operate in relation to the private entities that in increasing numbers are being contracted to the government to provide health services. I refer to one area on which we had some discussion. Clause 26 of the bill is headed "Department CEO may issue policy frameworks" and subclause (2) reads, in part —

> The Department CEO may issue policy frameworks to ensure consistent approaches to the following —

It lists in subparagraphs from (a) to (l) a range of matters that this bill envisages the department CEO can issue policy frameworks for to ensure there are consistent approaches. They range from financial matters, to employment matters, to service delivery and to health services. One of the questions I asked during deliberations of this bill was: if this bill covers a private provider such as St John Ambulance WA, which runs the ambulance service and which is contracted to the government to provide a health service, will all these policy frameworks this bill envisages the department CEO may issue apply to St John Ambulance? I have to say there were some quizzical looks around the table from the minister and his advisers when that question was asked. After a bit of consideration—I do not want to misquote people—the tenor of the response I got was that they would apply only subject to the terms of the contract with the private provider. If the contract is written in a way that policy frameworks, as amended or issued from time to time, apply to the private provider, they will apply. But if the contract does not require the provider to abide by those policy frameworks, they will not apply. The government could say that that is all right because it will write contracts to make sure these sorts of things are envisaged and accommodated. The trouble with that is that, as we all know, this government and successive conservative governments are in the habit of entering into these health contracts for inordinate periods. I think the contract with Serco was for an initial period of 10 years, with a 10-year extension. I think when the contract at Joondalup was signed, it was for 20 years. As a government, we enter into these contracts, effectively, for decades. In 2016 we are stuck with contracts that were written a decade ago. Every time we enter into these contracts, we say that the contracts are brilliant; they are modern and flexible, but we all know that often with the passage of time, they become quite inadequate.

A couple of years ago the provider at Peel Health Campus agreed to relinquish its contract and Ramsay Health Care came in as the new provider. There were lots of problems at Peel Health Campus under the original provider. When the government privatised that hospital originally, we were given assurances about the standard of the contract, but roll forward to 2012 or 2013, whenever Ramsay took over, and we were told there were lots of problems and the previous minister said he was mightily unhappy with the original provider, but that the new contract with Ramsay has been remedied and improved and all that sort of stuff. Having been told that when Peel was originally privatised the contract was the bee's knees, in the passage of time we realised that it was completely inadequate. On entering into a new contract with Ramsay Health, we are stuck with the contract for decades.

On reading clause 26 of this bill I thought: yes that is great, the government, through the department's CEO, will issue policy frameworks to ensure consistent outcomes across the whole health system. But we know that unless the contracts with those private providers are written in such a way that they are required to abide by them, they absolutely do not abide by them. Those private providers resist being bound by policies from the health department that change from time to time. When private providers sign up, they sign up for a price and they want to know what are the parameters around that price.

Sitting suspended from 6.00 to 7.00 pm

Mr D.J. KELLY: Before the dinner break I was talking about the complications that will arise in applying some of the provisions of the Health Services Bill to the ever-increasing number of private providers that the government is contracting to provide health services. I had drawn the attention of the house to the policy frameworks that the bill envisages the department chief executive officer will be able to issue to ensure consistent approaches on a whole range of issues, from IT to financial management and the like. But it is not just the policy frameworks that the privatisation of services will lead to complications on. We can look, for example, at clause 28 of the bill, which very sensibly gives the department CEO the power to issue directions; again, on a range of issues. My understanding is that they will apply to private providers only if the contracts that they have written with the government allow for that. So instead of the department CEO being able to issue directions on a number of things to public sector health providers and those providers having to jump and to jump how high to do whatever is required under those directives, that will not apply to those private providers—the contract will place a barrier between the department CEO and whatever directive the CEO wishes to direct. It creates a level of complexity that does not need to be there. When the government does cost–benefit analyses of things such as this, to the extent that it actually does do them before it enters into these long-term contracts with private providers, I have never truly seen these sorts of complications taken into account.

Clause 175 under part 13 of the bill again quite sensibly gives the department CEO extensive powers of investigation, inspection and audit in respect of health service providers, and for good reason. If something is not occurring as it should in a service that is providing health services in Western Australia and is the responsibility of the Western Australian government, the department CEO should have the power to go in and find out what is going on because public money is being spent. We all know that if the service has been privatised, the ability of the state to carry out those inspection, investigation and audit functions is restricted by whatever is in the contract. I mentioned Peel Health Campus before. There were serious issues at Peel Health Campus. I know that the government potentially dodged a bullet in respect of that scenario because one of the whistleblowers down there turned out not to be all that she said she was. Putting that issue aside, there were serious issues with the private contractor that ran Peel Health Campus for 15 years. The minister himself said at the time that he was not happy with that provider. The minister has very sensibly given himself some powers under this bill. All I am doing is ringing an alarm bell, because I know that when these contracts are entered into—contracts that the other side of politics is very fond of—they often come back to bite the government because it is inhibited by the terms of that contract when it wants to get to the bottom of something that has gone wrong. A company like Serco is an expert at putting up the shutters when something goes wrong. When something goes wrong at Fiona Stanley Hospital, Serco essentially goes to ground; we cannot get any information from Serco into the public domain on the issue. It is left to the government of the day—usually the minister or the Premier—to carry the can publicly for what has gone on. Under this bill, the minister is sensibly giving himself extensive powers to investigate health service providers when things go wrong, but so often we see that the state's ability to get the outcome that it wants is inhibited by the contract that it has signed.

Of course, the other issue that often comes into play here is that when conservative governments have entered into these contracts, they often do not want to know what has really gone on. Because it is a contested area of public policy, the government does not want to admit that one of the private providers it has contracted has actually not achieved the optimum outcome. I am sure that if it were to admit that Serco, Health Solutions (WA) or whoever else has not been up to standard, it would see that as a loss for the government and a win for the opposition. I know that is how the minister feels; I can see it in his eyes.

Mr J.H.D. Day: No; what I am thinking is that Labor governments have also entered into these arrangements in their more rational moments at times.

Mr D.J. KELLY: In more rational moments; that is interesting. I put to the minister that if he were to ask the public of Western Australia whether it was rational for the state government to enter into a contract with Serco to provide services at Fiona Stanley Hospital that the vast majority of Western Australians would say that it was an irrational decision. The other contract that the public of Western Australia would say was an irrational decision by the minister's government is the contract at Midland hospital, where it entered into a contract with a private provider to run a public hospital and allowed it an exemption so that it does not have to provide services that are

contrary to the provider's religious beliefs. The overwhelming majority of Western Australians think that is a bad decision. I know that because most of the people on the other side of the chamber agree. The Premier said he was not happy about it. He said he was not aware that that had happened, but I find that hard to believe. That contract came to cabinet. That was a completely irrational thing to do. The Minister for Health knows why it was done, and he can tell me if I am wrong. The government has an ideological commitment to privatising hospitals so it thought: here is a new hospital; let us see if we can privatise it. When it was put out to tender there were only two credible tenderers: Ramsay Health Care and St John of God Health Care. The contract could not be given to Ramsay because it already had Joondalup Health Campus. Peel Health Campus was on the skids, so the government had in mind that Ramsay could take over Peel. If Ramsay was to run Joondalup and Peel—it runs Hollywood Private Hospital and a number of other private hospitals—the contract for Midland Public Hospital could not be given to Ramsay because, effectively, one private provider would be running all those public hospitals. The then minister did not want to create a private monopoly because if he had done that he would have created a world of pain. Some bright spark—the then minister—thought: we can give it to St John of God, and we will just deal with that other issue some other way. At the same time the minister was getting a lot of stick over the Fiona Stanley–Serco debacle, so he thought: St John of God has a good public image, is a not-for-profit and will be much more palatable to people.

Mr J.H.D. Day: And it actually made a bid that involves quite a saving to taxpayers for the same outcome—for a high-quality outcome. You may not be concerned about the cost of the health system to the overall state budget, but I can assure you that your shadow Treasurer, the member for Victoria Park, is.

Mr D.J. KELLY: I would love the minister to open up the books on the bid and what it entailed. I have heard a couple of funny things about the cost-benefit analysis that was done. One of the things that was not done at Midland was St John of God being asked to kick in any capital for that project; whereas some private provider—for example, Ramsay—would have been more than happy to kick in capital, saving some money for the state. But capital was not made part of the deal, because if that had been done St John of God would not have been able to bid because it does not have the ability to raise the capital that Ramsay does. The government forwent a capital injection because it always wanted it to be St John of God.

The other thing is that I do not believe the government's figures compare apples with apples. The government is now saving money at Midland because procedures are being done there on people who would otherwise have come to Royal Perth Hospital. It is much, much cheaper to have procedures done at Midland instead of coming into Royal Perth. I suspect the government is comparing the cost of those procedures being done at Midland with what it used to cost to have them done at Royal Perth, and that is part of the savings.

Mr J.H.D. Day: I am sure —

Mr D.J. KELLY: Minister, I have limited time and I have a couple of other issues. Maybe the minister could respond to that later.

Mr J.H.D. Day: You are wrong on a couple of assumptions, but certainly using secondary hospitals for treatment that can be done at secondary hospitals is a better thing. It was also supported by the Labor government.

Mr D.J. KELLY: Yes, we support that. But that would have been a secondary hospital if it had been run by the public sector or private sector. That is my point.

I know the minister is either renegotiating or must be coming to a point of having to renegotiate with Ramsay over Peel. Given that we are in the process of debating the Health Services Bill 2016 and the terms of the new contract are being negotiated, I hope the minister is considering taking it back in-house. I hope it will at least go out to public tender. What happens during those contract negotiations will have a bearing on how this bill will be applied. I would like the minister to address in his third reading reply where he is up to with the negotiations at Peel in respect of that Ramsay contract. What is the minister going to do? Is he going to do a behind-the-doors deal with Ramsay and not put it out to tender? Is he going to recall public tenders? Is he going to seriously consider taking it back in-house, which is what I reckon should be done? Is the minister going to consider all those options or is he in the process of nutting out some sweetheart deal with Ramsay? Maybe the minister can tell us that when he responds.

The issues I have raised have financial and accountability outcomes, but they really impact upon service delivery. I raised this with the previous minister, and I will it raise it with the current minister. At Midland, St John of God will not provide contraceptive advice or terminations or vasectomies—all those services—and if people want to access those services they have to go elsewhere; some of them to the clinic down the road. That is, in my view and that of most people I have spoken to, a poorer outcome for the people of Midland. The example raised with me is that of a young woman presenting at the emergency department at the new

Midland hospital and discovering, after examination, that she is having a miscarriage. The woman did not even know she was pregnant. After being told what is happening—that she is pregnant and having a miscarriage—the young woman says, "Look, what do I need to do to stop this happening again?" But because the provider there will not give contraceptive advice, it will basically say, "Look, if you want those sorts of services we cannot provide them; go to your GP or go down the road." If that young woman, because her life may be chaotic—she has lots of other things going on—does not go to her GP, in 12 months' time she may be pregnant again. She is back in the same situation. Apart from what that would cost the health system, what about that young woman's life? Most people would say—having presented in a public hospital in the circumstance of being pregnant and not knowing it, having a miscarriage and seeking advice about contraception—there should be a seamless provision of health care for that woman. That would have given her the best chance of taking control of her life and not having another unwanted pregnancy. The system the government put in place—"We are not going to give you that advice; you have to go somewhere else"—provides a poor health outcome. The minister can respond to that in his third reading reply. I raised it with the previous minister and I just got, "Oh well, we think we've done a good job." That is the scenario I have never had a good explanation for as to why that is acceptable from the minister's side of the chamber.

Mr J.H.D. Day: Are you saying that was an actual example of a woman who was not given contraceptive advice?

Mr D.J. KELLY: No. St John of God Health Care has made it clear: it is called "restricted services" in the contract. It will not give contraceptive advice, it will not do terminations and it will not do vasectomies; there are probably a few others I cannot think of. Look at the contract: they are the restricted services. It is the organisation's religious belief, and I respect that. It has very strong views about those issues. The government's original answer to that issue was that it was going to build a clinic at the end of the car park to provide those services. It never happened, partly because St John of God said if the government was going to build that clinic down the end of the car park, it wanted a hard fence between the two. Its entrances could not be used, its car parks could not be used and anything of that nature could not be done because that would be St John of God facilitating those services. It said, "Build it down there if you like, but we want a hard, continuous fence." My understanding is that that is one of the reasons it became impractical to provide those services at a separate clinic at the end of the car park. That is why the government had to go to plan B.

I wanted to deal with some other issues, but I am out of time. I am really interested in hearing the minister's third reading response because these are very serious issues.

MS S.F. McGURK (Fremantle) [7.20 pm]: I am very happy to make a contribution to the Health Services Bill 2016. My contribution to the third reading debate will continue along the same theme and with the same sentiments that were raised by other members on this side of the house; that is, we welcome and applaud the parts of this bill that enable the modernisation, if you like, of the management structures of the Department of Health and the reconfiguration of its management of the public health system under what is a significant rewrite of the act. The bill enables a very sensible devolution of what is a huge budget, which I understand is over $8 billion a year. The government's credibility in trying to modernise the overall structures and management of the health portfolio in this state is lacking when we consider the way it has performed since it took office in 2008, in particular the transitioning to and commissioning of Fiona Stanley Hospital, and how it has implemented budget cuts to the health portfolio and the impacts of those cuts. As the member for Fremantle, I am particularly aware of the impacts of transitioning services to Fiona Stanley Hospital in the south metropolitan region. We have seen a significant number of services transition from Fremantle Hospital to Fiona Stanley Hospital. I said before that the community I represent did not object to services moving from Fremantle Hospital to Fiona Stanley Hospital, but they did object to the cuts that were made in that transition. They were given assurances that cuts would not be made to a number of services that had been offered at Fremantle Hospital, but there were, in fact, cuts to key personnel, particularly people in whom they put a lot of faith who were not transferred to Fiona Stanley. It is my firm belief that during the transition from Fremantle Hospital to Fiona Stanley Hospital, the state government took the opportunity to make cuts to the pain management unit, the renal unit and the inflammatory bowel disease unit and, as a result, I am in no doubt that patients are worse off. The worst example of that was in the inflammatory bowel disease unit. As the transition was occurring, the shadow health minister, the member for Kwinana, and I met with patients of that unit who were very concerned at the number of long-term specialist staff who were not transitioning to Fiona Stanley Hospital. They were also concerned at the winding back of a telephone service that they said had saved them a lot of travel time and inconvenience. They believed this was a much more efficient way of handling queries than having to front up to the hospital and be seen in person. The worst thing that happened was that a patient, Jared Olsen, died because there was poor record keeping as a result of that transfer and he was given medication that was inappropriate. Those sorts of stories from patients were ringing alarm bells. They were here at

Parliament House, and opposition members were asking questions on their behalf and taking up their case in the local media and sometimes in the statewide media, saying that these people knew how their health was being managed in the public system and that they were concerned about the transition that was happening. But changes went ahead anyway. Some of these patients were inconvenienced and some were worse off to a greater degree, which was a terrible outcome for them. As I said, the government lacks credibility in managing the health portfolio and in the overall management of a modern public health system in general in this state.

We have seen a huge change at Fremantle Hospital. Initially we were told that 1 900 or thereabout jobs would go from Fremantle Hospital when Fiona Stanley Hospital was commissioned, but since then another 70 jobs have gone from Fremantle Hospital, as well as a radical change in the management structure at Fremantle Hospital. That is the sort of chaos we have seen in the commissioning of Fiona Stanley Hospital, not only because of the Serco contract, when Serco was getting paid and costing the taxpayer millions of dollars before there were even patients in that hospital, but also because when the patients did hit the hospital, we saw ongoing chaos. The decision in February this year to take out a whole slice of management from Fremantle Hospital and for Fremantle to be managed remotely from Fiona Stanley shows that the dysfunction in this portfolio makes the general population very concerned.

I know that a lot of good stories come out of our health system, and I do not take that away from either our system or, in particular, the people who work within our system and do an incredible job. But when we hear, just under 12 months after commissioning Fiona Stanley Hospital, that a whole slice of management, comprising five senior positions at Fremantle—the director of nursing, the director of clinical services, the director of safety and quality, the director of operations and finance and the chief executive—are being taken out of Fremantle Hospital, I have to wonder about that transitioning and how the system is being run. It is always a challenge to find exactly what is being done at Fremantle Hospital, and it will be interesting to see what comes out of the state budget this week. Originally when the transition to Fiona Stanley Hospital was taking place, $13.2 million was allocated for the reconfiguration of Fremantle Hospital so that good use could be made of the health capital at Fremantle, which is a significant regional centre. It is a population centre, an entertainment centre and a working port. It is a key centre and, most importantly, the capital there should be properly utilised. Originally, $13.2 million was allocated to the reconfiguration, but last year we saw that amount go down to $11.5 million, so just under $2 million was taken away from that reconfiguration budget. Worryingly, $19.4 million of that is in the forward estimates—in the outer years. I have asked questions on notice about the plans for that reconfiguration budget, declining though it is, and the last answer that came back was that there were no specific plans for that reconfiguration, so it will be interesting to see whether that money stays within the budget that is due to be handed down this year. That sort of uncertainty about not only how Fremantle Hospital will be utilised, but how it will be managed, has a huge impact on the staff of that hospital. We all rely on the skilled and dedicated staff at that hospital to stay the distance and continue to commit to that facility. However, that uncertainty makes it very difficult for those staff.

The previous Minister for Health made much of the national statistics that show that Western Australia is incurring above-average costs in running the public hospital system, and therefore cuts are justified and hospitals have to find those cuts. The minister omitted to say that he has presided over that situation since 2008. This government is now in the final year of its second term. There are not many places in which the government can hide when it comes to who is responsible for those cost blowouts. The challenge for the government is to properly contain costs within this incredibly complex portfolio and not compromise patient care in the process. Too many stories have come out of the health system that show that this government has not succeeded in doing that in any way. I have already referred in this house to the terrible example of Jared Olsen. I have also referred to Sharon Heeley and her husband, Mark, who are constituents of mine. Sharon has multiple sclerosis. She went to Fiona Stanley Hospital because she had a compacted bowel. She was given laxatives and a bedpan, and she was then essentially left in a bed on her own. She was unable to move without the use of a hoist. Only one staff member on any of the shifts knew how to work the overhead hoist. After she used the bedpan, she asked for further help, but she was left on her own. Her husband came in and found her lying in a soiled bed, crying, and asking to be taken home. Mark worked out in a matter of minutes how to use the overhead hoist, showered his wife himself, as he had done since she had been in hospital because there were never any staff to conduct that sort of basic care, and took her home. That was an incredible situation. I hope it is not a common situation, but it is completely unacceptable nevertheless.

Another incident that has also been given some publicity is the case of Tricia Ray. In the final stages of her pregnancy, Tricia had moved house from Coolbellup to Kalamunda, and as a consequence her care was transferred from Fiona Stanley Hospital to St John of God Midland Public Hospital. She was assured by Fiona Stanley Hospital that she would be contacted by Midland hospital to arrange for the final appointment that she needed. She went to Midland hospital in the final week of her pregnancy and asked for an appointment.

However, she said that she felt that the medical staff had a patronising and dismissive attitude, and she was told to come back on 3 March. Her baby was due on 29 February. She said to the staff that her baby was due and she needed to see someone, and she persisted to such an extent that she was seen and attention was given to her. However, she ended up having a stillbirth. She is firmly of the view that that might have been prevented had the transfer of her care between Fiona Stanley and Midland hospital been managed better.

These are the human stories. I am sure the government does not take these things lightly. I am sure that the current minister and the previous minister do not like to hear these sorts of stories. However, that is the effect of the budget cuts by this government, the lack of attention and certainty given to staff, and the lack of detail that is required for proper management of the health portfolio.

[Quorum formed.]

Ms S.F. McGURK: I have been concentrating on the fact that this government has presided over fundamental changes to the South Metropolitan Health Service with the commissioning of Fiona Stanley Hospital. Of course we welcome that build and the capital investment in that hospital. The services that are provided by the staff at that hospital are incredible. However, there have been too many mistakes in the commissioning of that hospital for people to have confidence in this government. The third reading of the Health Services Bill provides an opportunity to make some comments about that. I note that the previous Minister for Health, the member for Dawesville, said in his second reading speech on this bill —

> The new legislation will clarify the roles, responsibilities and accountabilities at each level of the system, and by devolving decision-making to the local level, the legislation will drive the continued delivery of high-quality health care. It will modernise the governance and delivery of the health system in WA, with the model being based on the successful elements of the Victorian, New South Wales and Queensland systems.

That all sounds fantastic. However, hundreds of jobs have been cut from the health system, and political decisions have been made that have undermined the allocation of resources. The obvious one was the promise by this government to keep open Royal Perth Hospital, on the proviso that money would be allocated to refurbish that hospital. We know that that money has never been spent. Similarly, the government has always been vague about what services will stay at Fremantle Hospital and how that health capital will be utilised properly.

Part 19 of the Health Services Bill deals with transitional and savings matters. It provides for the hospital boards in the metropolitan health services of Western Australia and in country health services to be abolished. It also provides that the board of the Perth Quadriplegic Centre will continue to exist and has been established as a health service provider under this bill. It is cold comfort, if members excuse the pun, for patients in a quadriplegic centre to have a local board managing them. It is cold comfort when we read in today's *The West Australian* a story, which was uncovered by 6PR, about patients who were given cold showers because the government had not properly managed even the most basic maintenance at that hospital, let alone the centre's redevelopment, which had been recommended for some time, including by, I think, Professor Stokes. The way the government has handled the quadriplegic unit is again a very stark example of where it can put in place all kinds of changes and modernise the structure of overall management, but if the government does not provide the resources and does not keep its eye on what is happening at a local level and ensure that the accountability it expects from providers and individual services also applies to the government, then we are going to continue to see bad news stories coming out of our health service.

As I said, I will be looking closely to see what happens in this budget to health services, particularly those at Fremantle Hospital, and whether the reconfiguration budget remains—that is, about $9.5 billion. We will also be making sure that health services do not continue to take cuts when the government has elected to spend its money on vanity projects such as those in the CBD and the like.

MR C.J. TALLENTIRE (Gosnells) [7.42 pm]: I rise to make a third reading contribution to the Health Services Bill 2016. I begin by expressing my budgetary concerns, noting that with the passage of this bill we will be bringing in place several boards that will administer hospitals across the state. Those boards by necessity will have a bureaucrat structure. They are boards that have a high degree of responsibility. They are responsible for administering billion-dollar assets—very, very expensive pieces of our health services' infrastructure. Reasonably, those people whom we would expect to see on a health or hospital board should be well qualified and well experienced in the area and in a position to dedicate the amount of time and effort needed to put into the preparation and the necessary ongoing contribution between meetings when they have such a responsibility. It is a great responsibility to be on a hospital board, and one that warrants a degree of remuneration. We cannot expect people on boards such as these to provide their contributions without any form

of remuneration. We acknowledge that they are bringing to these boards their expertise and they are contributing their time and are making a contribution and effort to be as effective as possible to ensure that the hospital is run as well as possible. However, I am concerned about the timeliness of bringing into effect these hospital boards. It is going to be a big impost on the state budget. In total numbers, we are talking about around $500 000 to cover the payment to all of the various people across the network of boards. The legislation before us remains silent on how much a board member will be paid. However, clause 75, "Remuneration and allowances", states —

> A member of a board is entitled to be paid any remuneration and allowances that the Minister may determine on the recommendation of the Public Sector Commissioner.

That is very open-ended. It all depends on what the Public Sector Commissioner determines will be the appropriate remuneration rate.

Over the weekend I noticed an advertisement in *The West Australian* for positions on what was once the Healthway board. Again, we know that the Public Sector Commissioner has been in discussion with the Minister for Health and the Department of Health about what will be the appropriate remuneration levels for those people who become either the chair of that once Healthway board or officeholders in some other way. What is apparent though is that previously the chair of the Healthway board was paid a fairly meagre sum and some very committed individuals were paid very little indeed. What is obvious now, however, is that with this relationship among the Public Sector Commissioner, the Minister for Health and the Department of Health we, as taxpayers, will be forking out much more to cover the cost of that new Healthway board. Of course, in the case of Healthway, that will come out of the Healthway budget. All the money that previously was going toward all kinds of good works around preventive health, all those good messages, will be diminished so that we can pay for board members. That will be the same with the hospitals, I fear. We are setting aside out of the Health budget just over $8 billion—I think it equates to about 30 per cent of the total state budget. It is a little vague, but probably the best estimates are that half a million dollars will be set aside to pay for people to be on the various boards. I am concerned about the nature of these boards and the extra cost to the state budget and I question the timeliness of the creation of additional board places and, indeed, the composition of the board.

When the legislation before us talks about the sorts of people who will be on the board of a hospital, it is left very open to the minister effectively to put people who are of a like mind to the minister or who are friends—those sorts of people. That is a concern, because we should be requiring people with certain qualifications, perhaps people who represent certain organisations —

Mr J.H.D. Day: No. It's not representing organisations in my view. But have you had a look at who has actually been appointed?

Mr C.J. TALLENTIRE: No, I have not.

Mr J.H.D. Day: It's worth doing, because there's a diverse range of skills and there's been a very thorough process gone through.

Mr C.J. TALLENTIRE: I got to see who the chairs were, but I cannot recall all of them. There were a few familiar names, and I am sure they are worthy people.

Mr P.B. Watson: You do have form, minister, for looking after your own.

Mr J.H.D. Day: I don't think so! You're saying that about me?

Mr P.B. Watson: No, no; your government—not you. No, no; every other minister apart from you, minister.

Mr J.H.D. Day: Our general process has been to appoint people on the basis of their skills and expertise.

Mr P.B. Watson: The National Party aren't quite as good. They look right after their own.

Mr C.J. TALLENTIRE: If I could interject, Madam Acting Speaker!

Mr P.B. Watson: I'm sorry.

Mr C.J. TALLENTIRE: That is all right, member for Albany. I am very happy for the member to be engaged in this discussion.

The minister raises an interesting point and it is perhaps one of those areas of philosophical difference. The Liberal Party believes that people should be appointed to not only hospital boards but boards in general based on their merit and individual capacities. The Liberal Party believes that we should be moving away from the era of appointing people to boards because of their capacity to represent a particular organisation. I am not so sure about that. I think a lot of credibility comes from someone being on a board because they represent an organisation. It also means that we are certain to fill certain categories and we would not have only people who are perhaps of a like mind to the minister and very friendly with the political party in power. We remove that risk

of a political decision being made about an appointment if we leave the appointments to boards and who is available, depending on who is the head of a particular organisation. It changes the dynamic a lot.

Mr J.H.D. Day: I think the Labor Party had a pretty strong track record in appointing friendly people, from my recollection.

Mr C.J. TALLENTIRE: I thank the minister. I look at some of the legislation around and as far as I can tell it was passed during the time of previous Labor governments and I note that often it requires people representing particular organisations to be on a board. But no doubt this discussion comes up every time we debate legislation that involves a board of some kind. I note that the hospital that is closest to me, the Armadale–Kelmscott Memorial Hospital, which seems to be abbreviated to Armadale hospital these days, has a board and a community advisory council. A lot of effort is made to ensure that the council comprises people who speak English as a second language, which is a very worthy initiative. It means that our practices are, to use the jargon, culturally appropriate and part of the way that the hospital does business. The Armadale Community Advisory Council is very helpful to the operation of the Armadale hospital.

I cannot reel off the names of the members of the board, but one experience that I had there would suggest that there is a high degree of caution about how that hospital interacts with a member of state Parliament. On one occasion an association with which I am connected, the Australian Arab Association Inc, did some brilliant work negotiating with the hospital to get some of its cast-off medical equipment that was destined for the tip; it was no longer of any value to the Armadale hospital. The Australian Arab Association was able to put in a bid to obtain the old equipment and it organised for a shipping container to be taken to the hospital. Its members presented at the hospital and with hospital orderlies and other people were able to gather all the equipment and place it in the container for it to be sent to the Middle East to provide support to medical services that are necessary for people who have escaped areas of conflict. It is a great and very worthy initiative and something that I applaud. The general role of the hospital in this was outstanding, as was the role of the community organisation involved. But it was interesting; I was invited along to help with some of the work, such as carrying out bedpans and old beds and all sorts of things and storing them in the shipping container. I did a bit of that work and there was an opportunity for some photos to be taken, but then suddenly someone from the board or somebody who was acting on instruction from the board said, "How can that be? We have Mr Tallentire here who is a member of state Parliament, the member for Gosnells, and he is on hospital property and he has not been authorised by the minister to be here. We do not know what is going on. Mr Tallentire, you better move out." I was made to feel unwelcome and I thought that was unfortunate. It may have been a case of a junior member of staff perhaps over-interpreting the rules a bit.

Nevertheless, it suggests that the board, which is responsible for the policies of the hospital, has a culture for interaction with visiting politicians and somehow the word had got out that if a Labor member of Parliament is visiting the hospital, they have to suggest that they present to the minister before accessing the premises in any way. It is a ridiculous situation really, because I have had cause on several occasions to go to the hospital with constituents or to visit constituents or friends with some medical need to be there. I have no intention of declaring to the hospital that I am there as a member of Parliament when I am visiting people who are hospitalised there. Just to be clear about that, minister, we have to be careful that our boards do not overreact and overreach and become overcautious. They should be able to see the benefit in ensuring that a member of Parliament, albeit an opposition member, has full access to a hospital in a way that a member of the public or a member of a community organisation would have access to a hospital. There is an issue about how these boards interpret their role. We have a problem if they begin to believe that they are there as watchdogs for the minister of the day, which was my experience on that particular occasion. It was disappointing.

The previous Minister for Health was kind enough to reference me in his final question without notice to this Parliament. I say that advisedly because it was following on from some debate we had at the second reading stage of this bill. My contribution seemed to rile the minister in some way because I had mentioned that I was concerned that a board was fundamentally driven to make sure that the hospital acted efficiently, but it was probably also looking to make sure that it achieves certain key performance indicators and certain numbers of throughput and procedures. We were reaching a situation in which a board would be looking to drive a hospital in a way that means it delivers a greater quantity of services, rather than being a board involved in preventative health, which is very important to me. We should be making sure that even bodies such as hospital boards are designed to first and foremost keep people out of hospital by making sure that they stay as healthy as possible. They do not need to have the sorts of treatments and procedures that people will inevitably need if their health is not good. Our boards have a key role to play in helping maintain as strong a level of health as possible in the community through preventative health mechanisms. I put what I thought to the minister in my contribution to the second reading debate, but he did not respond to this in his reply to the second reading debate. It is unfortunate that we are having this rather truncated debate that I am continuing right now.

The minister wanted to say that he had delivered on preventative health. He tried to say that he was going to use the hospital boards to deliver on preventative health. He wanted to say that he had been involved in his time as health minister and one of his legacies was around preventative health. What shocked me most were the sums of money he cited when he responded to a question without notice from the member for Vasse. As I said, this was actually his last response to a question without notice in this Parliament. He said he had had his staff in the Department of Health check up on the legacy of his contribution towards an investment in preventative health in this state. He said the following —

> I asked my staff to get the figures and, as members would expect, the figures are somewhat good, otherwise I would not be standing here talking right now!
>
> I refer to direct expenditure on preventative health, largely through the section of the health department that deals with those things, and some is contracted out and some is done by Health itself. This does not include funding that is spent by Healthway on a large range of preventative health programs. In 2007–08, expenditure was $304 000 and in 2014–15, it was $505 000. That is an increase of $200 000 and represents an annual increase of a 9.4 per cent spend each year.

When challenged on his legacy around preventative health, the Minister for Health said that in his $8 billion health budget the sum going towards preventative health was a whopping $505 000. I find that shameful, but the minister actually wanted to highlight that point and set up a dorothy dixer question from the member for Vasse to expose the fact and talk about it as if it was something of great achievement and import. I find that very disappointing, because, yes, this bill we are dealing with is about hospital boards, but it is about making sure that those magnificent hospitals we have, which do such a great job, run as well as possible—that they are efficient and provide the best possible care for people who are ill and need treatment. But those hospitals will be even better if we keep people out of them as much as possible. If we can make sure our population stays as fit and well as possible, they are not going to need to go to hospital as much as would otherwise be the case. That is what we should be striving for and that is why I believe this legislation should have been designed in some way to have something in it that refers to the hospital's community itself. Bear in mind that it is a bit like our schools; our schools are hubs of our community and in many ways our hospitals are also hubs of our community. There is a capacity in those hospitals for them to be doing some kind of outreach work—I know in the medical world the word "outreach" has its own connotations—but this is another form of outreach. They should be hubs of wisdom when it comes to healthy living. They should be providing that message and reinforcing those programs that the minister went on to speak about when he gave his response to the member for Vasse's question. He talked about things like a school breakfast program, the healthier workplaces program and the LiveLighter program. We see the LiveLighter program advertised on television, which is very good. It is a program that deserves more investment. We need to reinforce the message that if someone is in their vehicle with their family, everyone is hungry and they are arriving at a fast food outlet, they have to be mindful of what kind of food they will be buying and what impact it will have on their health. If they make a regular habit of buying fast food, they are doing themselves harm. We have to have that message firmly established in the community, and at the same time we have to let the community know that there are much better alternatives that are just as convenient. Then people can make the choice. It will be kinder on their wallets as well. They will save money, they will live better, they will feel better and they will be healthier. They will be less likely to have the problems of high cholesterol levels, cardiovascular disease, obesity, diabetes and the other problems that present themselves in so many ways when people are unwell. It could be the prime role of the hospital board to deliver a strong public health message at a local level. I think that would be a major achievement, a major step forward for us.

Another advantage of having this preventative health message coming from the hospital boards, through the hospitals, into our local communities would be that we would be tailoring the message to particular communities. I do not doubt for one minute that the preventative health message that needs to be presented to the people who live in the area around, let us say, Sir Charles Gairdner Hospital is probably a different message from the one that would be ideally presented to the people who live around Armadale–Kelmscott Memorial Hospital. There would be ways that messaging could be tailored to meet the needs of those local communities. I think it is very disappointing that this legislation has failed to contemplate that preventative health role that a hospital board can play. But we have the legislation that is before us and I guess we have to make do with it. It is perhaps up to individual board members to drive this and to detect the need to talk about it with other board members and perhaps make it their own. I look forward to seeing that. It is something I will put forward to members of the Armadale hospital board when I meet and talk to them. I think it would be of great value to our Gosnells, Kelmscott and Armadale communities if their hospital was involved in local events presenting ideas on how a healthier lifestyle message could go out. We would be talking about the hospital being involved in encouraging people to take up active lifestyles—to be more involved in regular

physical exercise and in the sorts of community activities that improve people's mental health as well. There is that wonderful campaign with the words "act, belong, commit, believe". I might be misnaming it slightly, but there is a sense of people being involved in local community groups. They are able to give back to the community through those groups and they themselves are the beneficiaries because they get that sense of belonging and purpose. I see a lot of people who unfortunately have gone the other way and have somehow become isolated. They have lost those connections with the local community and they get into a downward spiral and get those mental health problems and depression. People are fearful of the community that they live in and that is a shame. We do not want to see that; we want to reverse that. I really believe that hospital boards have a strong role to play in doing this.

I acknowledge that the mental health ward of the Armadale hospital does an amazing job. It is one of the sections of the hospital that has one of the most demanding roles. I know constituents of mine who have unfortunately been unwell and had to spend time in the mental health area at the hospital. They have been greatly thankful for the quality of health care they have received. There was one sick person there who while she was in the hospital was able to come up with a wonderful idea to improve security. This is something that a person who is a patient in the hospital was able to present to me and then we were able to talk to the minister about it and ensure that it was picked up. It was all around swipe cards for security. This lady felt somewhat uneasy that patients were able to just wander around the mental health ward, as there were no locked doors. The reason I was given was that staff needed to be given full access to the whole ward. We came up with this idea of swipe cards that would enable staff to have full access, but not patients. There was an improvement. That is the sort of improvement that probably did not need to come to the local member of state Parliament; it is an idea that could have been presented to the hospital board —

The ACTING SPEAKER: Members, you need to keep your conversation level down.

Mr C.J. TALLENTIRE: Thank you, Mr Acting Speaker.

This very real issue of hospital patients being the ones who can sometimes generate the ideas to be put forward to make the hospitals even better is something that we need to look at. Where is the best place for those ideas to go? Is it best for those ideas to come through local members of state Parliament so that we then write to the respective minister and that minister can contact the hospital board, the medical superintendent or whoever is responsible for the delivery of an idea or a new practice? Is that the best way? Would it be more streamlined if the board was receptive to those ideas coming from patients? It is quite possible that that is already an option. In this particular case, for some reason the idea came through me. I think in many cases it would be preferable if the hospital board was in enough contact with hospital patients that its members would be the ones who would first hear of these ideas and be the people who would then set about implementing these sorts of improvements. I question the timing of this legislation. I see the huge impost that it brings. I seriously question why we have failed to ensure that our hospital boards are tasked with delivering a preventive health strategy that would be so usefully delivered if it was done at the regional hospital board level.

MS J.M. FREEMAN (Mirrabooka) [8.11 pm]: I am pleased to rise to speak on the third reading of the Health Services Bill 2016. It has been a very long, but good process that I have been involved in. The debate on this bill has been very important in going through the detail of it. Although the opposition opposes this bill at this time, it is not because of the provisions of the bill but because of the issue of putting forward a new bureaucracy at a time of cuts and wages freezes. I want to be really clear that in the course of going through this bill, the consultative process built upon the provisions of the bill. That will lead to a better bill. The opposition has been very much a part of that process. As outlined by the Deputy Leader of the Opposition, the member for Kwinana, this is at a time when hospitals are facing cuts, particularly staff resources. That is in fact a particular issue for my mother who is contemplating retirement. The hospital is trying to encourage her not to retire because of the impact that that will have on the hospital where she is currently employed. That is probably because she is a fantastic worker and all of those things. Although her work is valued, hospitals at the moment are asking people to extend themselves for the good of the public, to maintain a service during what is quite a harsh wage freeze. Although the government says it is not having any impact on front-line services, I do not think that is the case. People are always appreciative of hospital staff. No-one here wants to criticise staff, but staff cannot be asked to manage when there are not enough resources. I think the wage freeze is having a big impact. Although the Labor Party sees this bill as very important, the additional resources going into establishing an additional board should be put back into the public health system. Despite that, that does not diminish the importance of the bill and the work the opposition and the government has done in scrutinising the bill to ensure that it will make the best act possible.

The Health Services Bill has been in demand for some time. It replaces a very archaic piece of legislation. The health community has obviously welcomed the Health Services Bill, but not as much as the Public Health Bill. The Public Health Bill 2014 also came before this house. The 1911 act it will replace is also a particularly antiquated

piece of legislation that still refers to how we rid ourselves of soil from back alleys and things like that. It really was not responsive, yet we went through a process similar to the Health Services Bill. I will talk in a moment about it going to the other chamber. Despite the fact that the opposition said the Public Health Bill is a complex piece of legislation that, if we take it to a Legislation Committee, can be given the due scrutiny that it deserves and we can pass it in a manner that does not delay it, it now languishes in the Legislative Council. I take this opportunity to ask the Minister for Health, when replying to the third reading debate, because the Public Health Bill and the Health Services Bill are part of the modernising of the health system—it is not just about bricks and mortar; it is about the provision of services —

Mr J.H.D. Day: I entirely agree.

Ms J.M. FREEMAN: Because it is about that, can the minister give an update, in his reply to the third reading debate, about why the Public Health Bill remains languishing in the Legislative Council?

Mr J.H.D. Day: We actually want to get it through this year.

Ms J.M. FREEMAN: The Leader of the House; Minister for Health has the skills and capacity, and the credibility and respect in this house and in the other house, to see that that other very important piece of legislation proceeds in the other house. I am extraordinarily disappointed. I have to say that the communities that I work with are devoted to pursuing and delivering public health. They are communities that need public health assistance. To see us go through a process that we had not gone through for many years to ensure that the bill proceeded, for it to languish in the other house is an indictment on us to be here tonight debating the third reading of the Health Services Bill and not to be saying, "Congratulations, you've actually managed something that previous governments tried and failed." I am very disappointed. But I will let the Minister for Health respond to that during his reply to the third reading.

What was great about this particular process in the Health Services Bill was the establishment of the Legislative Assembly Legislation Committee. Members would know in this place that the big glamour moments in Parliament are question time, matters of public interest and holding the government to account, but the real work is scrutinising legislation. It ensures that legislation is responsive to the community and that in future, if there is a situation that requires someone to look at a piece of legislation to see how it should be delivered in the community, they can refer to the second reading speech, to consideration in detail and to the third reading debate for interpretations of different parts of the act. I will go into how we did that in consideration in detail. Having worked with pieces of legislation in industrial jurisdictions, particularly in workers' compensation, I know how one can get bogged down in the interpretation of one word. That can mean the difference between someone getting a weekly compensation payment and getting nothing. One or two phrases should have been clarified in the house. They were major changes. The particular ones I am thinking of were around stress claims, and that should have been clarified in the house. It was particularly important that the establishment of a Legislation Committee, as well as enabling the opposition, enabled the minister, if we look at *Hansard*, to ask his advisers what something meant. He would say to his advisers, "That's a really good question; can you tell me how that works?"

The ACTING SPEAKER (Mr I.M. Britza): Excuse me, member. I am going to have to ask some members to leave if they are not going to cease their conversations.

Mr N.W. Morton interjected.

Ms J.M. FREEMAN: Not that health is in any way important, member for Forrestfield! I am talking about one of the most important pieces of legislation, the Health Services Bill.

The ACTING SPEAKER: Thank you, member; you can carry on.

Ms J.M. FREEMAN: The establishment of the Legislation Committee resulted from a motion by the Leader of the House to refer the bill. Obviously, that is done by agreement in this place; it is negotiated. As has been aptly put by the member for Kwinana, the Public Health Bill and the Health Services Bill were particularly well suited to that. Also, the minister was very confident in his capacity to allow for discussion on the bill, and it did not hold up the house. Although it is considered colloquially as the second chamber, it is a Legislation Committee. The consideration in detail is similar, but the strength of a Legislation Committee, for those who have not had an opportunity to participate, is that it allows the advisers to be at the table and to be referred to. It is a bit like being in estimates hearings. We ask questions in estimates, and the minister will often say that he is not down to that level of detail, but if it is a good question, he will refer it to the advisers—in the first instance to the director general, who may refer it to someone else who can give us the specifics and the detail that we need to be able to represent our constituents appropriately.

That is the strength of that process, and this is a complex piece of legislation that changes the fundamental structures of health as we have seen them over the past 10 or 15 years. At the current stage, the minister is the

board; he is the employing authority; he is pretty much everything. This legislation understandably says that this is a massive budget and it is a massive organisational task to deliver a good public health system to Western Australia. We want to have good governance for that system, and good governance results from having boards. As the member for Kwinana said, at this point in time it is too early to have the third board, and the cost just does not justify it, but we can understand the process and the reasons for it.

Apart from allowing the advisers to sit at the table, the Legislation Committee establishes a quorum that is significantly smaller than that in the main chamber. It basically consists of the minister and two other members. The business must get done; it will not be held off because the chamber does not have the time. It means that opposition members must be in there. The quorum can be made up of the minister and just two other members, so opposition members know that they have the responsibility to get their act together, get in there and be prepared. It goes quickly. It is not a matter of standing up, sitting down and waiting for somebody else to stand up and sit down; we must be prepared.

It also cannot be as contrived, as sometimes may be the case in consideration in detail in this chamber. We are sitting across the table from the advisers. Maybe sometimes we might want to score some political points in this place during the consideration in detail stage. Far be it from us to want to engage in political point-scoring in this place, but perhaps there is a good reason for it. I did that during consideration in detail in here when we talked about being able to forcibly transfer people into the private sector, and I will bring that up again. The point is that in the Legislation Committee we are talking to the officers of the department who have worked long and hard on drafting and questioning, so obfuscation and other aspects of argument were not commonplace in the two occasions on which I have been involved in this process. Again, that can only be to the benefit of the communities that we represent.

The Legislation Committee process that we went through had not occurred since the Workers' Compensation Reform Bill in 2004—I just mention that that was not the debate in which we ended up arguing about one word—and, prior to that, the Environmental Protection Amendment Bill 2002. It had been some 11 years since we had used this process.

I take the opportunity at this point in my speech to thank the advisers—Ms Rebecca Brown, deputy director general of the Department of Health; Ms Robyn Daniels, senior solicitor in the Department of Health; Ms Kirsten Seneviratne, solicitor, Department of Health; Ms Lee Harvey, Deputy Parliamentary Counsel, Parliamentary Counsel's Office; and Ms Michelle Gadellaa, legislation officer, Department of Health. It took them a bit longer to warm up than it took the Chief Public Health Officer. He was in his element when we debated the Public Health Bill. They were aware that this was a bit of an odd process, but once they realised that it was not about political point-scoring and that we were really trying to move through the bill and make changes to it to benefit the community and enhance the bill, it became quite a seamless process. There was not the situation of the adviser whispering in the ear of the minister, and the minister having to stand and trying to interpret the advice. There was much more engaging discussion, which led to changes that were to the benefit of the community.

I want to talk about the achievements of the Legislation Committee, because they need to be highlighted. It ensured that the interpretation of the bill was clear and that the bill dealt with health services rather than just hospitals. It was made clear that the bill was about health services rather than just hospitals, and as the member for Bassendean pointed out, this has become necessary, unfortunately, I think, because of the contracting out of services to the private sector. While on this side of the house we argue that the provision of hospitals is an essential service that should be delivered by the public sector, this government has undermined that with the Fiona Stanley Hospital privatisation and the Midland Public Hospital privatisation. As stated by Ms Daniels, the senior solicitor for the Department of Health, at page 1631 of *Hansard*, the object of the bill is to integrate both the public and the private partnerships to deliver public health. This is a major change in our public health system. The deputy director general of the Department of Health, Ms Brown, said —

> … from a patient perspective and an employee perspective, we retain a sense of integration across the system. The word "coordinate" is very much around enabling that integration in patient continuing care and the sharing of patient information rather than the definition, which is about the actual—
>
> **Ms J.M. FREEMAN**: Supply or carrying out.
>
> **Ms R. Brown**: Yes.

Really, they are saying that the public health system has now become about coordination and not necessarily about delivery. The member for Bassendean rightly pointed out that this has now caused problems in the delivery of legal services to women around reproductive health and their right to choose if they want to have a termination of their pregnancy. That piece of legislation went through this house. It was debated, it was

contentious and it was difficult, but it gave women that legal right. Now our public health system in one of our public hospitals no longer provides that public health service as a legal right, and that is an indictment on our provision of public health services. Ms Brown went on to state —

> The bill itself creates a very clear role for the department as system manager and provides a level of leadership and stewardship for the system more generally and into the future.

That is at page 1631 of *Hansard*. As part of that systems management, it is really taking away a lot of the role of the minister. We can go further in exploring the role of the health boards and how they will operate and the roles of the minister and the department CEO, and how the CEO and the minister will now basically have to direct on many occasions. But the minister does retain some capacity to resolve complaints, which is sort of handy considering that people walk through our doors every day with complaints about health. We do not want to look at it as an overall system problem. We cannot say to them, "Well, you know, that's about the public health system and the provision of proper waiting lists for this period of time." We actually want to say, "What? You've been waiting for that for so long; let's find out about it." The bill states at clause 61(5)(c) —

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

I think it is worth sharing with this house that the Deputy Leader of the Opposition, the member for Kwinana, put to the minister whether it would be a complaint if someone went to *Today Tonight*. He asked whether that would make it a complaint so that the minister could suddenly go and find out information. The minister said in reply —

> My view is that if someone goes public about their medical condition, it is in the public eye. I expect that you are going to ask me questions about it and I will need to know the answer. It has limits, for example.

For the purposes of the bill, so that members do not get cut down in semantics about what clause 61(5)(c) means, if it is a complaint into our office, I think that is a complaint for the minister as well, and the minister has a capacity to respond to both the opposition and all members to find out individual information. If someone comes into a member's office and says that they have been waiting 10 years for an operation and the minister says that he cannot give any information on that under the new health act, the member can go back to the minister and say, "Actually, they have made it public by coming to me and you've got the right as the minister to find out that information so that I can work that back." There is a bit more about that in the bill, but I think it is worth all of us knowing about that in the process of these things.

There was a lot of humour in the Legislation Committee proceedings, which is quite good when one is going through a long process of considering a bill. One part of the humour was about the term "choses in action" and its definition. We had a debate about what that term means. It is a French term. For some reason we cannot use plain English around this term because it is too complex. It is a right to sue in action, so I was saying that it was about debt, but the member for Maylands heard it as being about death, so there was some cross-communication stuff going on there. I think the adviser's pronunciation of "debt" sounded like "death", so the member for Maylands was saying, "What? You can take action on death?" I would say to members that the humour makes it easier to be able to do something like this. I suppose one thing about going into the other chamber or the Legislation Committee is that it is still run on some of those formal lines, such as the Chair pulling members into line. I think that if we continue a process in which we take more complex bills into the Legislative Committee, we might want to think about the standing orders around that and how seriously they are taken and whether there should be the capacity for a bit of a flow of conversation. There was many a good Chair who allowed the flow of conversation, but there were a couple of Chairs who just wanted to run the debate like they would run it in this chamber. At some stages, that made the conversation stilted. I was going to talk about this a bit later but I will do it now, because this is a good demonstration of it. At one stage the Deputy Leader of the Opposition was talking about what happens with the old act. The Hospitals and Health Services Act 1927 will stay in operation, but all the public services will go across to this bill. He was asking how that would work, so the discussion was about the fact that it would need to be changed to take into account the regulation around private health. He started asking questions in particular about Healthy@Home services and how they work and how that meets up with delivery and Medicare benefits. What I thought was really interesting about what happened in the Legislation Committee, which I do not think would be possible in this house, was that the minister said that he did not understand the member's question and the Deputy Leader of the Opposition said, "Neither do I. That is why I am exploring it." We then went through what was really a quite good exploration of what that meant. What the member was trying to tease out was about Chemo@home and the fact that it cannot get Medicare benefits for its services unless it is contracted to the state government, but it still provides a service. The minister said —

> If they cannot get Medicare, they are like any other provider of services. If they wish to get Medicare that has to be an issue for them and the commonwealth. We should not have to license them to do that, unless there is some reason—and I would need advice here.

He went on to say —

> I am not even sure why we have regulations relating to private hospitals. They have nothing to do with the state. Why do we have them?

The adviser responded —

> I think, historically, the government became involved in regulation of private facilities because there were problems with private facilities not having a standard. So the state said, "This is the standard of the facilities that you have to have and the proportion of staff you have to have within those facilities."

All of those things and the fact that the Hospitals and Health Services Act 1927 is going to cover private hospitals—we now have four private hospitals delivering public health in WA—mean that it is imperative that that act does not languish like the Public Health Bill 2014 is languishing in the Legislative Council. It is not just bricks and mortar; it is about delivering services. If the government is delivering services through private health providers, it needs to get that part sorted out as well. I thought that was a very good example of how that worked out.

The committee deliberations were more than a pedantic scrutiny of words, although I note that there was a pedantic scrutiny of why there was a definition of "provide" in the bill when there was not a definition of "promote", "coordinate", "identify", "respond" or "engage". The adviser advised that the bill extended the meaning of "provide", whereas the definitions of the other words were not extended, so a dictionary definition could be used for them. I thought it was really interesting that the provision goes beyond a normal dictionary definition of "provide" and was an extension of that.

Beyond that, some great amendments came through the process. One of those amendments was to include patient engagement. Again, that came through a discussion about delivering services to patients, and from that a provision was inserted about patient engagement. There were also insertions so that when the government was looking at policy and at other areas it would take into account the experiences of not only the consumers of health services but also their carers, and that it would establish an efficient and effective procedure to deal with complaints about the provision of health services by health service providers. The Legislation Committee process achieved an amazing benefit for the community. By participating in the Legislation Committee process the opposition made sure that this bill is responsive to patients and consumers of health services. That is to be absolutely applauded.

I do not think the new minister will be quite as accommodating as that. He certainly allowed an amendment whereby if the minister sacked the whole board, he would lay that on the table of the house, but his comment on that was, "I will give the member a win." At no stage in the Legislation Committee process was there any notion that we were competing over this piece of legislation—we were working together! But the minister thought he had to give us a win. What the minister did not do was give the workers a win; he would not agree to an amendment that would ensure they could not be forcibly transferred into a private health institution. Under the new act, workers can be forcibly transferred. The opposition tried to make sure that those workers could challenge that so there was a fair outcome for an employee. That does not augur well for the process, and although the minister thought that he gave me a win, I did not feel I was involved in the process to win. I raised with the Minister for Health that the previous minister had said it did not seem right that workers could be forcibly transferred.

MRS M.H. ROBERTS (Midland) [8.42 pm]: I would like to speak on the Health Services Bill 2016 this evening at the third reading stage. As my colleagues have said, this bill signifies a different way of delivering health services in Western Australia, particularly in hospitals. The previous act was some 100 years old and was obviously designed in a different environment and era—an era in which state governments delivered services directly, where state governments were direct employers and direct providers of services. In more recent years there has been a continual push to effectively privatise or contract out services to the private sector, so rather than state government being a direct employer and a direct provider of services, it is choosing to use a contract situation. That is the primary reason that a bill like this has become necessary. The second reading speech for the Health Services Bill makes it clear that its aim is to reform the governance of the WA health system and to replace the Hospitals and Health Services Act 1927.

In December 2013, the government established a WA health transition and reconfiguration standing committee. This bill has been the best part of two and a half years in the making. Despite the Hospitals and Health Services Act 1927 being amended numerous times over the years, as it stands it is not appropriate for the governance of

health in Western Australia. This bill will provide some accountability and clarity of roles in the health sector, which is very important. However, as many of my colleagues commented on this evening and in earlier stages, this bill has been brought about by the change in philosophy and direction of state government, particularly the ideology promoted by those on the conservative side of the house who believe in the contracting-out model and in the private sector delivering services. One of the issues there is the potential for services not to be delivered to the standard that the community might expect. There is also the potential for the accountabilities not to be there so that government is not as directly accountable to the people it is servicing, particularly for essential services in the health sector. That is not to say that private hospitals or the private sector cannot provide very good health services; they can and do. In some instances, they provide excellent services; however, my attitude to this is that an essential service such as health should not provide top quality care for only those who can afford to pay or those who can afford to be privately insured; we also need a very good and appropriate standard of care for everyone, including the poorest in our community, and for the elderly, the young and everyone in between, irrespective of their financial means. Yes, the provision of these services is costly, but it is very important.

As the Minister for Health commented, the annual operating budget of Health is more than $8 billion. When we are dealing with an $8 billion budget, we need substantial governance. I am not going to attempt to go anywhere near some of the problems exhibited in the health sector in recent years, but we have seen numerous failures by government and failures of governance in recent years. This new legislation clarifies the roles, accountabilities and responsibilities, and also devolves decision-making to others in the system. Although on one level it sounds like a good thing to have localised decision-making, counter to that we want to make sure we have a consistent standard of service and that we are delivering to a standard. I would like to know that the poorest people in my electorate were getting a standard of service commensurate with those who are perhaps getting a service in the western suburbs or elsewhere.

The second reading speech states that part 1 of the bill provides that the WA health system is based on Medicare principles, enshrining the right for eligible persons to be given a choice to receive public hospital services free of charge as public patients. That is a good thing, but it is one thing to enshrine that and another to deliver appropriate services in a timely and caring way. It is all very well saying that people have an entitlement to certain procedures or necessary operations or other health treatments, but they need to receive that in a timely way. There have been numerous occasions when I have had to write to the Minister for Health because constituents of mine have been on the waitlist for far too long. Some of these people have been in debilitating pain unable to get back to work or to look after their children or grandchildren, or just to go about their daily lives, because the waitlist has been too long and the service for them has not been timely.

There have also been issues with the location of services. Again, it is all very well to say that as a public patient a person can have a service for free. Maybe there are some in the community who would say that people should be grateful because they are getting a service for free and are not having to pay other than through their taxes and that people should be grateful for getting the service wherever they can. But for many people in my electorate, especially in recent years, it has become onerous for them to get treatment as they have had to go further afield. As members would be aware, this government closed Swan District Hospital, and with the transition to the Midland Health Campus many people had to be "transitioned" for their services. Many of my constituents who had previously accessed oncology services, for example, at Royal Perth Hospital, were told that for future follow-ups they would have to go to Fiona Stanley Hospital. Whilst some people might say that Fiona Stanley is still in the metropolitan area, it is a brand new hospital and they should be grateful, cancer sufferers who need oncology treatment, chemotherapy or the like do not necessarily feel fit, well and able. If they do not drive a vehicle they would be reliant on public transport to get to Fiona Stanley Hospital, not just from Midland at the centre of my electorate but perhaps from one of the outlying suburbs, such as Stratton, Helena Valley or Jane Brook, and the bus services are not frequent. They would then have to be reliant on getting a bus from home to the Midland train station, getting on the train and then changing trains, and then getting off the train in the vicinity of Fiona Stanley Hospital. There have been instances in which people have been told that there would be some kind of bus service to take people there. In the early days that was non-existent. It is also not very frequent. People have had difficulty finding it. Many of my constituents have found that they have had to walk to the hospital. Then they would have to do the trip in reverse. That journey is well over an hour in each direction, probably well over an hour and a half, and it is onerous on people who are seeking cancer treatments. The only alternative would be to find someone who is prepared to drive them there, and if they have a family member who is able to do that, that person oftentimes would have to take a day off work just for the purpose of those people getting the treatment that they could or should have had locally.

I have written to the Minister for Health telling him about people who have said that they would rather seek treatment at Sir Charles Gairdner Hospital because getting to Charlie Gairdner on public transport from anywhere around Midland is easier and quicker than getting to Fiona Stanley Hospital. This new system is no

doubt aimed at creating some efficiency so that, potentially, people can have an operation or receive a service where there is a shorter waitlist or where there are spots available. The downside is that that is not suitable for a lot of pensioners. It is also not suitable for a lot of people who are very ill. It is also not suitable, potentially, for some young mums trying to manage children and the like. We can in a sense get too big, and whilst there is a lot of talk about local decision-making, what I am seeing in the system is a much more global service in which people in my electorate are being asked to go much further afield to access services than they would have had 10 or 20 years ago. In fact, in the last couple of years, people who have been having ongoing treatment at Royal Perth have been sent correspondence advising them that future services can be provided at Fiona Stanley Hospital, Charlie Gairdner or Rockingham Hospital. One can only imagine the reaction of some of my constituents when they are told that perhaps they could get serviced in Rockingham. I think that is a quite a ridiculous offer.

Part 2 of the bill sets out the powers of the minister and establishes the Minister for Health as a body corporate, known as the ministerial body, which is an interesting term but which obviously has a meaning in law. The second reading speech states —

> The establishment of the ministerial body will assist the Minister for Health in performing functions which are more suitably performed by a body corporate than an individual.

I am not sure how the ministerial body can assist the minister if the ministerial body is in fact the minister. I think what is being set up here is essentially legal entities rather than anything else and to the average person that is probably fairly confusing.

The second reading speech also states —

> Part 3 of the bill establishes the director general of the Department of Health as the system manager of the WA health system, purchasing health services from autonomous boards.

It goes on to refer to the director general as the system manager. Effectively, that is what is happening now with the push to privatise hospitals and those services. When I have inquired at the Midland Public Hospital, which is run by St John of God as the private contractor and known as "St John of God Midland Public Hospital", and I have asked how many various oncology or other services it is providing or can provide there, the simple answer in general terms is this: it will provide as many services as the government contracts it to. So, say, for example, the government contracts it to look after 100 oncology patients or 200 of A procedure and 300 of B procedure and demand exceeds those numbers, it is then a matter for the government to decide whether or not it will increase the contract, whether it will contract that provider—be it St John of God in the Midland instance or another hospital provider in another location—to provide those services. This is the new model of delivering health care in Western Australia.

I note that the Premier and others like to laud ad nauseam their delivery of health infrastructure and pretend that they have done something great for this state. They have said they have followed the blueprint of the Reid review, a review done for the former Labor government when the former member for Fremantle, Hon Jim McGinty, was health minister. The fact of the matter is that way back then—I think around 2003—a decision needed to be made by the former Labor cabinet on whether to do a major refurbishment of the Swan District Hospital, which is broadly in Midland, or whether to build on a greenfields site. It was under consideration for probably well over six months within government circles as to which direction we would go. The problem with Swan District Hospital was that it was like a district hospital or a little country hospital that had grown like Topsy over the years. Whilst it was on a big site, it had been added to in and bits and pieces here and there. It was in pretty shocking condition. There were wings, let me call them, of the hospital that had asbestos in them and were really not suitable for refurbishing; they were only suitable for demolition, so that would have proved difficult. We decided that given the strong economic circumstances of the time we would go down the route of building the new hospital for Midland, and that was our priority. I have here some brochures that were put out at the time that referred to Midland Health Campus, as we were calling it at the time, as another state government project and that the new Midland Health Campus would open in 2011. That was our commitment and we were on track to deliver it. We announced the new Midland hospital in 2005 and gave ourselves six years to complete that public project. In fact, in June 2007 the North Metropolitan Health Service put out a staff update, which I have a copy of, headed "Master plan gathers momentum". It states —

> The development of the new Midland Health Campus master plan—which is an important part of the preparation of the Business Case—is progressing well and now moving into its second phase of development.

> The more detailed planning phase involves the development and evaluation of alternative options for the site and, through stakeholder consultation, the selection of a preferred option. The assumptions of the earlier indicative master plan are also checked.
>
> Consultation
>
> The development of the master plan involves continued consultation with a range of stakeholders to deliver the best possible outcomes.
>
> In late May, a master planning forum was held with key staff members at Swan District to discuss the indicative master plan. The feedback gained from this forum was then used to develop various options, which were further refined at a master planning workshop in mid June …

Keep in mind that this is in 2007. It further states —

> Discussions have also been held with the Midland Redevelopment Authority to ensure that the new health campus integrates with the surrounding precinct.

That document goes on and drawings and plans are attached to that staff update that went out in June 2007. I want to highlight that we were moving towards a fully public hospital. We were replacing Swan District Hospital with a fully public hospital in the same way that Royal Perth Hospital has operated as a public hospital since its inception and the way that the Swan District Hospital had operated as well. The priority for this hospital was dropped; it dropped off the radar. That was deliberate and understandable, because the Premier had gone out during the 2008 election campaign and promised a new children's hospital for Perth. A new children's hospital certainly had not been announced by the previous Labor government. It was not our priority at the time. We were going down the path of making do with Princess Margaret Hospital for Children for the immediate future. However, it was certainly part of the Reid review and that would have followed on logically as the next project that the former Labor government would have moved onto in following the Reid review as we had committed to do. What happened? With the new government came new priorities.

Midland hospital got pushed backwards and the Perth Children's Hospital was suddenly put onto the agenda in 2008, and Premier Barnett set about delivering the new Perth Children's Hospital. It is very hard to argue against prioritising a new children's hospital. Of course, all of us want to see the best possible facility for the children of this state but the decision to bring that forward meant that Midland moved back. Essentially, Midland hospital was put on the backburner for a good two or three years. Then the government decided that it would look at different options for delivering the hospital, other than a fully public hospital. That was certainly disappointing, particularly for publicly employed staff at Swan District Hospital and the community. I will not canvass some of the issues that a couple of my colleagues have already canvassed about services that are not provided by the private hospital provider. I take no issue with St John of God not providing those services. My only issue is with the government because the government said it would deliver those services on site.

The Premier expressed his disappointment and lack of knowledge that St John of God would not provide those fertility services on location. I really wonder what rock the Premier had been living under if he ever thought that a Catholic health provider would ever provide fertility or termination services on site. This is the range of issues and no matter what the government decided it wanted the contract at St John of God to do, it would be impossible to expect the government to say that it wanted to contract St John of God to provide those services, because St John of God just plain does not provide them. We were told for a couple of years that a freestanding facility would be put on site to deliver those services and they would be delivered separately. Of course, we now know that did not eventuate and this government has chosen to fund a private organisation, Marie Stopes International Australia, to provide those services.

I am seeking to make a couple of points. One is that the hospital project that we had committed to back in 2005, which was well advanced by 2007 let alone 2008, was clearly put on the backburner. Under that proposal, we were to deliver the new Midland hospital on the site that we had selected at the Midland railway workshops, to open in 2011. Of course, it is a matter of record that that hospital opened only at the end of 2015, some four years late.

In the meantime though, a huge amount of work had been done on the Perth Children's Hospital and other health facilities. I make that point about priority, because Labor was in the process of delivering on its commitment and had we remained in government in 2008, we would have delivered a fully public hospital on that site years before the government delivered its hospital on that site. I note that the money was put on both the state budget and an allocation of funding in the order of $160 million was committed back in about 2007–08 by the then federal government.

The further point that I make is that the Health Services Bill is brought about because of the government wanting to provide hospital services by contracting out services. Clearly, the standard of health care is absolutely important and it is of great concern to people when we get a private provider to provide services on contract. Another concern that has been raised with me in that environment is the security of people's personal medical records. Although people have some confidence in the state maintaining confidentiality, there is certainly a concern about private organisations collecting very personal information about members of the public. Again, that is not something I have time to dwell on tonight but I raise that issue.

Part 3 of the bill establishes the director general of Health as the system manager for the WA Health system whereby it then purchases services from autonomous boards.

He or she will have the powers and functions set out within part 3 of the bill, but effectively I think it exemplifies the model we are talking about. We are talking about a model that allows the director general to effectively purchase health services on contract, and that is what is happening at Midland Health Campus.

In the time remaining I will quickly point out that I have had some complaints. I look on Facebook and social media to see what experience people are having at the privatised public hospital in Midland. I have seen many great pics of mums and babies and smiling faces that have been promoted, and that is all great news—people with very, very good outcomes. Occasionally, though, I read about people who have not had such good outcomes or who are disappointed with the service. I noticed one lady posted on Facebook in the last fortnight saying that her neighbour had just become a great-grandmother for the fourth time. The baby was a little boy and the mum was fine after a caesarean section. The lady commented that less fine was the situation at the new Midland Hospital. The mum pushed her little heart out for four hours before they decided to intervene. There was nowhere for the family to sit. There was no covered internal area to wait. The front entry area of the St John of God Midland Public Hospital was all locked up. The grandmother was not permitted stay in the mum's room. It was a disaster. There were benches outside the hospital but it was raining, so the 73-year-old great-grandmother sat in her car all night. Whilst this woman is as fit as a flea, she should not have had to sit in her car all night. Not to mention that the grandma was told to leave the hospital when the lady and her partner went in to have the caesarean section. There was also some further commentary on that. It certainly surprised me and it is a matter I will raise directly with the hospital. Especially around Midland, people travel in from neighbouring country areas and the like, and if there are more than one or two support people, I think there needs to be accommodation for them.

DR K.D. HAMES (Dawesville) [9.12 pm]: I rise to put on the record some of the alternative facts. The fact that they are alternative suggests that one of us is not stating facts regarding the history of Midland hospital. I will respond to some of the comments by the member for Midland. Quite clearly, as shadow health minister at the time, in 2008, and then minister in late 2008, I was fairly intimately involved with the planning of Midland Public Hospital and the timings related to it. Clearly, I was not in government in early 2008, so I did not have access to records from the Labor Party at the time, but I do recall —

Several members interjected.

The DEPUTY SPEAKER: Order, members!

Dr K.D. HAMES: It was a very similar story to what happened with Albany Hospital. The Labor Party had been planning a refurbishment of Albany Hospital. It went over different plans and different versions of what was going to happen there—all refurbished versions of the very old and rundown existing hospital. Quite luckily for us we were leaked a report that had been done by the Minister for Health into options for what redevelopment should occur at that hospital.

Mr P. Papalia interjected.

The DEPUTY SPEAKER: Member for Warnbro, the member for Midland was heard in silence. I think you should give the same courtesy to the member for Dawesville.

Dr K.D. HAMES: The option chosen by the Labor Party was a major refurbishment, and in fact the report that was leaked to us made the recommendation that the refurbishment was totally inadequate and a brand-new build was the best option for the hospital. Being a good opposition, we did what all good oppositions do and we made a commitment to build the new hospital.

Mr P. Papalia: You were never a good opposition. You were terrible.

Dr K.D. HAMES: We won and we beat the Labor Party, so that suggests we were perhaps not so terrible after all, and the subsequent comments I will make about Midland will probably add to that.

Several members interjected.

The DEPUTY SPEAKER: Thank you, members! Order!

Dr K.D. HAMES: We made a commitment to build a new hospital if we were elected, and subsequently in the last week or two—the polling must have been showing that the member for Albany was in trouble; the Premier at the time, Mr Carpenter, went down to Albany and announced that, despite four years previously having put off doing anything at the hospital, Labor too would build a new hospital.

I get back to Midland. The commitment from the Labor Party had been to do a major refurbishment of Swan District Hospital. That was its plan for a long time. The member was saying that back in 2005 and 2006 the plan was for a new hospital in town. That is certainly not my recollection and that is certainly not the information that I saw put out by the Labor Party. I know in 2008—I do not remember the exact dates—we had again been considering putting forward building a new hospital in Midland. We were given leaked information that the Minister for Health in the period leading up to the election in 2008—I do not know how long it was—was about to announce that instead of doing the refurbishment, he was going to build the new hospital in Midland town. We got out early. We did a media event and a press release, because we were told that within the next two weeks the minister was going to make a statement.

Mrs M.H. Roberts interjected.

The DEPUTY SPEAKER: Member for Midland, order!

Mrs M.H. Roberts interjected.

The DEPUTY SPEAKER: Member for Midland, I have asked you —

Mrs M.H. Roberts: You have got your elections mixed up.

Dr K.D. HAMES: We came out announcing that we would build a new hospital in Midland. If I got the election mixed up and the member for Midland is talking about the election campaign before in 2004–05, the Labor Party got re-elected and she says it was ready to go with all that money in the kitty. So, the Labor government must have then sat there for another four years and not built the hospital. I do not believe that is the case. I believe that this occurred in 2008, when that announcement was made.

Mrs M.H. Roberts: I've got all the documents.

The DEPUTY SPEAKER: Member for Midland, will you allow the member for Dawesville to speak as you were allowed to.

Dr K.D. HAMES: I am happy to check it later, but I let you talk in silence, so perhaps you could do the same. We announced that we would build the new hospital in Midland. Even if that was four years earlier and I have my dates wrong, the point remains the same: we committed to doing that new hospital. Remember, I was only shadow Minister for Health from 2004 to 2008, so it could not have been the previous election. It is impossible for it to have been the previous election, because I was not there in that previous election. I was only there from 2004 to 2008 as shadow Minister for Health, so it makes sense that that is when it was. In 2008 we announced that we would build a new hospital in Midland while waiting for the then Minister for Health to say the same. He did not. There was this delay and we were waiting and waiting and we wondered why he was waiting so long. About four to eight weeks later he announced the hospital in Midland and $180 million—I am pretty sure it was $180 million and not $160 million—to go with it. When I came in as minister in 2008, I thought, "Great, the plans are all there. They are ready to go. There is enough money to build the hospital." But no, there was no federal government commitment at that time. There was $180 million of state government money to build a hospital that was going to cost an enormous amount more than that.

Mr D.J. Kelly interjected.

The DEPUTY SPEAKER: Member for Bassendean.

Dr K.D. HAMES: I will tell the story. It is my story. I will tell and if the member stops talking and listens, he will get the picture.

Mr D.J. Kelly interjected.

The DEPUTY SPEAKER: Member for Bassendean.

Dr K.D. HAMES: I am trying to do a 10-minute speech and members opposite are turning it into a 30-minute speech. It is true that when we came into government, we prioritised the Perth Children's Hospital over Perth Stadium. That was the statement made by the Premier. Members can check that on the record for sure.

Mrs M.H. Roberts interjected.

Dr K.D. HAMES: I did not interrupt the member for Midland—fair go.

We put the children's hospital before the stadium and delayed doing the stadium. Regarding Midland hospital, no plans had been done, no design work had been done and only half the money required to build the hospital was there. It was nowhere near ready to be built. It was the same as Labor party's announcements of dates for Fiona Stanley Hospital. Every year it was put back a year, because Labor was not ready. It was nowhere near it. The federal government at the time—a Labor government—decided it would spend money that had been put aside in the Future Fund by John Howard for infrastructure across the states. Western Australia was offered infrastructure funding by the commonwealth and was asked what we would like to use it on, particularly in health. The federal Minister for Health and Ageing, I think it was Nicola Roxon at the time, asked me what I would like the funding to go towards. I put forward two areas that I wanted the money to go towards—one was for the rehab component of Fiona Stanley Hospital, which had not been funded. That was about $240 million. That was agreed to by the commonwealth government. The second component was Midland hospital. I asked for $180 million to match the $180 million that was already in the budget to cover the $360 million cost of building that hospital. The federal government agreed to that funding. I subsequently wrote a letter, which might be the one the member for Bassendean is talking about, to Nicola Roxon to say —

Mr D.J. Kelly interjected.

Dr K.D. HAMES: Listen, for goodness sake. Give me a go!

Mr D.J. Kelly interjected.

Dr K.D. HAMES: You are seriously pathetic!

The DEPUTY SPEAKER: Member for Bassendean, I call you for the first time. I have asked you to give the member an opportunity to speak. We heard the member for Midland in silence.

Dr K.D. HAMES: I wrote to the minister at the time to ask whether she had a philosophical objection to us doing this through the private sector; that is, getting a private organisation—it turned out to be St John of God Health Care—to manage the hospital using the federal government's $180 million. I asked whether the federal government would object and withdraw the $180 million. The response was no; providing it provided a public service, there was no objection to us doing that. We proceeded to call for expressions of interest. We knew that St John of God did not provide a small number of procedures. It was a very small number in comparison with the total numbers being provided at Swan District Hospital. The other large competitor in the bid was Ramsay Health Care. We wanted to make sure we had two very strong competitors to get a competitive bid to get the best outcome for the taxpayers of Western Australia. As it turned out, the St John of God Health Care proposal was the best and it was awarded the contract. We originally planned to provide those additional services on site, but in going out for expressions of interest we had no suitable bids to do that, and finally agreed that we would fund them at Marie Stopes International Australia down the road. That is the history of those.

The member for Midland has provided me with other information that I am happy to follow through. All I can say is that I bet if I go through my records, which I was actually looking at yesterday, I will find those records of my announcement and the federal minister's announcements, and the dates of those that occurred in 2008. We have two alternate versions—one of us is correct. Time will tell which is true.

MR J.H.D. DAY (Kalamunda — Minister for Health) [9.22 pm]: Does the member for Warnbro really want to speak? If he does not, we will go home after I have spoken. We can either listen to you or go home after I have spoken. I will be generous with you.

MR P. PAPALIA (Warnbro) [9.23 pm]: I will make a short contribution on the Health Services Bill 2016 only because I have been asked to do so. I thought that the former Minister for Health's contribution illustrated the real purpose of this bill, which is to retrospectively fit a framework around a system that he messed up. He established a system that is philosophically driven. It was interesting that the former minister used that phrase when relaying the story about the advice he sought from the federal government regarding Midland hospital. That is what this government has done to the health system and what has driven its actions within the health system and across government. In many different portfolios, a structure that had been established for decades, and in many cases was the best way to ensure that there was oversight and good governance provided to a system, has been undermined by a philosophical drive to introduce privatised services wherever it can. Regardless of whether it is a better outcome for the taxpayer or a better outcome for the provision of services, the priority has been to introduce the opportunity for privatised services. The government had to retrospectively fit a legislative framework around it to enable that undermined system to continue.

We found that the health service already had elements of privatised service provision, but it has been expanded and rolled out substantially. In my view, that happens when responsibility is devolved. The former Minister for Health made the argument in his second reading speech that —

> … the WA health system lacks clarity of roles and accountabilities. The current governance arrangement for the WA health system concentrates all authority and accountability in the office of the director general, either in the office holder's own right as chief executive officer of the Department of Health or as delegate for the Minister for Health as the board of all Western Australian public hospitals and health services.

Interestingly, providing better governance will fragment the chain of command. It will fragment the responsibility by providing subordinate levels of responsibility across the system. Some will be privatised and some will be public services. Some services will be provided to other agencies like the Mental Health Commission through a memorandum of understanding. Somehow the argument goes that that enhances governance and the ability of the system to be held to account, and that devolving responsibility somehow improves the provision of services and accountability. I do not think it does. I have not watched it inside the health department but I have in Corrective Services, where a similar process has been undertaken under the leadership of this government. A global system that provided oversight and accountability to the very top through one recognised authority also provided the ability to share knowledge across the system without failures or successes having to occur in every single part of the system. One global system enabled the sharing of knowledge through what is the greatest asset—the people involved in the system. That global system was broken up into multiple organisations that will have separate motivations. They will all not be inclined to share successes and/or failures. In the case of private enterprise, they are motivated by profit margins. Not only is there a disincentive for them to notify a failure, there is also a disincentive for them to notify a success. If they succeed in the provision of a service or develop a new technique for the provision of a service, they are hardly likely to share it with a potential competitor. They see the competitor as being the public system as well because they are always trying to expand their footprint across the public sector in the provision of services. Instead of a system that has one individual authority or one point of responsibility at its apex, that person, without really having the authority and without necessarily having a responsibility—what they have is plausible deniability—will be able to say, "We have an arrangement with this organisation over here for all the responsibility there. They are a private enterprise. I have the contract with them. If they fail to comply with their contract, if we are lucky enough to identify that they have failed, we will prosecute them or we will pursue them through the courts but it was not ever my fault." Subsequently the lack of responsibility flows up the chain to the minister, so there is another layer of responsibility between the minister and the people on the ground providing a service.

That is what happens. When a system is privatised and there are multiple entities providing that system, the delivery of services within the system is incentivised not to share failures and successes. In my view responsibility is diminished. There is a good likelihood that accountability is diminished and there is a very high likelihood that governance will be eroded over time. If members want to see an example, look at the report that was tabled today by the Auditor General entitled "Audit of Payroll and other Expenditure using Data Analytic Procedures". This is where we are going to go in the future. If we use big data analysis to snag the occasional failure by the system, if we are lucky enough to identify it, that is how we will be able to identify whether the system has failed retrospectively. We will not very often be able to find the failures in the absence of someone like the Auditor General looking backwards. We will not have that single point of authority and responsibility. The Auditor General's office looked at four million transactions totalling over $7.5 billion from the systems of 12 agencies. I am not very comforted by the report. I do not think it is that comprehensive; I do not think it has really drilled down to the level of failure across the system that it identified. The conclusion of the report states —

> We found no evidence of fraud from our tests at any of the 12 agencies. However, we did identify errors including overpayments and a need for improved controls at 6 agencies, and in particular, at the Department of Corrective Services. Without improved controls, there is a heightened risk of fraud or error occurring.

There were 12 agencies, and 50 per cent of them had failures. If there is a failure across a system that is spending $8 billion a year on health, there is an enormous potential for the taxpayer to be damaged and exposed, and we know that. I have no confidence at all that the health system has good governance and oversight of its expenditure. That is why it keeps blowing out its budget. There are enormous opportunities within Health for efficiencies and savings, and better service provision, but accountability and oversight is necessary to provide that. To be able to identify opportunities for better provision of services, we must have the knowledge to identify those opportunities and change them. However, when the responsibility is devolved to such an extent as the

government has done through privatisation, there will be elements within the organisation whose sole motivation will not be to identify more efficient and cheaper methods of operating unless it is for withholding and retaining any savings they make within their organisation for themselves and for the profit margin of their organisation.

The whole purpose of this Health Services Bill seems to have been, beginning in December 2013, to retrospectively establish a system to accommodate the mess that the government has created. I fear that, in the future, it is likely that Auditor General's reports and some hard work by external agencies will result in the identification of failures that the government has set up through this process. In the meantime, resources that are essential across the system are being cut to fund this sort of process. We see the South Metropolitan Health Service cutting the jobs of people who actually provide health services to patients so that administrative processes can be left untouched, because they have been contracted out. It does not make sense. The whole bill has been retrospectively foisted on the people of Western Australia, and it reflects what has happened across a lot of portfolios. There will be many instances where we come to grief as a consequence of the system that the government has established.

Apart from the philosophical intent of the government to always establish privatised services wherever it can and to outsource government services, part of the motivation for this legislation is to avoid responsibility for ministers. Essentially, there does not appear to be a reason for ministers to do their job. The ministers seem to think that their job is to provide a commentary and never be responsible, and if they can avoid responsibility through outsourcing, privatisation and the reduction of government services, they will do so but what they will not do is relinquish the benefits that they receive for occupying their jobs.

We are closing in on the next election. I saw the former minister trying to defend his legacy in advance of his departure from this place, and it was interesting to watch. However, in the event that Labor takes office at the next election—I do not think it can come soon enough—there will be a lot of opportunities for reassessing and placing on the record what actually happened, and I do not believe that there will be many things that will reflect well upon the restructure that has occurred within Health. That will be exposed as one of the great failings of this government. There are quite a few failings, and it will be a competition to determine which are the worst, but I think, within Health, the manner in which the system was fragmented and torn apart, and privatisation at all costs was pursued, will be exposed as one of the great failings amongst a vast array of failures.

MR J.H.D. DAY (Kalamunda — Minister for Health) [9.35 pm] — in reply: I thank members for their contributions on the Health Services Bill 2016. It has been a relatively lengthy process, because it is a very substantial piece of legislation with a large number of clauses and different aspects. Consideration of the bill started off under my predecessor, the member for Dawesville, and is now my responsibility as of the last five weeks or so. It has generally been a constructive debate, from what I have heard, and using the Legislation Committee process has been very helpful to the consideration and passage of the bill. I am pleased to say it was supported by the opposition, and it allowed the use of the process whereby officers of the department and those involved in drafting the legislation were able to provide advice much more directly than is normally the case in this chamber.

As has been outlined, the bill will replace the Hospitals and Health Services Act 1927, and will have a substantial effect in reforming the governance of the Western Australian health system. It is the view of the government, and I believe it is a view more widely held, that there is insufficient clarity about the roles of the different parts of the system, and insufficient accountability. As has been reported in the media, I have made the observation since I have been back in this role that the amount of expenditure on the public hospital and health system in this state has almost quadrupled in the time since I last had responsibility for the health portfolio in the previous coalition government. In 2000–01, the budget was about $2.2 billion, and in the next financial year it will be around $8.5 billion on the recurrent side, with about another $500 million in capital works. The budget has almost quadrupled in the past 15 years. Fifteen years is a rather lengthy period, but I am sure that the growth in the health budget would be far greater than in any other area within the state government. The proportion of the state budget that the health system consumes has grown over the past 10 years from about 24.5 per cent to approximately 30 per cent. That growth in the rate of expenditure and the proportion of the state government's resources, particularly in financially constrained times, is obviously having a major impact on the state's finances.

It has also been reported, and it will be outlined in more detail in the budget papers on Thursday, that the cost of providing health services in Western Australia is currently about 18 per cent higher than the average national efficient price—the unit cost of providing services across Australia on a comparative basis—and that is a substantial differential. Other states have been reducing their costs comparatively to Western Australia—I emphasise comparatively—whereas our rate of growth of expenditure has continued to rise substantially. About half of that differential is due to the fact that the Western Australian health system has higher salaries and wages compared with other parts of Australia. Generally speaking, staff in the health system in this state are paid about 20 per cent higher than the health staff in other states. I am not saying that that is a bad thing—it is obviously

a good thing for the many thousands of employees in the Western Australian public hospital and health system—but the rate of growth that we have had, including in salaries, is not sustainable into the future. I also make the observation that all of this is in the context of the state government facing a $3 billion deficit approximately in relation to recurrent expenditure—we are spending about $3 billion more in the current financial year than we are receiving in revenue at the moment. Therefore, the impact that the health system has on the state's overall finances is very significant.

At the moment, all of the authority and accountability for the health system is placed in the office of the director general, either through the director general's own role as chief executive officer of the Department of Health or as a delegate for the Minister for Health. It is a governance arrangement that is not sustainable for such a large and complex system; therefore this model is being put in place with a number of area health services and boards to govern them. We believe that the bill will clarify the roles, responsibilities and accountabilities at each level of the system. In particular, by devolving decision-making to a more local level on an area basis, the legislation will therefore continue the delivery of efficient and, in particular, high-quality health care across Western Australia. The bill has the effect of reforming the governance of the system by establishing the director general of the department as the system manager of the WA health system, who will be responsible for ensuring consistency and integrity across the whole system by establishing separate statutory authorities to be known as health service providers, and for the delivery of health services. Essentially, a purchaser and provider model is being put into effect. As the system manager, the director general will have the responsibility to ensure consistency in the delivery of health services through the use of binding service agreements and policy frameworks and by making directions to health service providers. The bill also provides for regulation around, for example, the charging of fees for health services, employment, information management and the control of traffic on health service provider land.

During the consideration in detail stage of the bill, the opposition raised some key issues in relation to community and patient engagement, industrial relations and employment aspects, the potential for dismissal of board members and the contracting out or privatising of health services. In relation to community and patient engagement, the government agreed with the opposition's view that the legislation should recognise the importance of community and patient engagement in the delivery of health services. As a result, three amendments were made to the bill to accommodate that view. The first of the amendments was to ensure that the objects of the bill, as set out in clause 4, highlight the active role of patients as participants in the healthcare system. The second amendment was to ensure that the functions of health service providers, as set out in clause 34, include a function to establish an efficient and effective procedure for dealing with complaints about the provision of health services. The third amendment was to the constitution of the health service provider boards, as set out in clause 71, to provide for experience as a consumer of health services or as a carer to be recognised as a relevant qualification for appointment as a board member. Another amendment that was agreed to was about the minister's power to dismiss all members of a health service provider's board without any requirement for the minister to table such a significant decision in Parliament. The government—this was following my assumption of the role—did agree with the concern, and clause 102 was amended to require the minister to table the decision before both houses of Parliament and to include the decision in the health service provider's annual report. As I commented at the time, in the event that a whole board was dismissed, the requirement to table in Parliament would probably be a pretty academic exercise, because I think it would be impossible for such an action to occur without it becoming publicly known; however, it does really complete the process to require that there will be a tabling in Parliament of such an action. The final amendment that was agreed to was in relation to clause 24 to restrict the director general from delegating to health service providers the function of managing WA health system industrial relations negotiations.

Other issues were raised by the opposition on the adoption of the Public Sector Management Act provision for the redeployment, redundancy and transfer of staff, and on the health service providers' powers to enter into contracts with the private sector for the purpose of providing health services. The government did not agree to those proposed amendments. Firstly, regarding the matter of redeployment, redundancy and transfer of staff, the bill reflects the present Public Sector Management Act provisions. On the suggestion that these provisions may be used to privatise services, it has been made clear that this is not the intention of the government; however, the bill does need to provide flexibility for health service providers to enter into contracts. Any actions by health service providers to privatise services would be monitored by the government through service agreements, policy frameworks and directions, and a requirement to seek the approval of the minister and the Treasurer for certain transactions.

As I have said, I thank members for their contributions on this bill, particularly through the Legislation Committee process, which I think was a helpful aspect of the consideration of this bill.

I will put on the record one other aspect which I understand is being changed by this legislation and which I think will be very welcome. It is the current requirement for any leasing agreements within the health system to be approved by the Governor. In other words, before any agreements involving facilities that are owned by the WA health system or are going to be leased by the WA health system are put into effect, those agreements need to be approved through the Executive Council process. That requirement must involve an enormous use of resources through the public service and then through Government House. At least 50 per cent of the Executive Council meetings that I have been to over the last almost eight years, and which every other minister has been to, have required the Governor to sign off on any such leasing arrangements. I recall that one that I signed only recently was for about 50 square metres of accommodation in Tom Price for use by a dentist. Fifty square metres is not a very large area and the rental involved was a peppercorn amount, but this lease obviously plays a role in ensuring that dental services are available to the community of Tom Price. However, the requirement for that agreement to be approved through the whole Executive Council process must be, as I said, an enormous use of resources. Putting in place a much more contemporary and still accountable system for leasing arrangements will produce a much more efficient system and will have a role in reducing red tape; it certainly should reduce the costs involved in administering the whole system.

Some specific issues were raised about Peel Health Campus; for example, what will be done about the current agreement with Ramsay Health Care, which I understand will expire in about two years—I think in August 2018. We have not made any decision at this stage about what will be done post that point. That issue is currently under consideration. Questions were also raised by the member for Mirrabooka about the Public Health Bill. I and my predecessor, the member for Dawesville, share the very strong desire for the Public Health Bill to be approved by Parliament this year. As far as we are concerned, it is not languishing in the upper house. A whole range of other legislation has needed to be dealt with in the Legislative Council and I very much hope that the opposition will facilitate the passage of the Public Health Bill during this year, if not before the end of June.

Ms J.M. Freeman: Like we did this piece of legislation.

Mr J.H.D. DAY: Yes, and I look forward to both pieces of legislation having their passage facilitated through the Legislative Council. This bill is more critical because it needs to take effect from 1 July, or in a bit less than two months. The Public Health Bill is not as time critical but, as has been noted on many occasions, the review of the public health system and the rewriting of the legislation has been underway for about 20 years or so and the government is very keen for a much more contemporary public health act to be put into effect in Western Australia as well.

Once again, thank you to all the members who have contributed to the debate. Generally speaking, the passage of this legislation has been reasonably well facilitated. Probably things have dragged out a bit longer than has been absolutely essential, but that is the nature of the parliamentary process. It will be a very substantial achievement for the government and for Parliament when this bill is put into effect because it will put in place a much more contemporary arrangement in the extensive health system that we have in Western Australia, which, as I said, is being very strongly supported by Western Australian taxpayers in providing world-class services for people right across Western Australia.

Question put and passed.

Bill read a third time and transmitted to the Council.

House adjourned at 9.52 pm