HEALTH SERVICES BILL 2016

Second Reading

Resumed from 23 February.

MR R.H. COOK (Kwinana — Deputy Leader of the Opposition) [4.15 pm]: Mr Acting Speaker (Mr I.M. Britza), thank you very much for the opportunity to speak on this legislation and I am pleased to see that even though it is afternoon tea time, at least three people are in the chamber and I thank them for their presence.

I want to speak on the Health Services Bill 2016. Health governance is a very important area and so from that point of view it will not surprise the government that I and others wish to spend some time talking about the detail of it. I say from the outset that I do not have a fundamental problem with this legislation. From all the opportunities I have had to examine it and be briefed on it, I think it is quite competent legislation. From comments that I have made publicly in the past, members know that I think it moves us in the sort of direction we are looking for to bring greater innovation into our health system and provide more nimble and more relevant health services with decision-making being devolved closer to the coalface. We all have differing views about where those decisions should be made. Of course, doctors believe all decisions about resources should be made at the coalface where they reign supreme. Perhaps, from the other extreme, the minister would want all these decisions to be made up towards his or her end of the decision-making process. Nevertheless, this is a debate that goes on continuously.

The bill before us is fundamentally good legislation. I think it does a range of good things but at the wrong time and in the wrong place. The legislation comes at a time of acute budgetary constraints in the health budget. It also comes when the reconfiguration of health services has caused significant structural dislocation in our hospital system. The minister has talked time and again about the difficulty the department is having adjusting to the reconfiguration of health services in south metro and the enormous consumption of health resources in relation to that. I am personally quite surprised that we now have legislation before us that seeks to bring more reconfigurations and more disruptions to the health service via the stated intention of the government as a result of this legislation, which is to create another health service provider—namely, East Metropolitan Health Service.

We do not have a problem with the issue of an East Metropolitan Health Service. It is important to have a strong emphasis on providing good quality health care right throughout that eastern corridor. But we do wonder whether this is the time to implement such a policy. We seek guidance and advice from the minister about why we are moving in this direction when he says that the budget is under such constraint and the department is experiencing such great upheaval through the reconfiguration of health services and the big shifting of resources through the clinical redesign around Fiona Stanley Hospital, the commissioning of Midland Health Campus and other significant events in the life of the Department of Health. In particular, it is extraordinary that we are indulging ourselves by this governance rethink in the health sector when the very services upon which we depend are under attack. Some of the most oppressive human resources policies in this department's history are now in place. The policy of staffing freezes and the cost cutting that the minister is demanding, particularly for the South Metropolitan Health Service, are putting our clinical services under extreme pressure. Time and time again the minister has said that he believes cost cutting is necessary because our state price for hospital services is too high and we therefore have to find extra productivity. We have to cut back and reduce the number of staff, we have to have constraints on the staff we replace when people go on leave or leave the service, and we have to constrain wages growth and the growth of hospital budgets. The minister is on the hunt for every saving he can find. That is why at the moment we find things such as the partial closure of the hydrotherapy pool in the rehabilitation service at Fiona Stanley Hospital. That is why the eye services at Rockingham Hospital are shutting —

Dr K.D. Hames: Ophthalmology.

Mr R.H. COOK: Are they classified as doing ophthalmology down there?

Dr K.D. Hames: It is ophthalmology.

Mr R.H. COOK: Yes. The ophthalmology services at Rockingham Hospital are closing. Latterly, shutting the ophthalmology services at Royal Perth Hospital has been reprieved, and they are being consolidated at Fremantle Hospital to create savings.

The cuts are the reason that I have been approached by medical scientists who say that their contracts had been simply cancelled while they were working at PathWest. The cuts are the reason why the government is imposing a 25 per cent tax on the pharmaceutical allowances that patients receive from the commonwealth government. The minister tried to answer a question on this the other day, so I will take the opportunity to explain.

Dr K.D. Hames: I tried not to answer it!

Mr R.H. COOK: The minister looked completely flummoxed by the question, which was from left field, so I will explain to Parliament what is happening. For those people who currently pay Homeswest rent and also receive a pharmaceutical allowance from the commonwealth government, the state government will now deem that pharmaceutical allowance as income for the purposes of calculating their Homeswest rent. As we know, Homeswest requires a payment that is 25 per cent of a person's deemed income. The pharmaceutical allowance is now effectively a tax of people's pharmaceutical benefits by the Barnett government.

Dr K.D. Hames: The advice given to me by the Minister for Housing was that, firstly, that is done in every other state in Australia, and, secondly, the money that is given does not have to be used to purchase medicines. They decided to increase payments by calling this a pharmaceutical benefit when it is actually just income generally.

Mr R.H. COOK: I note the interjection from the member for Mirrabooka, who just said that that is in fact not the case. But it is the case that people are being cut to the bone. We have seen the mishmash of policy processes for Bentley Hospital maternity services. First, it was stripped of its management and was consolidated under Royal Perth Hospital. The government announced that maternity services at Bentley Hospital would be shut. The government then backflipped and said that maternity services at Bentley Hospital would be given a reprieve, but the services are clearly under significant funding pressure.

While we are talking about cuts to hospital leaders, the leadership people at Fremantle Hospital are losing their jobs as that hospital is consumed by the management of Fiona Stanley Hospital. Organisations that are threatened by funding cuts, such as the Unity of First People of Australia, are concerned. That association provides health services and preventive health services in the Kimberley. Funding for the Midland Aboriginal maternity services organisation Moort Boodjari Mia will be cut in June this year. That organisation provides very important services to young mothers who come from the lowest socioeconomic group in our community to ensure that they deliver happy, healthy babies. The clients who are managed there have achieved great birth weights. Despite the increase in the number of people it is serving, that is another organisation whose funding will be cut.

Dr K.D. Hames: It's a federally funded program. We topped it up for a year after that.

Mr R.H. COOK: That is right; the government topped it up and it will no longer do so.

We have people such as John Davies who waited almost three years to receive his hip operation because of resource difficulties in the health department. Heather McCulloch waited for a knee operation for almost three years. We have received reports that two clinical nurse specialists in the haematology–oncology unit at Fiona Stanley Hospital have had their hours cut because that unit's services are being stripped to the bone. We have also been told that ward clerks at Fiona Stanley Hospital have been told that due to staff shortages and cuts, sometimes wards will not be staffed. In that instance, staff are required to put a notice on their keyboards that states, "Due to staff shortages, the ward will not have a ward clerk available to cover it today. Please contact your closest ward." Staff numbers are being stripped back to the bone at Fiona Stanley Hospital. Under the staffing freeze at the moment, we know that if a staff member goes on leave, they are not replaced. If they leave the hospital altogether, they will not be replaced. The hospital and health system is under extreme funding pressure.

What does the Health Services Bill 2016 do? This legislation creates another bureaucratic process that will ultimately put an administrative cost on a department that is telling ward clerks in hospitals that in the event that they cannot work, there will be staff shortages and they are to simply put a sign on their keyboards to say, "Sorry, we can't help you today." The legislation is the simple optics of this government coming to this place and Parliament approving a process that will cost extra and provide extra administrative frameworks in a hospital system that is already struggling.

As I said, I do not have a huge problem with the idea of the boards and the way that they will operate, but I do have a problem with the government bringing this legislation forward at a time when, quite frankly, we have bigger priorities to stand by the staff who are working on the front line. At the moment, they are doing it tough, and the minister says that there are reasons for that because we are under particularly harsh fiscal economic times. Therefore, what is good for the staff must surely be good for the whole show. If it is good for our front line to do without for the moment, perhaps the minister should apply the same sort of discipline to himself when it comes to legislation before this place.

Let us look at what this legislation does. This legislation essentially sets the government, through the director general, as the systems manager of a health system that we know is growing year on year. Back in 2008, the health minister's budget was around $4.5 billion.

Dr K.D. Hames: Around there.

Mr R.H. COOK: Now, it is around the $8 billion mark.

Dr K.D. Hames: It is $8.2 billion.

Mr R.H. COOK: So the budget is getting larger and larger.

Dr K.D. Hames: Fantastic!

Mr R.H. COOK: Health ministers around the world rejoice! We now have around 45 000 staff working in the system. It is a very complex and unwieldy system and one that must be an extraordinary challenge for the director general to drive from a single management tool—the Department of Health. This legislation attempts to establish boards that are responsible for managing health service areas. These boards will be in charge of what are called health service providers. By and large, the boards match the current health service areas that that we see in place currently—the North Metropolitan Health Service, the South Metropolitan Health Service, the Child and Adolescent Health Service, the WA Country Health Service, and the new health service that the minister seeks to bring about through this legislation, which is the East Metropolitan Health Service. This legislation will put in place boards responsible for driving health services in their area. Under this legislation, they will be given a financial framework to work in and will be charged by the director general, through services agreements, with the purchase of health services. They will be provided with a health workforce who will be dedicated to that health service provider, and they will be required to undertake the assigned service levels, preferably inside what the minister would hope is an efficient price that matches the capability of, and ultimately takes us on a glide path towards, the national efficient price determination for the purchase of health services.

The evolution of boards has been some time coming. Back in the 1990s, there were hospital and health boards all around the state. From 1995 to 1998, those health boards were consolidated to district health boards, and then in 2001, following the election of the Gallop government, the health boards were further amalgamated and, frankly, abolished, and the minister was appointed as the board, as it would be envisaged, under the current Hospitals and Health Services Act. In addition, the minister at the time set up a range of country district councils that were to advise the WA Country Health Service on the delivery of local health services to provide what I believe the minister at the time described as a more grassroots consultative approach in the provision of health services in the districts. The savings that were reaped from cancelling those health boards were put back into health services. At the time, the patient assisted travel scheme was the major recipient of those savings. Following the national health reform process under the Rudd and Gillard federal Labor governments, and through the National Health Reform Agreement, we had the instigation of area health networks, which the current minister used as an opportunity to put back in place some health councils consistent with those area health networks. At that point in time, there was the North Metropolitan Health Service Council, the South Metropolitan Health Service Council, the Child and Adolescent Health Service Council and the WA Country Health Service Council.

As we have seen over history, the idea of boards and councils in the management of health services has waxed and waned. From my own armchair view, we have a pendulum floating between what are centrally driven health services consistent with modern health management practices and what is considered to be a devolved system with the idea that decisions should be made closer to the hospital itself. For my sins, I find myself moving more towards the idea that we should be driving decisions as much as we can to the hospital level, and this legislation goes some way to putting some of those things in place. Of course, at all times, we have to try to find a balance between maintaining central control over costs and the more devolved role of decision-making in health boards. Strangely, there has not been a hell of a lot of consultation in the community about this bill. I understand from the department, in briefings that we have had, that there was consultation earlier in the conceptualisation of this legislation, but by and large the stakeholders I have spoken to have been taken somewhat by surprise by the tabling of this legislation. Some of these stakeholders thought there would be greater opportunity to influence the government's thinking on this legislation. For instance, some members of health unions are unaware of the legislation's detail. That is of some concern. Others with perhaps more resources have been able to have a closer look at it and are concerned about some aspects of the bill. The Australian Medical Association is concerned that the legislation in its current form has not created health boards that are independent enough.

[Quorum formed.]

Mr R.H. COOK: It is always interesting when we have a quorum call at this time of the day, because members come into the chamber with crumbs around their mouths and some return to the chamber looking like cows chewing their cuds.

Mr D.A. Templeman: The member for Bunbury's got some carrot cake.

A member interjected.

The ACTING SPEAKER (Mr I.M. Britza): You are speaking while out of your chair, member for Bunbury.

Mr R.H. COOK: Members always look somewhat resentful. They know who has interrupted their afternoon tea, and they look glaringly at the member for Mandurah. I remind members that only Thursday is vanilla slice day; on other days we should limit ourselves to fruit kebabs and the bowl of nuts provided by the dining room staff. That is just another way of saying that I am trying to work out where I was up to.

Dr K.D. Hames interjected.

Mr R.H. COOK: I thank the minister.

I think stakeholders would like to have had a greater opportunity for some input to this legislation. I accept that there were some earlier briefings and discussions about what the government was contemplating, but some of the health unions were completely unaware that the legislation was to be presented when it was, which is somewhat surprising. In terms of the opportunity the Australian Medical Association has had to look at the legislation, it is concerned that the boards do not enjoy enough independence and the legislation does not return to boards the independence that existed under the previous legislation, and that the director general holds too much power as a financial authority.

Dr K.D. Hames: That's not a point it has raised with me. It is more concerned about the number of doctors on the boards.

Mr R.H. COOK: Yes, I am coming to that. This is from the AMA's current glance at the legislation, because it has said that it did not have the opportunity to look at earlier drafts. As the minister has correctly interjected, the AMA's main concern is the minister's failure to guarantee the presence of medical practitioners or doctors on the boards.

Dr K.D. Hames: What do you think?

Mr R.H. COOK: I think that the minister has done a pretty good job on the make-up of the boards.

Dr K.D. Hames: Can I just explain that my reason for doing that is there are perfectly good nurses and other professions out there and it makes sense to have clinicians—our boards will have a lot of medical clinicians on them—but I didn't want to lock future ministers into having to have certain numbers of each, because, otherwise, why would you say three nurses or three someone else or whatever mix you wanted? This allows ministers, or governments, to make their own sensible decisions.

Ms J.M. Freeman: While we are interjecting, will the board have a patient or client rep?

Mr R.H. COOK: I am not up to that yet.

I note the minister's contribution; we always need to strike a balance on these things. I am not sure whether the minister intends to go back to the AMA to continue that discussion. Perhaps, as the minister said, we now have this wealth of clinical experience, not only of doctors but also nurses, allied health professionals such as physiotherapists and so forth, who are very clever in their trade but also bring insights on the provision of clinical services. Perhaps there is more scope to provide positions for clinical staff or people with clinical experience. Additionally, as the member for Mirrabooka rather unhelpfully interjected to take away my thunder, no consumer advocates or patient advocates are noted as potential board members.

Dr K.D. Hames: Can I say that the reason for that is that every one of those people on the boards is potentially a consumer and potentially a patient, but you guys put the DHAC people in place, which I think was a really good move, and we are continuing those DHAC people, and they have to work closely with the boards, providing that advice from a large group of people. But there is nothing stopping any minister putting a consumer rep on the board. It's not restricted.

Mr R.H. COOK: What is a DHAC person?

Dr K.D. Hames: The Department of Health advisory committees—the things that you created when you got rid of the boards.

Mr R.H. COOK: Indeed, striking that balance on the boards is an important part of this legislation. Although the minister has already discussed that issue through interjection, we look forward to him providing us with further clarification on the make-up of the boards, because, obviously, that is something that concerns the AMA. We have a fairly pluralistic approach to public sector decision-making, but it would not surprise the minister to hear that maybe we would want someone with health work experience on the board to bring that perspective to the board.

There are some great opportunities for the health boards to bring innovation to our health service. In 2014, I had the opportunity to go to the United Kingdom to talk to a range of people involved in the delivery of health services, particularly around the question of innovation. In particular, I heard about the capacity of the UK health

trust boards to respond quickly to patient concerns about hospital-specific issues. Indeed, the former Secretary of State for Health said that he required the boards of those particular trusts to look at patient feedback surveys as the very first item of their agendas and to make that the first point around which they would govern or confer at their meetings to make it clear to the boards that customer service had to be front and centre of everything that they did. The key focus for those boards was to deliver a service to the patients they were there to serve. Through that we have seen some interesting and clever innovations brought into hospitals. Salford Royal Hospital, a public hospital in Manchester, is presented as a centre of excellence in the delivery of hospital services and innovation. The only way that that can be delivered is to have a more devolved decision-making structure in the hospital system. I looked at aspects of this legislation from that point of view, and I think that there are some useful key elements in it that are worthy of further discussion.

Another area of concern to health unions is the way that the workforce will be treated under this new structure. To give a sense of how that will look, people will no longer be employees of the Department of Health, although they will be Department of Health employees. Predominantly, people involved in the delivery of clinical services will be members of the South Metropolitan Health Service or the North Metropolitan Health Service. As a result of that, I think there will be greater cohesion and better coordination and focus for the engagement of that particular element of the health workforce. I am informed that roughly 43 000 of the 45 000 workers in our health system at the moment will be treated thus. I think it is very important that we maintain the central negotiation of enterprise bargaining arrangements for the doctors and nurses working in our hospitals and the clinically based health administrators covered by the Health Services Union. That is the only way we can continue to drive a global workforce development strategy.

Dr K.D. Hames: That is the case. The individual boards are not able to renegotiate wages; they have the standard agreement.

Mr R.H. COOK: That is right. I believe that is a very important aspect of the legislation. This is a point that I was very keen to clarify in the very generous briefings that we received from the department. This is an important part of the legislation. We want to ensure that we put on record our endorsement of that aspect of the legislation. We do not want to see wages and conditions being undermined by a workforce isolated to particular health service providers. The other aspect of this that we have to be able to ensure is that the wages, conditions and entitlements that workers currently enjoy are fully transferable between the health service providers. A nurse currently working at Fiona Stanley Hospital might move to Sir Charles Gairdner Hospital, so they cease being a member of the South Metropolitan Health Service and move to the North Metropolitan Health Service but take with them all those wages, conditions and entitlements that they currently receive.

Dr K.D. Hames: And that is the case also.

Mr R.H. COOK: Indeed. I also assume that it is possible for someone to simultaneously be a part-time worker at the South Metropolitan Health Service as well as a part-time worker at the North Metropolitan Health Service if they have roles that are divided between hospitals.

Dr K.D. Hames: I don't know that. You'd have to ask during consideration in detail. I presume so. I do not see any reason why not.

Mr R.H. COOK: Importantly, the payroll, wages and conditions, negotiations and conclusions will all be done centrally. They will still be handled by the health corporate network, which takes me to the health support services, another section of the overall health system. I understand that about 1 200 people will be working in that area. That will include the health corporate network, the health information network and, I think, a number of other areas that are providing support services to the health services provider. Creating the health support services division is an incredibly important opportunity to get right what we on this side of the chamber are often told has gone so wrong in the past. I refer of course to the ongoing problems of people getting their payroll correct and accurate on an ongoing basis. I also refer to the ongoing problems that we encounter in the health information network that the Auditor General commented on so effectively the other week. In addition, I understand that about 800 departmental staff will essentially be directly engaged by the director general.

In addition to the contracts that are entered into with the health boards through the service agreements, the director general of Health will also be entering into those large contracts with organisations like St John Ambulance and the Royal Flying Doctor Service. The director general will negotiate and deliver those contracts centrally as they provide a joined up service statewide. There will be an overlaying of contracts. We went into some discussion in the briefings about how they would complement each other and join up. I want to talk about two aspects of this for a moment. First, I want to talk about activity-based funding. Hospitals will be paid for the activity that they generate. There is a danger that rather than hospitals working in a joined up way to ensure that patients who do not need to be there are elsewhere, hospitals may be tempted to bring patients in as they represent activity for which they will be receiving some funding. This is particularly important for an

emergency department because that is often the gateway for patients to come into the hospital system. I would be interested to hear from the minister how he sees that aspect of the process working to ensure that hospitals do not stop becoming part of a joined up service working in tandem with a local GP and other health services to ensure as best we can that patients stay away from hospitals but how the minister will incentivise hospitals to ensure that they are not sucking them in. We can bet our lives that if the minister, through the director general, goes to a board under the service agreement arrangements and says, "We want you to take on this level of service", that hospital will provide that level of service right up to the point at which it is told to stop. We want a situation in which hospitals are incentivised to do the exact opposite to see what role they can play to keep patients away.

While we are talking about the financial arrangements, one of the points that I wanted to understand fully through the briefings is how this would work with the national health agreements and the clinical services framework down through what is called a policy framework, which then informs the service agreements that are struck with the health service providers. These are primarily about working out how we bring alive the clinical services framework and therefore see that long-term strategy implemented. As we have seen from the minister over the last six to 12 months, governments can have a change of mind. Whereas the clinical services framework can paint a five-year picture, for instance, of Bentley Hospital providing maternity services, a government can say, "Despite what is in the clinical services framework, we now have to change tack and realise some savings elsewhere in the system." While we would like to believe that we should have a strategic, predictable and stable funding stream through the service agreement arrangements with the board, we concede from this government's actions that we might find the exact opposite and the minister puts the brake on clinical services in a particular area because of funding constraints. I would like to hear from the minister how we are going to set up a proactive system through these service agreements rather than a reactive system, which is responding on a six-monthly or 12-monthly basis to the budgetary winds that might be blowing at a particular time.

I do not blame the Minister for Health for the Barnett government's wholesale wrecking of the state's finances, although as a member of cabinet and as the Deputy Premier for much of that time, he had a key role to play in that. The minister, who is now turning to his service providers, will be saying, "Whatever we said in the past, we now need to repudiate to respond to the new fiscal reality; that is, we cannot keep spending at will. We have to take a different approach." While this legislation anticipates a long-term predictable and proactive funding model, in fact, we have the exact opposite. The minister is now turning to hospitals like Fiona Stanley Hospital and saying, "We want you to realise significant savings through cost cutting, cutting the hours of places such as the hydrotherapy pool and wage freezes and other measures." I am not sure how that sort of approach fits inside what is clearly anticipated as a very different sort of funding process under this legislation.

Obviously, one of the big differences we have with this government is the extent to which the private sector is engaged in providing public services. In particular, we have been critical of large contracts that have realised the situation we have at Fiona Stanley Hospital whereby a big slice of our valued hospital services has been outsourced on a 20-year, $4.3 billion contract. We have seen the havoc and disruption that has occurred as a result of the privatisation of those services. One of the things I was keen to discover in this legislation to satisfy myself is that this will not allow boards to exercise a flurry of ideological fancy and undertake a little bit of a privatisation program themselves. Members can picture a board under budgetary pressure from a minister who is rightly demanding absolute value for money on behalf of the Western Australian taxpayer and strongly pushing for savings to be found in the delivery of hospital services. I want to be assured that we will not have a health service provider board in that instance say, "I know of a way we can make some quick savings. Why don't we look at outsourcing service A or service B?" From what I can gather and from the briefings I have had, it is clear that the policy framework within which these boards have to operate will not allow the board the opportunity to do so. I want to hear the minister place on record how he sees those financial policy frameworks working to ensure that we do not see our public sector services under further attack because of the devolution of the authority of the management of hospital services to the health boards.

As I said in my opening remarks, I think that the intent of the government with this legislation is pretty good. The balance that has been struck with this in isolation of the political times in which we live is not too bad. The intent of the government in the crafting of this legislation is fine and sincere. However, at this time we cannot support legislation that seeks to increase the administrative burden on our hospital system, while at the same time our hospital services are under such financial and fiscal constraint. Our staff are under extreme pressure. The clear message coming from government is that hospital services have to cut back on costs and on hours and they have to realise savings for the government, while at the same time trying to maintain excellent clinical services in a caring and warm environment for the patients. However, what the government is intending to do with this legislation will cost more, because the savings that we accrue as a result of cancelling the current health councils will not offset the costs associated with the implementation of the new health service provider boards. It is not a huge difference; I think it is in the order of $600 000, which in the context of an $8 billion budget is not

a great deal, but that $600 000 might be an extra blanket for a patient that is feeling cold under an overly exuberant air-conditioning system.

Dr K.D. Hames: That is an expensive blanket.

Mr R.H. COOK: It is a lot of blankets, admittedly. It is an extra pillow. It is numerous operations—the operation that John Davies and Heather McCulloch have been waiting for for many months.

Ms J.M. Freeman: A decent IT system.

Mr R.H. COOK: No; a decent IT system will probably cost more than $600 000 unfortunately. I suspect it will cost significantly more.

Our hospital system is being told that savings have to be found everywhere and no saving is too small, but, at the same time, it is okay for us to provide sitting fees for an extra set of board members. Although the minister's intention might be fine in the creation of these boards, it is not good enough for him to provide himself with the luxury of creating a new health board with the costs that are associated with it, while at the same time demanding extreme savings and savings everywhere in the cost of delivering clinical services.

Dr K.D. Hames: The savings are that they've had a 4.5 per cent increase in budget and they're spending more than that, so the savings they're asked to make is just to stick to their budget.

Mr R.H. COOK: And $600 000 is not a hell of a lot in the scheme of things, minister. This is the optics. At the same time as a nurse has to explain to a patient why they cannot meet a particular request or why they cannot get to that patient in time and is thinking, "Why am I working so hard?", that nurse is thinking about an extra set of board members receiving sitting fees and the administrative costs of servicing that board. There probably will be a time that we should have a new board to deliver health services in the east metropolitan area.

[Interruption.]

Mr R.H. COOK: I delight in those moments, Mr Acting Speaker, as everyone scrambles to check that their own phones are on silent!

It is the sheer optics of having to say to staff on the one hand that savings must be found, but, on the other hand, that there is a new board to oversee those savings. So the moment they find $600 000 worth of savings in their hospital, that $600 000 savings will immediately be gobbled up in the sitting fees of this new board. Is that the message that we want to send to our hospitals and to our doctors and nurses who are working on the front line? Is that really the message that the minister wants to send to the workforce that is working so hard on his behalf? I do not think it is. I think the minister should be saying, "We will work as hard as you are to try to find those extra savings. We will stay our hand with some of these measures that will provide extra administrative costs on the health system because we know that you are working as hard as you can to deliver good health services with the resources that you have. And I will do my best to do the same also."

Although this legislation is a competent and good effort and we can give the government a good B+ for content, we give it an F for spirit and delivery, because this will send the wrong message to our hospitals, to our patients and to the hospital workers. While the Minister for Health is demanding they count every cent spent, he is not prepared to apply the same discipline to himself.

DR A.D. BUTI (Armadale) [5.10 pm]: I also rise to contribute to debate on the Health Services Bill 2016. It is quite a substantial bill; it has 20 parts and 300-odd clauses. It is only about half the size of the Mental Health Amendment Bill 2015, but it is still quite comprehensive. What does the Health Services Bill 2016 really deal with? It does not deal with the core issue of trying to improve our health system. The bill tries to improve the governance of the Western Australian health system, which is important obviously—the governance needs to be right. The bill seeks to replace the quite outdated Hospitals and Health Services Act 1927. Even though that has been amended a number of times, the Health Services Bill 2016 seeks to replace it completely.

The minister's second reading speech states —

> Part 1 of the bill provides that the provision of health services by the WA health system is based on the Medicare principles, thereby enshrining the right for eligible persons to be given a choice to receive public hospital services free of charge as public patients.

It is interesting that this minister, and presumably this government, agrees with the Medicare principles because its conservative counterpart at the federal level has always tried to reduce or get rid of the Medicare health system that Australia has enjoyed for a number of years. The Minister for Health often says that we have a brilliant health system.

[Interruption from the gallery.]

The ACTING SPEAKER (Mr N.W. Morton): Members of the public gallery, you are more than welcome to sit and observe proceedings, but you cannot stand in the public gallery. You need to take your places, please, in your seats.

[Interruption from the gallery.]

The ACTING SPEAKER: It is also for your own safety, members of the public gallery. I urge you to either take your seats or leave the public gallery; thank you.

[Interruption from the gallery.]

The ACTING SPEAKER: Members of the public gallery, I once more ask you, and urge you, to either take your seats in silence to watch proceedings or please leave the public gallery.

[Interruption from the gallery.]

The ACTING SPEAKER: I will leave the chair until the ringing of the bells.

Sitting suspended from 5.13 to 5.19 pm

Dr A.D. BUTI: Mr Acting Speaker, your command of the gallery was wanting, I must say!

The ACTING SPEAKER: How many strikes are you on, member?

Dr A.D. BUTI: I noticed they did not interrupt while the lead speaker from the opposition was on his feet because they probably considered his contribution much more important than mine. They were protesting about a very important issue —

Ms L.L. Baker: I thought they were protesting about your speech!

Dr A.D. BUTI: They probably were. That is the danger of the bill the government is trying to introduce. They will not have the right to interrupt on boring parliamentary speeches. The government should reconsider whether it wants to introduce that piece of legislation!

Mr A. Krsticevic interjected.

The ACTING SPEAKER: Members, we have had our fun for the day.

Dr A.D. BUTI: Part 1 of the Health Services Bill 2016 refers to the provision of health services based on the Medicare principles. It is good to have a health minister who, I assume, is a great supporter of Medicare. I think support for it in Western Australia has generally been bipartisan. It is a shame that many times at the federal level conservative governments have not supported it. I go back to when Bill Hayden introduced Medibank in the mid-70s. When Malcolm Fraser got in, it was abolished. John Howard was a great opponent of Medicare, but he realised the will of the people was that we should be supportive of a universal health system. One of the downfalls of the Tony Abbott government was its first budget, the Hockey budget, and the issue of a co-contribution. Some people may argue that a co-contribution is something that one should consider because health costs are phenomenal. It may now be 34 per cent or —

Dr K.D. Hames: About 29 per cent.

Dr A.D. BUTI: It is about 29 per cent, but going up. It has been going up for a long time. Health costs are a problem for any government. Some people may argue that the co-contribution might be advantageous in that people at least think about whether they actually need to go to the doctor.

Dr K.D. Hames: Can I interrupt to correct what I said: those figures I gave are for the state government payment. I do not know what the commonwealth government payment is.

Dr A.D. BUTI: I was thinking of the state government too.

For many low-income families, co-contributions can add up, especially if they need to go to the doctor numerous times about health issues. The federal government has now reduced some of the medication on the prescribed list. Is it called the prescribed list, the one that reduces the cost?

Dr K.D. Hames: The list of things for which you get discount is called the prescribed list.

Dr A.D. BUTI: Yes. That has also been reduced. That is a problem in the federal sphere. I do not know of any conservative state government that has not been in favour of Medicare. At least that is something that we have bipartisan support for in this state. I wonder how this bill will improve the delivery of health services in Western Australia. I want to bring it back to my local area, the east metropolitan area, particularly the Armadale region. As the minister would be well aware, at numerous times in this house I have raised issues with regard to Armadale–Kelmscott Memorial Hospital, and I have also written to the minister's office. I must say that the

minister has efficient staff. They always seem to respond in a timely manner, although not necessarily with the answers that I and my constituents want —

Dr K.D. Hames: You should stop saying that! They already have swollen heads!

Dr A.D. BUTI: To work for the minister and keep him reasonable, they must be pretty good!

Dr K.D. Hames: Are you happy with the East Metropolitan Health Service Board that we are creating?

Dr A.D. BUTI: I am not sure about that. I want to know how that will improve the delivery of services in my area. If the minister can present me with a case that shows that it will improve the delivery of health services in my area, I will consider it. However, I am concerned about the number of health boards that will be established under this new governance system. If boards are needed, it is probably more important to have one out my way than to have one in the western suburbs. Will there be a board in the western suburbs by any chance?

Dr K.D. Hames: Yes.

Dr A.D. BUTI: Why can we not have just one board in Perth that deals with the western suburbs?

Dr K.D. Hames: The south metropolitan board will cover the area from Royal Perth to the Peel. It will focus solely on that area. Royal Perth will be the hub, and it will cover Bentley, Armadale and the new Midland hospital. That board will be responsible for that area, and therefore it should be able to focus on the services that your area needs. That is how the people in your area should get better health services.

Mr P.B. Watson: What about country Western Australia?

Dr A.D. BUTI: Exactly. As the member for Albany has asked, what about country boards and country services? Is the minister going to increase the number of boards for the country?

Dr K.D. Hames: No.

Dr A.D. BUTI: So for Albany, the board will be in Bunbury, I assume?

Dr K.D. Hames: No. The members of the board will not necessarily come from any particular place. They will probably come from a lot of different places.

Dr A.D. BUTI: Anyway, minister, I will wait to see the business case, or the arguments the minister has made with regard to the East Metropolitan Health Service Board.

Dr K.D. Hames: To do what? You're not supporting the legislation anyway.

Dr A.D. BUTI: No, but I am looking at that specific issue. The legislation as a whole we are not supporting, but of course as the member for Armadale I am interested in anything that is germane or relevant to my electorate. However, regardless of whether we have a board, it will make no difference if sufficient resources are not provided to deliver the health services that are needed.

I mentioned some time ago that the government has put on hold the further development of Armadale–Kelmscott Memorial Hospital. The minister mentioned the East Metropolitan Health Service Board. That will make no difference if there is not a sufficient increase in both capital works and personnel at Armadale-Kelmscott hospital. There is not enough bed capacity at Armadale hospital to cater for the catchment area that is serviced by that hospital. The minister had to do a U-turn the other day on Bentley Hospital. The minister needs to look at the provision of hospital and healthcare services in the Armadale region. The Acting Speaker (Mr N.W. Morton) would, of course, be well acquainted with some of the challenges in the Armadale region in certain socioeconomic categories. Until recently, there were only a few doctors in the Armadale region who would bulk bill. That meant that a lot of people who could not afford to go to a general practitioner ended up in the emergency department of Armadale hospital,

Ms S.F. McGurk: It's the same in Fremantle.

Dr A.D. BUTI: Did they not get rid of the emergency service at Fremantle hospital? That is a very good point, member for Fremantle. Fremantle is basically our metropolitan second city. It is appalling that Fremantle, which is a port city, has a vibrant night life, and has a large catchment area, has lost its emergency department. My wife trained at Fremantle Hospital. That is actually where I met my wife. Therefore, it has sentimental value for me. However, for the people of Fremantle, it has a more important function.

Mr D.A. Templeman: Has that rash come back?

Dr A.D. BUTI: I was a patient, actually!

Ms J.M. Freeman: Too much information!

Dr A.D. BUTI: Yes, too much information!

I hope the minister is listening to this. It is appalling that the government would get rid of the emergency department at Fremantle Hospital. Fiona Stanley Hospital is a great hospital. That was a Labor initiative—a Labor idea. However, the problem it has created, and it is a difficult one, is that it sucks up so many resources —

Dr K.D. Hames: I thought it was an independent committee idea, from the Reid report.

Dr A.D. BUTI: We will claim it. It was a Labor idea; definitely a Labor government idea.

Ms J.M. Freeman interjected.

Dr A.D. BUTI: There is no doubt it is a massive state-of-the-art facility, but it has a lot of teething problems. At this stage it has not been the success we wanted it to be. Hopefully, it will be, but it has sucked up so much of the health service budget or resources that other hospitals, such as Fremantle Hospital, Armadale–Kelmscott Memorial Hospital and Bentley Hospital, could have used. Of course, the member for Albany would attest that although there is a great hospital in Albany, it could do with more services. I am sure Bunbury Hospital could do with more services.

Mr P.B. Watson: Staff.

Dr A.D. BUTI: More staff—exactly. The government needs to consider that it cannot be concerned with only one hospital, even if it is a major hospital, being Fiona Stanley Hospital, and neglect other hospitals in the metropolitan area and the regions. This governance structure in the bill will do nothing to alleviate those issues.

[Member's time extended.]

Ms L.L. Baker interjected.

Dr A.D. BUTI: I will have an extension, thank you very much, member for Maylands. I am sure the member is very interested in what I am saying.

The issue I will go onto now is really important. I understand that it is very difficult for the hospital to deal with it, but I think we need to look at legislation in this area—that is, the issue of smoking. I have written to the minister's office a number of times and the minister has written back stating the situation and the power or lack of power of the hospital staff. Often I would get off at McIver station and walk through Royal Perth Hospital to go where I had to go. I would come out the front of Royal Perth Hospital and in the space of 30 metres I would be engulfed in smoke, and it was just appalling. The situation may not be as bad in Armadale, but a number of people smoke just outside the entrance where there are non-smoking signs. I am told that staff occasionally go out and tell people not to smoke, but they continue to smoke.

One of the letters the minister sent back to my office regarded a person complaining that hospital by-laws do not allow them to do anything else but say, "Can you please not smoke?" Maybe we need to change those by-laws. I know the problem then will be who will enforce that. Will that mean we will need security officers et cetera? That will be an additional cost. It is an incredibly important issue when people at a health facility are smoking where people enter and exit the hospital. That is an incredible problem. May I also say that it is not a very good look when hospital staff are down at the bus station on the highway smoking away.

Dr K.D. Hames: It isn't a good look. The reality is we would have to employ security staff and I'd rather spend that money on patient care. It's not great; smoking really annoys me, but I find it easy enough to avoid it. You can generally walk away or get away from people smoking. At Royal Perth, it might not be like that, but I would think at Armadale it would be a bit easier. It's just a matter of available money.

Dr A.D. BUTI: Royal Perth is not. It is not that easy, necessarily. The point is that at Armadale it is not as easy for patients whose movement is restricted and who want to go outside for a bit of fresh air to move away from the smoking area. Surely the orderlies could be given greater power. We do not want bouncers et cetera, but it is an issue that we need to turn our minds to.

Dr K.D. Hames: I look forward to seeing your policies at the election and seeing whether that's included.

Dr A.D. BUTI: I do not know whether that will be included, but hopefully issues regarding preventive health will be included. I am not sure what this government has done in the area of preventive health.

Dr K.D. Hames: We've spent a lot more than you.

Dr A.D. BUTI: No, we are not talking about the government spending a lot more. What has the government done in the area of preventive health? You are the Minister for Health. Tell me!

Dr K.D. Hames: A lot more than you. I'll send you a list because it's too long to do now, but preventive health was there under you, the same as us. We have increased funding in preventive health progressively over the years since we have been in government. It's been a steady progression. There hasn't been a leap forward under our government; I give you that. But neither has there been a decline.

Dr A.D. BUTI: I am not being overly critical, but would the minister not agree that preventive health is an area on which governments of all persuasions should focus more attention?

Dr K.D. Hames: Sure, but preventive health stops people getting sick in the future.

Dr A.D. BUTI: Yes.

Dr K.D. Hames: You've still got to deal with the person who comes in the front door with a heart attack.

Dr A.D. BUTI: That is exactly right. The minister is 100 per cent right.

Dr K.D. Hames: We have already gone to 29 per cent, as we said before, of the budget just on treating people with health problems. I'd love to spend a lot more on preventive health.

Dr A.D. BUTI: Of course, if the government also did not take money out of the education system, that might help to improve the delivery of health education in schools, which is a preventive health measure.

Dr K.D. Hames: We put a huge amount of money into improving education.

Dr A.D. BUTI: I know we keep having this argument. I do not know whether I live in a parallel universe. Maybe some members think that I do. I sit on the board or school council of about eight or nine schools in my electorate. I do not know whether I am in the *Doctor Who* parallel universe or something, but I cannot but hear the challenges that have been brought about by the changes in the education funding model that this government has made in the last two or three years. The government will always put out the line that it has increased funding. It has increased the overall funding but not the funding per student —

Dr K.D. Hames: I do not want to get into discussions about education on the health bill.

Dr A.D. BUTI: No; it is important.

Dr K.D. Hames: Show me one person out there who doesn't think McDonald's is bad for them or doesn't think it's not good to do exercise. The preventive health message about a low-fat diet, lots of exercise and not eating rubbish is out there in the community. I challenge you to find a single person who doesn't know that that's the case.

Dr A.D. BUTI: We have to move from people knowing —

Several members interjected.

The ACTING SPEAKER (Mr N.W. Morton): Members! Members, I am on my feet. You are making it very difficult for Hansard. Member, I have allowed a bit of leeway between yourself and the minister to answer some questions, but perhaps you can bring your comments back to the Chair and continue your contribution.

Dr A.D. BUTI: Thank you, Mr Acting Speaker. There is a difference between educating people to know and changing culture and changing people's attitudes. The government has to find a sophisticated way of trying to change the culture from people living a lifestyle that is not very healthy. The minister mentioned that maybe that will save health costs in the future, but we need to deal with health costs today. We do, but the government has to do both. If it does not deal with both, that 29 or 30 per cent of the total budget will become 33, 34 or 35 per cent.

Dr K.D. Hames: My point is we do both.

Dr A.D. BUTI: The government may do both, but I will tell the minister one thing: the government may do both, but it does not do that well in my area. Firstly, I do not know what preventive health measures the government has taken in the Armadale area. Secondly, in the short or immediate term, the government has not matched the exponential increase in demand for hospital services in the Armadale region. That is a major problem. People who go to Armadale hospital generally have very high regard for the hospital staff. As a whole, the staff at Armadale hospital are high-quality people working under incredible demand, but they can do only so much. Of course, we will never have a situation in which everyone is happy and we provide health services to the degree or standard that everyone would like in a timely fashion, but it could definitely be improved.

I would like to refer to one of my constituents, who is aged 57 and has multiple sclerosis. This was a couple of years ago. He was recovering from bowel cancer and had been diagnosed with aggressive lung cancer and had not been given long to live. He was undergoing chemotherapy and radiation at Fiona Stanley Hospital, but he was unable to source funding for respite or transportation to the hospital because he was confined to a wheelchair. He had a major issue. He needed to get to Fiona Stanley Hospital. It is not very easy at all to try to

get from Armadale to Fiona Stanley Hospital in a wheelchair on public transport. The social worker at Fiona Stanley Hospital told him that the hospital had only three volunteer drivers and they could do only short runs of a couple of kilometres from the hospital. I do not know whether things have improved now. Does the minister know how many volunteer drivers are at Fiona Stanley Hospital to help with cancer patients who need transportation to the hospital for treatment?

Dr K.D. Hames: No, I do not know any of that detail; I'm sorry.

Dr A.D. BUTI: Being able to make their way to Fiona Stanley Hospital is a big problem for people in the Armadale region, especially if they are confined to wheelchairs, as one of my constituents was. It became very difficult because Armadale Home Help Service, which sought to help this constituent, also had a shortage of drivers due to a federal funding cut, not a state funding cut. A number of constituents have come to me about issues with trying to access appropriate transportation to receive treatment for cancer. Whether it is at Sir Charles Gairdner Hospital or now Fiona Stanley Hospital, it is a major problem.

As the minister would know, the mental health unit at Armadale–Kelmscott Memorial Hospital is severely under strain. One of my friends went to see a family member at Armadale hospital. My friend is from the medical profession. He said that he was absolutely appalled by the general standard of the mental health unit at Armadale hospital. He said that all it required was a coat of paint to make it look just a little bit more presentable. I would think that in a facility where people are admitted with mental health issues, we would try to present an environment that was at least more homely than Armadale hospital is currently. I am told that the resources at the Armadale mental health unit do not match up with the level required to service the client base there. The child and adolescent mental health unit at Armadale is also a big issue. It is a big issue in a number of areas in Western Australia.

Of course, minister, I am bringing up problems and difficulties that my constituents have. One of the greatest challenges for any government is to try to meet the increasing demand for health and mental health services. As a state government, health, education and policing are probably three of the most important issues that we have to deal with. We cannot throw our hands up in the air and say that we just cannot meet that demand. We have to find ways to meet that demand. A lot of money was wasted before Fiona Stanley Hospital took in its first patient. Even if we leave out the philosophical arguments about Serco or no Serco, the fact is that the government had a significant contract with Serco at Fiona Stanley Hospital when there were no patients for a number of months. The situation keeps bringing me back to the *Yes Minister* episode in which the minister goes to the hospital without any patients.

Dr K.D. Hames: It's a great episode. I like that one.

Dr A.D. BUTI: It is a great episode, but that was a television comedy; unfortunately, it is not very humorous for the state of Western Australia when all that money has been wasted and there were no patients. Fiona Stanley Hospital is a great hospital but it was a great hospital until we had patients.

Dr K.D. Hames interjected.

Dr A.D. BUTI: The Minister for Health would have thought that the brand-new Fiona Stanley Hospital was going to be his time in the sun before he retired. But it has been nothing but a headache for him. The number of issues that have arisen from Fiona Stanley Hospital is phenomenal to the extent that doctors are whistleblowing and a number of people have complained about the delivery of health services that they have received at Fiona Stanley Hospital. I think it is just terrible that all that money was wasted in paying Serco to look after a hospital without patients.

I will get back to the Health Services Bill 2016. It is a comprehensive bill with over 300 clauses and 20 parts. It deals with reforming the governance of the Western Australian health system. I do not think the minister's second reading speech sets this out, so I will be interested in his response. I want to know how this bill will improve service delivery to patients in Western Australia, particularly in the Armadale area. I have lived in the Armadale area for a long, long time. Armadale hospital is within walking distance of where I grew up and I live only within walking distance of it now. Of course, it has increased in size since the 1970s.

Dr K.D. Hames: Our government did it.

Dr A.D. BUTI: Not all of it, did you? All of it?

Dr K.D. Hames: I'm pretty sure.

Dr A.D. BUTI: I do not know about that. If it did, it was an aberration because the way it usually works for Armadale when a conservative government is in power is that services are moved to Cannington. When Labor governments are in power, services come back to Armadale as a major regional centre. When a conservative government is in power, it forgets Armadale. This government has forgotten Armadale like the

Minister for Police has forgotten Armadale. The courthouse in Armadale is a disgrace. Solicitors are trying to provide advice to clients in hallways—forget about solicitor–client confidentiality. When Alannah MacTiernan was the member for Armadale and also the Minister for Planning and Infrastructure, a massive injection of resources and planning was put into the Armadale region.

MS J.M. FREEMAN (Mirrabooka) [5.48 pm]: I, too, rise to speak on the Health Services Bill 2016. I thank my colleagues for their contributions. In particular, I point out to the member for Armadale that we are looking at a comprehensive bill. It is a very large piece of legislation that will have quite substantial and serious impacts on the health industry. Unlike what we did for the Public Health Bill 2014 and the Mental Health Bill 2013, there has been very little consultation. How little consultation there has been comes as a great surprise to me when just today the health department put out a consultation paper on the review of the the Health Professionals (Special Events Exemption) Act. The paper discusses the health professionals act and whether it is effective, yet major changes are coming before us today with very little outside discussion on the impacts that they will have on our communities and the delivery of health services, particularly the way our hospitals operate and the bureaucracy that surrounds them. At the moment, we are telling our frontline services that they have to tighten their belts and shape up to meet all these areas, yet we are increasing the bureaucracy around health services. We are told that it will cost only a small amount of money, but when has increasing bureaucracy ever cost only a marginal amount of money? I will take us back to the reason that the previous Labor government, under the minister at the time, Hon Bob Kucera, changed the way that the health system was administered. He got rid of the board system and put in the district health advisory councils. To do that, the then minister sought a report from the Health Administrative Review Committee. That committee took 2 005 written submissions from a wide range of individuals. The committee had wide terms of reference, including the best possible levels of health care in the community, expert appropriate advice to the minister, early action to implement the government's election commitments and a clear vision and direction for the delivery of health services, and effective and efficient administration. The government has form. It was happy to ask people about a review of a small insignificant act, but on this bill that will amend a major act there has been little, if any, consultation. If we go back to the review of 2001, which may not seem like a long time ago to you and to me, but for some it is a lifetime—it is for a 15-year-old!

The introduction in the 2001 review referred to the Western Australian health system as a large and complex network responsible for a budget of more than $2 billion, employing more than 20 000 staff and directly affecting the health and wellbeing of Western Australians. Now, we have an $8 billion organisation responsible for 45 000 workers, but do we get a review or a consultation paper or an opportunity to discuss this new bureaucracy? We are talking about boards, but the devil is in the detail and the legislation will require the adoption of provisions of the Public Sector Management Act. That means that once these reforms go through, employees could forcibly be made redundant from their job in the public health system. The report that the Labor government commissioned before it made major changes to the health system asked the Health Administrative Review Committee to address specific matters relating to the structure of the health system. The committee was conscious at the outset that its time lines were short, so it would be important to seek as much guidance as possible and then to focus on the key recommendations, which would inform the structure of the system. The committee was also conscious of the discussions about the social determinants of health and the importance of ensuring that these were seen as the responsibility of the broader system in the community rather than simply the Department of Health. Under a Labor government a review was conducted in that area. Under this government, we learn from the second reading speech that the minister set up a review board and a committee in December 2013—we are now in 2016. This government established the WA Health Transition and Reconfiguration Steering Committee. The committee recommended, along with various other reforms, replacing the Hospitals and Health Services Act. That was it! It was a recommendation. There was no report and no green paper—none of the stuff that we traditionally have had when we have looked at amending the Health Act or the Mental Health Act. It is just not good enough. I point out what Hon Bob Kucera said in response to a question without notice on 15 November 2001. He was referring to the changes that the Labor government had announced because of the review conducted by the Health Administrative Review Committee. He stated —

> This is about peeling off layers of bureaucracy to make sure that the funding goes where it should—to patient care ... They are exposed to the kinds of financial management problems that occur with the management of enormous amounts of money.

I am not suggesting to the minister that this may not be the way to do that; I am suggesting that the health community has a role to ensure that patients and consumers of health get the best use of this $8 billion being spent in health. That means that they, too, should be part of the consultation process.

When I picked up the report of the Health Administrative Review Committee, it referred to a paper by Professor Fiona Stanley, Associate Professor Ann Sanson and Professor Tony McMichael titled "New Ways of Causal Pathways Thinking for Public Health", which was attached as appendix G to the report. I think this was the period in which they were trying to get a unit together to look at various studies, which I understand was eventually established. Far be it for me to miss the opportunity to say what this paper made clear to me. In looking at causal pathways, although we might look at epidemiological studies and percentages of health in those areas, and although paper after paper describes the association with outcomes, these three professors pointed out —

> As a discipline, modern epidemiologists seem to have forgotten that to understand the causes of disease in a population it is essential to study its historical and social context and how diversity or cultural norms influence pathways. Mathematical models concentrating on proximal risk factors actually preclude causal pathway analyses involving more distal risk factors, because in a multi-variate model …

I do not want to go into this in any great detail, but their paper states that we have to look at the social, contextual and economic factors. I remind the house that the Australian Bureau of Statistics' small area labour market statistics in the last year, from the September quarter in 2014 to the September quarter in 2015, show that unemployment in the area of Balga–Mirrabooka, statistical area level 2, increased from 16 per cent to 23 per cent. Such a huge increase in unemployment must have a social and economic impact, but also a massive impact on health. The new SA4s for youth unemployment were released today. They are done in clusters and are not broken up into suburbs, so the Balga–Mirrabooka area is included in the statistical level SA4 with Hillarys, Ocean Reef, Osborne Park, Balcatta and right up to Yanchep. Balga–Mirrabooka has the highest percentage of youth unemployment in Western Australia at 14.5 per cent.

Dr K.D. Hames: Are you sure? The member for Mandurah said just last week that Mandurah was the highest in Western Australia.

Ms J.M. FREEMAN: The SA4s were released today. I am relying on the small area demographic statistics. I can go back and look at the SA4s; I have not pulled them out, but there was a report in today's paper on them. Because of the way the SA4s are determined, we cannot break the figures down and work out what impact that has in Balga–Mirrabooka, but the SA2s, which is the smaller area statistics, break that down and we can see that unemployment is running at greater than two people in every 10 in the area of the Balga–Mirrabooka. It is clear that we have a massive youth unemployment problem in Balga–Mirrabooka.

Mr C.D. Hatton: Do you know why, member?

Ms J.M. FREEMAN: There are multiple factors, but one part is a lack of training and assistance, which has been provided in the past. To tell you the truth, I think there is a bit of racism going on in employment there, because many young, newly arrived Australians who live in the area are not getting employment. Certainly, that is the feedback I am getting. Many of them get training, if they can access it, but when they turn up for employment they are told that they have to have experience. The member for Balcatta and I, as people who grew up in Australia and have lived here all our lives, make contacts throughout our lives and we would be able to get part-time jobs. If someone is a newly arrived Australian who has a qualification and is of a certain age group, people start to say, "But you need experience in that area." I think that has an impact. I also think that some of the changes to government policies around people on the disability pension have had an impact. It has taken people with mental health issues and other people and placed them on Newstart and they are being counted in the figures. I also think that we do not have regional employment in that area, which is why the building of the nursing home that will occur on what was previously Department of Health land may assist, because there are skilled positions to be filled—as long as they are filled from around those areas. It does not help that we have had cuts in TAFE and people are not able to access technical and further education. It does not help people in those areas. The minister is texting away there on the basis of that, and I know what he will say.

Sitting suspended from 6.00 to 7.00 pm

Ms J.M. FREEMAN: During the break I had an opportunity to go back and have a look at where those figures came from. They are from a Brotherhood of St Lawrence publication titled, "Australia's Youth Unemployment Hotspots: Snapshot". Perth north west, which goes from Yanchep right down to Osborne Park and includes Ocean Reef and Hillarys, has 14.5 per cent youth unemployment. Mandurah has 11.9 per cent youth unemployment.

Dr G.G. Jacobs interjected.

Ms J.M. FREEMAN: The member for Eyre is asking what this has got to do with the bill. I was talking about the new ways of causal pathways thinking for public health and referring to a report by Professor Fiona Stanley

and others, and I was pointing out that one of the biggest issues that faces the health and wellbeing of the community I represent is the high rate of unemployment.

[Member's time extended.]

Ms J.M. FREEMAN: I am happy to be able to point to what is a very serious thing. The national youth unemployment rate for 15 to 24-year-olds is 12.2 per cent, and is now higher than when the global financial crisis hit in 2008. In Western Australia, the youth unemployment rate sits at 10.7 per cent, which is below the national rate of 12.2 per cent, and in Perth north west it is at 14.5 per cent. What I have drawn from that is that when I was quoting the figures from the "Small Area Labour Markets Australia" report from the labour market research and analysis branch of the Department of Employment, I was talking about the September 2015 unemployment rate for Balga–Mirrabooka, which sat at 23 per cent. The figure increased to 24.3 per cent in December 2015. That is nearly two and a half people in every 10 who will be unemployed, or about five people in every 20. It is a major issue in terms of the health and wellbeing of our community. I wanted to point that out because it was part of the review that established the precursor of this Health Services Bill in 2016.

I want to go through and comment on some of the points in the second reading speech, one of which was that this bill enshrines the Medicare principles, which is welcomed and celebrated. People have been given a choice to receive a public hospital service, and they might also want to do that in a public hospital. I want to put on the record my view that St John of God Midland Public Hospital is not a public hospital. The public purse may pay for it and services may be provided to the public, but the fact is that public hospitals should stay in public hands. I note, in raising St John of God Midland Public Hospital, that my understanding from a number of people with whom I have associations is that the hospital is grossly understaffed. In fact, I was recently having coffee with friends when one of my friend's friends—I did not know this woman very well—got a text on her phone. She held it up to her other friend, who is also a hospital worker, and said, "Midland hospital again. You know, I could work 24 hours a day, seven days a week at Midland hospital just based on how many times they text me to say they're short-staffed and need someone to come in." My understanding from that discussion is that whilst that hospital has 12 beds for maternity patients, it fills only half of those beds and then puts the hospital on bypass for the other beds. That is not a public hospital. That is not taking public people. That is not adhering to the Medicare principles when people cannot have their children in the public hospital in their area. So it came as a little surprise to me that the minister kept Bentley Hospital open. If that story was anything to go by, the system needed a maternity hospital to stay open because the private contractors that are running the Midland hospital cannot meet the demand, so the public hospital has to meet the slack. We again have a cost-shifting situation in which a private contractor underquotes to deliver a service and then cannot deliver that service. We saw that with Fiona Stanley Hospital and the orderlies. They are called porters at Fiona Stanley. Because the porters cannot shift and turn patients, we ended up with a greater number of nursing assistants to pick up that role, which was cost shifting.

I note that one purpose of this bill is to establish the WA health director as a health services purchaser. That language is not consistent with the idea of a public health system; it is the idea that it will just contract out to everyone the services that it wants. Whilst we have had assurances that no further contracting out will occur, I am not sure whether that language can be relied upon. Again, without proper consultation and a capacity to rigorously analyse the bill through a green or a white bill, that has not been able to be seen. I note that under part 5 of the bill, there will be detailed service agreements between the system manager and the health service provider. I often think that that sort of bureaucratic management system leads, I suppose, to a mentality of asking for forgiveness rather than permission, because they might as well just go and do it because they really need to get it done and then they can go back and explain why they did not do it within those areas. It is interesting because I had a meeting with the members of the Queensland Parliament's Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee when they came to Western Australia, because I sit on the Education and Health Standing Committee. They were asking about certain funding for Healthway. Three nurses, a doctor, an ambo and one layperson make up this committee. I said, "Well, you know Health. It's like this military bureaucracy. It has this chain of command. If you try to force a command model on top of that, they'll just push back because that's how that sort of chain of command works." If the government is going to change this system, it will need a culture change in the organisation as well. That does not come about when a government does not consult in the first instance.

I notice that part 6 of the bill establishes a mechanism for the setting of fees and charges. I assume that this is not a taxation bill, so these will just be fees and charges to cover the cost of providing the services and will not raise any additional revenue. That will be interesting to see when we go into the consideration in detail stage. I also want to find out whether that takes gazetted fees away from the system and whether the fees will just be set by the department without the rigour of Parliament being able to look at those gazetted fees. More of a concern is that the provisions will also allow the recovery of fees from individuals who have received a compensation

payment for an injury that was treated at a public hospital. I say this because often there are long periods before people's workers' compensation claims get picked up. In fact, they may not have their claim picked up at the end but they can come to a settlement on the basis that they will not continue their claim. That settlement will pay for lost income, which Centrelink takes a bit out of if that worker has received Centrelink payments. Now the public health system will put its hand in and take a bit out. The problem we have is that so often workers are not told by their lawyers at the time of that settlement that Centrelink payments will come out or that the public health system will take something out. A lot of workers will be screaming in pain from an injury they sustained that they had difficulty getting treatment for and are caught up in a horrible system of workers' compensation in any event, and now the public health system is going to come after them. I am not sure how that fits into the Medicare principles of a public health system that is available for everyone. I am really interested in how that gels with that idea. For me, that is just a money grab.

[Quorum formed.]

Ms J.M. FREEMAN: I also note—the member for Kwinana raised this—that the people who will be elected to the boards will have high calibre skills and experience. Would that include anyone from the consumer areas or patients? I want to put on the record that I think it could also include a receptionist who has had a long and illustrious period of employment, having won the Osborne Park most valuable employee —

Ms S.F. McGurk interjected.

Ms J.M. FREEMAN: I would not suggest that I have any conflict of interest in this. The minister is not even listening so I do not know why I am bothering. He has missed my mirth in the midst of it all. Bad luck; I was mirthful and entertaining and the minister completely missed it.

Mr D.A. Templeman: I liked it.

Ms J.M. FREEMAN: I thank the member for Mandurah.

Mr R.H. Cook: He doesn't care.

Ms J.M. FREEMAN: No, he does not care about long-term committed employees.

I also want to put a big caution around the employment arrangements that will be introduced in this bill—in particular, part 12 of the bill, "Redeployment and redundancy of employees", which provides for the adoption of part 6 of the Public Sector Management Act 1994. This means that those hideous and very harsh laws passed in this place will compulsorily force people to become redundant if they do not take a position that the hospital deemed suitable for them—not one that they agree is suitable for them—and that is not fair to long-term employees in the health system.

I also note that the Minister for Health will be able to transfer any interest in land or any other asset, right or liability between the state, the ministerial body and the health services provider. I am wondering whether that fixes the problem with the Mirrabooka land that the minister encountered recently with Myvista. I am happy to hear the answer to that in the minister's response. I also notice that part 16 of the bill contains provisions relating to parking fees. If there is one big complaint from people, it is about being able to access parking, especially for people who are elderly and frail and need to access Sir Charles Gairdner Hospital.

Last night I went to the multicultural awards. I commend and congratulate the Mirrabooka Square shopping centre for working with the health department, in particular, the public health area, to provide sessions within the shopping centre on healthy eating. I want to give my condolences but also note and make the house aware of the good work of the Sharing Stories project, which was funded by the health department under the Metropolitan Migrant Resource Centre to equip young people, in particular young people from newly-arrived Australian families, around sexual health, in particular HIV–AIDS, and other sexual health aspects. They have done good work. It is with great sadness that the health department no longer saw fit to continue the Sharing Stories funding. It was a very successful project, having won awards.

I want to conclude by saying something about the mental health epidemic in our community at the moment. I want to recommend one of the tools that I think the government should be looking at to assist people deal with the stresses of day-to-day living in Australia as it presents itself. I note the report presented to the United Kingdom Parliament from the Mindfulness All-Party Parliamentary Group entitled "Mindful Nation UK". It recommended —

> MBCT (Mindfulness-Based Cognitive Therapy) should be commissioned in the NHS in line with NICE guidelines so that it is available to the 580,000 adults each year who will be at risk of recurrent depression.

It has been shown that mindfulness-based cognitive therapy reduces relapse rates amongst patients who have multiple episodes of depression. A meta-analysis—that is an analysis of a lot of studies—of 209 studies, with

a total of 12 145 participants, concluded that mindfulness-based interventions showed large and clinically significant effects in treating anxiety and depression and the gains were maintained at follow-up. Those people living with long-term physical and depressive illnesses can only benefit from some mindfulness-based therapy that should be available in our public hospitals. It is a preventive technique.

MS S.F. McGURK (Fremantle) [7.19 pm]: I want to take the opportunity as we address the Health Services Bill 2016 to talk about the lack of services in my electorate in Fremantle, particularly the minister's plans for Fremantle Hospital. That is an enormously important asset for the Fremantle area and, in fact, for the surrounding suburbs. If there is a plan, it does not seem evident. That is something that I wanted to take the opportunity to bring to the attention of the house. We knew there were going to be changes to Fremantle Hospital when Fiona Stanley Hospital came online. That was obvious. Labor had been a part of the process of putting in place the plans for Fiona Stanley, so it was no surprise to anyone and no-one objected to some services being relocated to Fiona Stanley. However, they did object to the cuts that occurred when some services were transferred, the downsizing of the remaining services at Fremantle Hospital and the lack of any obvious plan to reconfigure and fully utilise Fremantle Hospital. It is not the first time that I have said in this house that we only have to walk past Fremantle Hospital to see the neglect and disregard that this government seems to have for Fremantle Hospital. It looks very poor.

I requested a tour of Fremantle Hospital and the chief executive officer, Dr David Blythe, was good enough to show me around some of the wards. The former emergency department is now the day surgery facility, and it looked good. I also toured the former children's ward, which has been reconfigured and refurbished, and it looked good. But apart from that, I did not see a lot of change. We only have to look at the cuts to budget allocations for that reconfiguration for an explanation of that. For instance, the 2014–15 budget contains an estimated allocation of $13.2 million for the reconfiguration of Fremantle Hospital, optimistically called "Reconfiguration Stage 1". Minister, I do not know whether that is just a way of taunting us, but reconfiguration stage 1 in 2014–15 was allocated $13.2 million and, ominously, $11.5 million of that was in the forward estimates for 2017–18. Sure enough, in the next year—that is the current budget that we operate under—at page 141 of the current budget papers, under "New Works", the amount allocated to the Fremantle Hospital reconfiguration has decreased to $10.16 million, and that decrease in the 2017–18 forward estimates is still $9.4 million. When I asked a question on notice about the government's plans for that spend on the reconfiguration, the answer I was given—I am sorry I do not have it in front of me; I am speaking earlier than I thought I would tonight—as I recollect, was that there are no firm plans yet for that money. A person does not have to have been involved in politics long to be a little concerned to hear that that sort of money is in the outlying forward estimates, has already been decreased and that there are no specific plans for it.

I would be interested to know whether the minister could enlighten us on the plans for Fremantle Hospital. I think about 1 900 full-time equivalent staff were taken from Fremantle Hospital in the initial transfer of services to Fiona Stanley. Then in the latest round of job losses announced in December last year people were told at a staff meeting that around 70 more would be offered voluntary redundancies as a result of the intention to reduce staff even more. For example, in December last year the intensive care unit was downgraded to a high dependency unit. Therefore, we have seen a rapid stripping away of important services provided at Fremantle Hospital. Of most concern to the community has been the relocation of the emergency department. I know the minister has addressed this before and has said that this was always Labor's plan. I reiterate that in 2013 it was a clear Labor promise that it would keep an emergency facility open at Fremantle Hospital. Before the state election we were concerned that the GP clinic that sat alongside that emergency facility was relocated to East Fremantle. One of the Reid review's recommendations was that it made sense to co-locate a bulk-billing GP clinic near an emergency department so that people who should be seeing a GP would not otherwise clog up the emergency department. Notwithstanding that recommendation of the Reid review, in 2013 the Fremantle GP clinic was moved. It was a very popular and successful clinic. The emergency department at Fremantle closed and since then a whole series of services do not operate from either Fremantle or the surrounding facilities such as the former Woodside Maternity Hospital. Kaleeya Hospital has been sold off. As I said, in the case of some of those changes, people understood that it was simply a relocation; that is not what they objected to. But I have spoken to patients of the pain management clinic, for instance, and the renal services and the inflammatory bowel diseases unit that operated out of Fremantle, and they have been clear that there has been a reduction in the services that were being operated in the course of the transfer and key staff with whom they had had long relationships were also not transferred. In the case of the inflammatory bowel diseases unit, those concerns played out tragically when a patient, Mr Olsen, lost his life because incorrect records were being kept at Fiona Stanley Hospital.

Another example of the frustration of patients is with the loss of a phone service previously available for patients of the inflammatory bowel diseases unit to ring experienced nursing staff to explain over the phone their symptoms and to get advice. A similar service was not transferred to Fiona Stanley and now people have to

make appointments, and that is not only inconvenient and time consuming for patients, but also bad for the health system and expensive for the hospital. Only a few weeks ago I took a call from a patient who had raised his concerns about the transfer of the renal clinic. He said that he feels frustrated because he had been assured that he would be able to maintain his relationship with the physicians that he had dealt with when his file was transferred to Fiona Stanley, but that was not to be the case. Now he simply has to see whatever doctor is allocated to him when he goes to Fiona Stanley. That is the frustration that people were feeling. Travelling to Fiona Stanley was not the issue; it was that when the services were moved, there was a downgrading of those services. The personnel whom patients were used to and who they felt understood their clinical issues were not transferred. Patients feel they are a lot worse off as a result.

We also learnt in February that little attention and proper planning has been given to how Fremantle Hospital was going to be managed while the lion's share of the work is being done at Fiona Stanley. As I understand it, one of the problems is that there is no motivation for physicians operating at Fiona Stanley to send patients over to Fremantle Hospital to recover, for instance, because the physicians would have to go to Fremantle to see those patients, and they would rather keep them at Fiona Stanley where they mainly operate. I do not know whether that is because there are dollars associated with that patient care, but in February we saw the decision to bring the management of Fremantle Hospital under the umbrella of Fiona Stanley. I do not know how that will play out in practice for people at Fremantle Hospital. I am interested to hear from patients and my community, but I suspect that people do not really understand where to take their concerns. In February this year, in PerthNow, Liam Bartlett reported —

> A DISTURBING thing happened last Monday. For the first time in its long and proud history, Fremantle Hospital began operating on remote control.
>
> What's especially concerning about that is the holder of the remote happens to be the same chief executive who is struggling to run the beleaguered Fiona Stanley Hospital.
>
> In just 12 months, the new, much-heralded premier hospital has staggered through IT problems, telecommunication issues, patient care controversies, mould infestations and localised flooding—and that's what we know about.
>
> …
>
> A week ago, the Health Department brains trust abolished no less than 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 finances and the chief executive.

I am not clear about what clinical operations are now occurring at Fremantle Hospital. I know that there is some elective surgery, some day surgery, and they were doing some specialisation in hand surgery—I do not know how much demand there is for that service—and other medical procedures associated with the elderly. That is all very well, but a massive amount of hospital capital is invested in Fremantle, and we only have to walk past it to see how underutilised it is. In November 2015, in answer to questions on notice, it was revealed that nearly one-third of the available beds at the hospital were empty. That was at one point in November, although we can pick various times. Thirty beds in the Gage Roads Transit Lounge and almost half the beds in two of the wards, B7N and B7S, were empty. That is at the same time that there were headlines saying that Fiona Stanley Hospital was at capacity, and there were unacceptable waiting times. These are major management issues that I am not satisfied have been addressed. I would like to hear from the minister, and perhaps even receive a briefing, about the plans for Fremantle and how that hospital is tracking.

[Member's time extended.]

Ms S.F. McGURK: The other report in December last year was that figures were showing at that time that about 10 per cent of patients for elective surgery were not receiving their elective surgery within the recommended time frame, far behind other general hospitals in Perth. The underutilisation of Fremantle Hospital, the frustration of patients who had been used to a very high level of service at Fremantle Hospital and the overall mismanagement of our hospital system really concerns me.

I want to briefly address the case of the call I had from some Palmyra residents a couple of weeks ago. Their names are Mark and Sharon. I have just forgotten their surname at the moment, but I will recall it as I speak. This matter was reported in the media. Sharon has multiple sclerosis, and she had a compacted bowel. Her husband, Mark, is her carer. She was taken to Fiona Stanley Hospital and admitted. In her four days at Fiona Stanley Hospital, the only time she received a shower was when Mark gave her a shower. In that time, there was only one nurse who could use the overhead hoist. As Sharon has MS, she could not walk. She was reliant on a wheelchair, so she needed to use a hoist. Only one nurse knew how to use the overhead hoist, and when that nurse was not on shift, Sharon could not be moved from her bed.

Mr R.H. Cook: Their name is Heeley.

Ms S.F. McGURK: Thank you, member for Kwinana—Mark and Sharon Heeley.

Sharon was admitted for a compacted bowel. She was given quite strong laxative medication. When she asked whether she could be put onto a commode or a toilet, she was told that she could not do that, and she had to be given a bedpan. She was given one bedpan and asked for a second bedpan after that and was told that the nursing staff would come back with it, which never happened. She was left alone in the bed. She could not reach the bell to notify that she needed nursing staff, and she was left in the bed. Her husband came in to find her in a soiled bed, crying, and he finally said that that was enough. He worked out how to use the hoist within a few minutes, showered her himself and took her home. It was a disgraceful story. I know that the minister made statements and the Heeleys made a complaint at the hospital level, after there was media coverage of that story. But the Heeleys would really like to know what will change. They came to me with their story because they wanted to say that it is important that this multimillion-dollar facility has a regard for a high level of patient care, and that people should not have to go through this sort of treatment at this new, state-of-the-art facility. I was very glad to give them a hand in making sure their story was made public, because I know of other instances of people having had a bad experience at Fiona Stanley Hospital but not feeling confident to come forward. To give an example, a constituent who is reliant on using the hospital's facilities was concerned that if they went public, they may not be able to use the facility again as easily. I emphasise that this is not a comment against the staff; I am sure many good stories come out of that hospital and throughout the health system. But to be in the situation of the Heeleys—Sharon Heeley describes that multiple sclerosis has taken away a lot of her dignity, basic rights and mobility—and have that experience in the hospital is humiliating. She had an ulcer on her leg at the time, and she and Mark were concerned the ulcer could be infected by the contamination in the bed.

I am glad I had the opportunity to speak on the Health Services Bill 2016, because I have been able to speak about the concerns around Fremantle Hospital. I hope to hear the plans for Fremantle Hospital from the minister, and hope that the capital is properly utilised to ensure that good services are available to the people who live around and in Fremantle. I hope we are spending our health dollars wisely and our health system is being managed properly. I hope the situation Mark and Sharon Heeley found themselves in is behind us.

MS M.M. QUIRK (Girrawheen) [7.43 pm]: There is no doubt that from a clinical perspective we in Western Australia are blessed with world-class experts in a range of areas, and I think our health system reflects that level of expertise. We even have Nobel Prize winners in Western Australia. From a clinical perspective, there is no question that we in this state enjoy a fantastic health system. We probably do not say that often enough, minister. But I think the Health Services Bill 2016 reflects the other side of the coin—that is, the administration of our health system. I think we would all agree that any measures that help the administration of the health system are to be applauded. My northern suburbs constituents go to Joondalup Health Campus hospital, which is a hybrid model, so some of the reforms this legislation will implement will not necessarily apply across the board. Generally, I think anything that improves health service delivery and reduces the, frankly, huge health bureaucracy and makes it more effective is to be congratulated.

A political theory or principle favoured in particularly Europe is subsidiarity, which relates to service delivery at the level most appropriate for that service: the service is delivered at the lowest level possible while still being effective. For example, it is often argued that it is inefficient for the health department in Canberra to make decisions about the delivery of health services in the Kimberley. Similarly, the service needs to be delivered at the tier of governance appropriate for that service. Anything such as the framework included in this legislation that will get that level of service delivery right is to be commended. The United Nations Development Programme described the principle of subsidiarity in its 1999 report on decentralisation. It noted that subsidiarity parity was an important principle. The report reads —

> Decentralization, or decentralizing governance, refers to the restructuring or reorganization of authority so that there is a system of co-responsibility between institutions of governance at the central, regional and local levels according to the principle of subsidiarity, thus increasing the overall quality and effectiveness of the system of governance, while increasing the authority and capacities of sub-national levels.

I am not saying that I support the GP co-payment model, but that was one of the principles behind it. If the consumer went to the general practitioner and had to pull money out of their own pocket, they were much more likely to assess the quality of the service than if it were free. I think we are over the co-payment argument now, but that is the same kind of principle as I am talking about now. I always say that we are much more forgiving of the quality of the movies on a plane because we do not have to pay for a movie ticket. In this case, if services can be delivered locally, responsibility for the delivery of those services is at a level that is accessible, accountable and much more transparent. Obviously, that is to be welcomed.

No doubt the minister is thinking: what would she know? I think that is a fair thought for the minister to have, except that I was on the board of Sir Charles Gairdner Hospital many years ago. I, of course, have followed the progress of Charlies with some interest since, and I recall some of the issues that arose during my time on the board. When this is raised, I always mention that I was enjoying my experience on the Charlies board when I received a letter from the then health minister, Peter Foss, thanking me for my service on the Charlies board and reluctantly accepting my letter of resignation. The only problem was that I had not sent in a letter of resignation, but I knew when I was beaten!

I recently had to go with a family member to Charlies, and I will reflect on some of the issues that arose during the two or so weeks she was there. This person is almost 90 years of age, has been diagnosed with dementia and had been brought into hospital after a fall; the preliminary X-rays showed no damage. The family member and I waited in the emergency department for 14 hours because not only were there not any beds in the hospital, but also there were not any mental health beds anywhere on that day. In addition to the many people in emergency waiting to get a bed, there were mental health patients and a cohort of police keeping an eye on the mental health patients. It was explained to us that the patient would go up to a ward at some stage and that she would be given a magnetic resonance imaging scan to double-check and would stay in for a day for observation. Almost two weeks later there had not been a consultation with any medical personnel—they did not seem to be in evidence any time I went there—and there did not seem to be any notes anywhere, so it was not possible to talk to nurses about what was going on. After two weeks, when we had decided we would send this person to residential aged care, we were then told that she could not leave because they had not yet done the MRI that had been identified on day one. The whole ward was full of people in the same situation. I pleaded with the nurses and said, "In my capacity as a taxpayer, surely tertiary hospital beds shouldn't be filled up with elderly people with dementia in this situation." The ward was not suitable in any event, with people wandering around; a lot of patients were sat down in seats that had a sort of guard over the front so they could not wander around the ward. Eventually, after I had had discussions about whether it was appropriate for that patient to still be there, they said that they were worried about her mobility. I said, "Well, no wonder. She's been stuck in a seat for two weeks and not walking anywhere."

I am really concerned that there is nowhere else to send people. We have an ageing population and there is not sufficient planning for the transition of patients like that who are taking up tertiary beds, which is very costly. It seems to me that buildings such as the former Shenton Park Rehabilitation Hospital or the old Swan District Hospital would be great transitional points for the elderly until they can be found permanent residential care. If they have had an operation and are unfit to go home, they could be put in those transitional hospitals. I raised this issue at the time we debated the former Sunset Hospital site. That would be a great place because it is near two or three tertiary hospitals and would be a great step-down facility after elderly patients or patients who have no-one to care for them have had an operation.

Having a focus on how we manage our tertiary hospitals is very important, and we should have this checklist to make sure it is as efficient and sensible as need be and that we are not using a sledgehammer to crack a nut. In this context, I also make the point that because Fiona Stanley Hospital has now opened, patients from the northern suburbs who have suffered road trauma or stroke, for example, are now dealt with not at Osborne Park Hospital but at Fiona Stanley Hospital, so for family and relatives that is extra distance to have to travel. I would hope—I have certainly raised this issue with the minister in the past—that some consideration is given to Joondalup Health Campus for the treatment of stroke and road trauma victims.

Dr K.D. Hames: Can I just ask a question? This is obviously about boards across large areas. Do you feel that, as a former board member for Charlies, that you had better on-ground management at the hospital and that in the incident of the lady in question, you would have been able to have better management being as a board there than the current system, where it is in effect managed from head office?

Ms M.M. QUIRK: Yes, certainly, and that is why I quoted this theory of subsidiarity. I think the regional local peculiarities were better identified at a local level, whether that picks up the synergies between hospitals and whether there are greater efficiencies in transferring between one hospital and another. If it is under regional control, it is probably better handled.

Dr K.D. Hames: Which is what the proposal is, of course.

Ms M.M. QUIRK: Yes. In answer to the question, the other issue I was going to raise was about two fairly senior specialists who were at loggerheads with one another, and instead of banging their heads together and telling them to act professionally—as we might do in other professions—the doctors were king. We set up separate departments for each doctor—they were in related fields—so they each had their own bailiwick, their own fiefdom. We paid at that time—it would be three times as much now—$75 000 for an additional registrar just to keep these doctors happy and contented, so they did not go to another facility. I must admit that there was

a level of groupthink on that board because people personally knew the personalities involved, knew that they were both intransigent and knew that they both had had attitude problems for years, so maybe the issue was approached differently than it would have been if it were a head office decision, where personalities did not come into it.

Dr K.D. Hames: Pity the member for Armadale isn't here to listen to your speech! He asked what good's it going to do for his area, and you've just given an excellent example.

Ms M.M. QUIRK: Yes, well that is certainly a concern that I have had. When I left the board—as I said, a bit quicker than I had hoped to—the CEO at the time actually said to me in his speech that I challenged groupthink. At the time I was actually quite offended by that, but then I thought about it afterwards and was actually quite chuffed that, because I was an outsider, I had come in and asked the basic questions.

There was another thing that transpired in the time I was on the board. When I first got on the board, I would ask questions like, "What do the unions think of this development?" or "How is this going to affect the workers? How is that going to affect shifts or hours?" Initially the response was, "Well, we don't care what the unions think", but near the end, when they realised that it is better to get everyone in the tent at the same time, information was being volunteered that they had consulted the relevant unions and had in fact got some helpful suggestions as to how better to run the facility. As I said, I think we should not be complacent about how we run our system. It is a huge and very expensive health system and we need to go through processes like this and update our legislation from time to time so that we can really focus on managing it efficiently.

In that regard, I want to say something about waste. We frequently talk in this place about Elizabeth Quay, for example, and whether it is a waste of money and how our primary focus should be on basic services like police, health and education. However, I have to say that the waste at Elizabeth Quay pales in comparison with the waste throughout the health system. Luckily, the minister has put some of that waste to good use and has, for example, sent second-hand medical equipment to Africa, and I commend him for that. But I have heard all sorts of stories about things like stainless steel scissors that probably cost $5 or $10 each being used once rather than going through the costly exercise of sterilising, and that there is a bit of a black market in buying stainless steel surgical scissors that are otherwise thrown out. If we multiply that across the health system and against all the consumables that are used—such as, for example, three weeks' worth of drugs being issued to a patient who is leaving the hospital when they probably need only two or three days' worth of drugs—it amounts to enormous wastage, and I really do not think a robust approach has been taken to those sorts of things. The accountants have gone in and have said, "Oh, it's cheaper to buy a new pair of scissors than it is to sterilise them because of the labour costs." Frankly, that is a scandal and we should look at areas where we can save money. As I said, having an elderly patient with dementia in a tertiary ward at Sir Charles Gairdner Hospital for two weeks is just a complete scandal and unnecessary, but that is because aged care is a federal issue and never the twain shall meet.

I had a very good meeting the other day with the federal Assistant Minister for Health and Aged Care, Ken Wyatt, out at Forrestfield, because I was frustrated about there not being enough planning for aged care in this state. I have heard frequent and many stories about the lack of aged care beds and the need to address dementia in places like the Kimberley, and there just does not seem to be anything being done at a state level. All the concerns here are about capital expenditure on things like new hospitals where there can be ribbons cut and photo opportunities, but in terms of actually caring for the people of Western Australia as they get older, there is no strategic thinking on how to deal with that influx of older people and the fact that in Australia we will have more than a million people with dementia by the year 2050.

In my last couple of minutes, I want to commend a couple of people who have been active in various health fields and who have recently been recognised one way or another. The first person I want to recognise is Dr Penny Flett, AO, who is the chief executive of Brightwater. She is retiring, although I hear that she will continue to do some work at Oakwood Crescent. Under her leadership, Brightwater has done some groundbreaking work, especially in the area of dementia and in assisting patients, particularly younger patients, with acquired brain injury.

[Member's time extended.]

Ms M.M. QUIRK: I want to acknowledge on her retirement the great contribution she has made to Western Australia's health system, particularly in aged care.

Last night the Minister for Citizenship and Multicultural Interests presided over what is described as the champions of multiculturalism at the Western Australian Multicultural Recognition Awards. I noted that one of the winners of the outstanding service for multiculturalism was Maria Bunn, who is the president of the Western Australia Multicultural Association. Maria has worked in culturally and linguistically diverse

communities, aged care and disability advocacy for 30 years. I formally congratulate her work in that area. A commendation was given to the Chung Wah Association, which is a fantastic organisation. I recognise in particular Theresa Kwok from the Chung Wah Association.

The individuals, the expertise and the medical and clinical knowledge within our system in Western Australia are world class, but how that system is administered certainly leaves something to be desired. We need to ensure that legislation such as this means that we have the most accountable and transparent delivery of services at the appropriate level so that there is maximum consumer satisfaction and the capacity for feedback when services are not delivered.

There is one last thing I want to talk about; that is, interpreters in the health system. For some time a group of interpreters has been used throughout the public hospital system. The group is accredited by the National Accreditation Authority for Translators and Interpreters, but those in it also have expertise in conversations about health and understand the cultural nuances of different languages. They have ensured that communication between medical staff and patients is unambiguous and certain so that everyone knows what position they are in, the procedure being performed, the likely outcome of that procedure and the way to provide feedback on any issue they have concerning their treatment. Unfortunately, instead of having an in-house, part-time person, it is now the policy of most public hospitals to employ from a contract firm interpreters who do not necessarily have medical expertise. I have had cited some examples in which a lack of or incomplete or imperfect communication has caused a medical mishap, but luckily it was averted at the last minute. As I understand it, it is more expensive to use contractual interpreters and less efficient. They do not have a complete knowledge of medical terminology but for some reason that is being done. One has to think it might be for ideology.

Another issue is that the number of interpreters does not seem to bear any relation to the prevalence of a particular community language. I am told, for example, that there is considerable expertise in Spanish at Princess Margaret Hospital for Children because a person employed there is, I think, from somewhere in South America. On the other hand, it is quite difficult to access an interpreter who can speak Arabic, similarly the various permutations and combinations of common community dialects; for example, a person from South Sudan might speak a number of languages or dialects. One-third of Western Australians are born overseas. The ageing population tends to revert to its first language. These are both challenges that require better communication in the first language, yet it seems that the service delivery in that regard has declined and is less satisfactory. I draw that to members' attention and suggest that the government reconsider how it delivers interpreter services within the health system.

MR C.J. TALLENTIRE (Gosnells) [8.07 pm]: When I learnt that we would be debating the Health Services Bill 2016, I was very pleased and excited by the prospect of looking at how we would improve the health of Western Australians. I thought we would look at the sorts of services that the government would provide to improve that level of health right across the community. I looked at the object of the bill, which is an act to provide for health services in Western Australia. My mind went to this bill delivering on what I think is one of the most important aspects of our health service—namely, preventative health and delivering on providing preventative health services. Unfortunately, that is not the case with this bill at all. It does not even go there, although I stand to be corrected by the Minister for Health. This has set my mind to think about the legacy of the current Minister for Health, Minister Hames, and his achievements. There is a glaring omission, an area that was not tackled during his time, and that is preventative health. I am deeply sorry about that because it means that we have lost seven or eight years of work on preventative health, of getting ahead of the game and of keeping people out of hospitals. This bill is all about the administration of people once they are in hospital. Surely our ultimate aim should be keeping people out of hospitals. I do not see how this broad mechanism begins to contemplate that. On the contrary, the bill provides for boards to have the incentive to see more people come into the hospital system. The reality is that we all need hospitals. We need and deserve the very best hospital system. I am sure that members around the chamber have already had an encounter with the hospital system. I think statistically the averages suggest that most of us will breathe our last breath in a hospital. There is clearly a role for hospitals. When I have been to a hospital, I have noticed a lot of elderly people. I also see people who do not look in good condition and who look a lot older than they are. When I start talking to them I think that they are well into their 70s, but as I chat to them I find out that they are about my age, mid-50s, but they are not in good condition. Where have we gone wrong? How have we let people get like that? Sometimes it is just luck of the draw. There is no question about it—some people are unlucky. But I do know that a lot of people have not had a preventative health education about diet, exercise and the consumption of alcohol, all those things we know about. Those are the key preventative health measures that we should really be working on, and that is where this legislation lets us down terribly—totally fails us. I think of conversations that I have with various medical practitioners. My own general practitioner, Dr Richard Yin, in Shenton Park is a very, very considered man. I have never heard Dr Yin say to me that we need better board structure at the nearby Charlie Gairdner Hospital, or any other

hospital for that matter. He always says to me, "Chris, why aren't we doing something more about preventative health? Why aren't we making sure that we've got the programs in place and that we're encouraging people?"

Yes, in some other portfolio areas there are some good things. In fact, just this morning members from this place participated in the Bike Week ride that was put on by West Cycle. We had the opportunity to test out the new Urbi system. This is one of those systems under which people can pick up their bike at one location and drop it off at another. It looks fantastic. It is great. I acknowledge that the member for Cockburn, the member for Geraldton, the Minister for Transport and the Minister for Local Government were there. I am sorry more members were not there. Perhaps the nature of a Tuesday morning did not help things. That is an example of members from this place and local government officials realising the importance of exercise—getting out there and doing it. That is very good.

I suppose the relevant government agency is the Department of Sport and Recreation, but I look at its budget relative to the $8 billion budget of the Department of Health and think that surely we could be investing a whole lot more of that $8 billion budget into all sorts of preventative health programs. I think of some of the opportunities in schools in my electorate and how we could be doing so much more to educate children in schools about what a good diet looks like and eating well, and making sure that they at least finish their primary and secondary education with a good understanding of what should be included in their diet and that they are not being sucked in by that constant bombardment of advertising that comes from big junk food and big alcohol. There is all that talk about how Coca-Cola will change their lifestyle and all that sort of myth put out there that young minds are susceptible to. As our youngsters go through the education system, we need to be arming them with the ability to do the critical thinking and the ability to see that if they are consuming large amounts of Coca-Cola and fast food, they are being conned, they are being fooled, they are wasting their money and they are doing damage to their health. That is the message that people should be getting. I think the health budget should be one of the major drivers of programs in that space, because it is all about preventative health that will keep people out of hospitals.

I will look at some of the detail of this bill. As I say, I came to this bill with a high degree of optimism, realising that it was replacing legislation that is about 90 years old and that there had been some amendments. It is all about the government's arrangements for hospitals and the accountability practices. Yes, that is perhaps necessary stuff, but in the detail of the bill in, say, part 3, there is mention of purchasing health services from autonomous boards. In part 4, there is mention of the establishment of new autonomous health service entities known as health service providers. It is all about generating business in the health sector; it is not about reducing business at all. I am sure we do not call people who use these services clients—we call them patients—but it might as well be there in the bill that the key performance indicator is to do more hip replacements or do more aortal surgery. Excuse me, minister; I am sure I will get the terminology wrong, but I am talking about all those treatments that are done through our system to an amazing standard. I will certainly grant that; the standard of delivery is just fantastic, but that need for so many treatments that people have to go into hospital for simply because they have not respected those important principles of healthy living could be avoided in the first place. I know there is an attitude on the other side that if people are instructed too much about what a healthy diet looks like, if they are told too much about the dangers of alcohol, if they are told to avoid eating fast food and if they are talked to too much about calorie and fat intakes, that is being a nanny state. It is telling people what they should and should not do, and they react negatively to it. However, I think, especially when it comes to younger people, that there is a great enthusiasm to learn these messages in a very positive way to send people off in the right direction. The reason I believe that is the case is that we only have to look at the enthusiasm that kids have for sport; that is one example. They are passionate about doing well on the sports field. If they are helped to make a connection between healthy living, eating well and performing well on the sporting field, they have suddenly had a nice incentive built in for them to really consider what they eat and drink, and that will stay with them into later life. Perhaps it will stay with them into their mid-teens when they are exposed to drugs and serious alcohol intake. Those are some of the things that I came to this bill with, and I have those concerns.

This has to be done in connection with other aspects of the whole health service. It was very interesting listening to *Background Briefing* on ABC Radio National on the weekend. That program discussed the problem now facing pharmacies. Interestingly, pharmacists are recognised as being very trustworthy individuals. Surveys have been done and I dare say that they rate more highly than parliamentarians, unlikely as that may be! Pharmacies have a serious problem because now they realise that they have a significant profit that comes from the retail of all sorts of pills and potions. These are things like herbal remedies or vitamins. Products that claim to detoxify the liver are allowed to be sold in pharmacies. I think the minister will be able to confirm that that is what the liver does—it is a detoxifier—so that claim is a silly nonsense. However, because the claim about what a particular potion does is vague, these people get away with it, and unfortunately pharmacies are prepared to go along with this. Too often they have staff who are not pharmacists and do not have training. Somebody may come in and say they are feeling a bit unwell or jaundiced or something, and before they know it they are being

proposed a particular pill or potion and it really has no foundation at all—it is not evidence based. I think our pharmacies have to make sure that what they retail, what they sell to people, has benefits that are evidence based and that they are not just retail outlets. They really have to work at that.

There was another example of a claim that a vitamin B3 pill would release energy from the blood. I understand that physiologically that just does not make sense at all, and in most cases it would never work that way. It was pointed out, though, by a gentleman by the name of Adam Phillips, who is an adviser to the Therapeutic Goods Administration, that there is real reason for concern and the industry needs to be greatly troubled by this. There is not only this problem with our health service and hospitals that want to get more efficient but also promote the services that they provide and have more people go through them, but also the undermining of the credibility of medications in general, and I think that is a great concern. I think one remedy would be that people speak to their GP before they take on these various herbal remedies. I will not go into the whole issue of homeopathy treatments and all the information put around there. When I talk to Dr Yin about my Nexium 20 tablets for that typical middle-aged man's disease of gastric reflux, we talk about how it can be avoided or how we can reduce the need to take this medication. Remarkably, losing 10 kilos meant that I could avoid taking them for an extended period. There is another message: exercise does us a great deal of good and is a great solution to these ailments.

There is no doubt that our health service provides some excellent treatments, but I see some people who somehow manage to miss out. Recently the shadow Minister for Health worked with constituents of mine Hannah Rainsforth and her mum Michelle, who had been waiting two years to get in. We cannot imagine that everything is perfect. A lot of extra work needs to be done. Another major area of preventive health is the issue of what we are doing around drugs. I have had an exchange of letters with the Minister for Mental Health about the work she is doing on the "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025". I must admit that after I had first received correspondence from her on this in December last year, I pointed out to her that—I think it might be abbreviated to "WAMHADS Plan 2015–2025"—there was little to be seen in the way of discussion and planning concerning a whole-of-government plan to reduce consumption of mind-altering drugs. I wrote to the minister about it. I am kind of relieved that we are getting away from that old notion of a war on drugs; we are moving on, but I wanted to nail down the measures in place. I mentioned to her, and I quote —

> Many people are concerned about the power of the alcohol lobby, for instance. I note that $89.2m is identified for 'prevention' over the life of the Plan. Will some of the resources target underage and binge drinking?

That is a simple enough question. The answer I got was an outline of the evaluation process, and I quote —

> The Plan is underpinned by a comprehensive evaluation framework and outlines a series of performance indicators which aim to evaluate the success of the Plan against the expected key achievements.

Naturally enough, I asked her to please let me see the evaluation framework. I thanked her for her reply but unfortunately I got a framework about a framework—an outline evaluation reporting an accountability plan. I found that disappointing and I think there is a lot more work to be done. There are a lot of words in this plan. Mr Acting Speaker, you know my interest in seeing targets being set and setting dates to see that we are meeting the targets and what the baseline is and how important it is if we are going to evaluate something. I put that to the minister but what I received was exactly the same kind of thinking we see from boards of the various hospitals.

[Member's time extended.]

Mr C.J. TALLENTIRE: The plan evaluation framework outline indicators have been selected on the basis that, and I quote —

- they meet the SMART criteria outlined by the Department of Treasury
- they align with existing plans and reporting requirements
- where possible the data are currently available
- where possible, the indicators are able to be benchmarked.

I went into the detail beyond that and it does not really give us the clear numbers. It refers to full-time equivalents that might be involved. That in itself is interesting but it does not help me know the targets that we are aiming for.

Finally, I want to come to an issue that the Minister for Health knows I am very keen on watching and that is the formulation of health policy in this state around the influence of big alcohol. We had an extensive debate on the Healthway organisation and how it had the laudable objectives of making sure we were bringing about social

change. In many ways, it was a behavioural change organisation. It was described in other ways by supporters as being about making sure we had good health promotions. I think perhaps the more accurate description is health promotion fund. However, through FOI I received a copy of a letter from the West Australian Football Commission Inc—I do not have the signature; it was redacted—that was sent to Mr David Malone, the executive director of Healthway in 2011, and it reads —

> I have had discussions with Foster's in relation to this matter —

The matter being the potential for Healthway not to give funding to the WA Football Commission. It continues —

> and I wish to advise that the Foster's contract obligations of the WAFC in relation to this sponsorship will stand.

I think it is very sad that the WA Football Commission chose to prioritise funding from Fosters rather than look at an alternative arrangement with Healthway. I was very disappointed to see that. There are many elements to this issue of developing good preventive health: making sure we are getting the messages out and not sending contradictory messages so that when someone turns on to watch the AFL, they are not bombarded with alcohol advertisements; making sure that when people go to a stadium, they are not given some idea that there should be a constant mixing of sport and alcohol. That is just one element. The other ones are about making sure we have a strong preventive health campaign that is directed from this Parliament and goes through the government agencies in a coordinated, coherent manner so that no Western Australian is in doubt that if they want to live a healthier lifestyle, they can be given the support and assistance to achieve that. They can be given the encouragement and help to reduce their alcohol intake to make sure they are thinking about their diet and are doing exercise when possible. They are the priorities. Of course, we need a strong hospital service because inevitably—as I said earlier—many of us will end our lives in a hospital. That is the way it is; we do not live forever. Many people have some degree of misfortune and they have no choice but to go through lengthy medical treatments, whether it be for heart disease or cancer—all sorts of ailments that people unfortunately have. It is a reality and we have to have a good hospital service to deal with them. However, for us in this place to talk about a Health Services Bill that is all about health services but does not mention preventive health is a great disappointment. I think we are letting down the people of Western Australia.

MS L.L. BAKER (Maylands) [8.28 pm]: I would like to address the Health Services Bill 2016 and the governance of health service providers. As my colleagues have pointed out tonight, this bill has been a long time coming. Before I start my 30 minutes of discussion about the bill, although I am looking at you, minister, I am going to acknowledge the hard work of Robyn Daniels and her crew in the Department of Health for putting this bill together. I am sure it has been a labour of love.

Dr K.D. Hames interjected.

Ms L.L. BAKER: She is still awake, which is remarkable in itself, really.

This bill has been a long time coming and a lot of hard work has been put into its development. It is a shame that some feedback is indicating that some consultancy still needs to take place around that. Although I have not had direct contact with the organisations that have commented on that, I am well aware that a bill of this importance should really be thoroughly agreed to and accepted by the key industry stakeholders. It is a very important time. I assume that we will not write another one of these bills for another hundred years or so, so it is very important that everyone involved gets it right at this stage. A little care and attention and a bit of further consultation to close some of the gaps that we have been alerted to would seem to be a logical way to proceed. It is a bit sad that we are not able to support the progress of this bill right at this moment, but it is not because we do not think it is a good bill.

I would like to start by raising some issues around the boards themselves. Looking at the briefing that was provided on this bill back on 24 February 2016, I read that the Minister for Health can establish health service providers for a health service area that does not have to be a geographic area. I listened to my colleagues talk about some of the other critical issues around health in our society, such as preventive health and mental health. Indeed, the five boards that are proposed at this point are the North Metropolitan Health Service, the East Metropolitan Health Service, the South Metropolitan Health Service, the Child and Adolescent Health Service and the WA Country Health Service. The minister might like to address in his response whether he could identify how a decision is made about whether to constitute a new board and on what basis the minister would make that decision. For instance, I refer to some of the issues that have been referred to by speakers tonight. The issues around mental health are a particular concern to many members of this house. Mental health also seems to have been of particular interest to this Liberal–National government and its ministers. Mental health is certainly a big issue for the Western Australian Labor Party into the future. It would be interesting for me to find out

whether it would be possible to establish a health service provider for a health service area around mental health, preventive health or women's health.

In relation to mental health, I will give an example of a case in which the health system and the mental health system have collided with a fairly disastrous outcome. I am grabbing the letter that I recently wrote to the Minister for Mental Health. She has acknowledged the letter and responded to me earlier today. I have a constituent who has two children, both of whom suffer from autism. I am sure that they will not mind me talking about Henry by name. Henry Chandler is aged 13 years and is currently in the care of Nulsen Disability Services. I should say at the start that this case came to my attention when my staff member, the wonderful Jordyn Rados, who is my electorate officer, came to me very distressed and said that she had just opened some attachments to an email from a constituent. She said, "Lisa, I don't know what to do about this case; it's just awful." The email included a picture of Henry when he was in Princess Margaret Hospital for Children. As I said, Henry is currently in the care of Nulsen Disability Services. Henry's parents, Nicole Ikin and David Chandler, contacted me with concerns about the Disability Services Commission's decision to cut Henry's emergency funding on 5 March 2016 with a view to transitioning him back into the family home. That might seem like an ideal thing for a child, and his parents want him back desperately. I have been advised that Henry has had two host families over a three-year period. Those families were unable to manage him. This is just a remarkably sad occurrence. Henry has just spent 100 days at Princess Margaret Hospital. He has spent most of that time in a room on his own, unclothed and becoming more aggressive towards staff and less connected with everyone around him. The families who hosted Henry over that three-year period became increasingly unable to manage Henry. He clearly is a highly traumatised and, they claim, an abused child who has been let down time and again by a system that, as has been suggested to his mum by a staff member of the Disability Services Commission, does not want "another half a million dollar baby to care for."

The long-term plan for Henry after he left PMH was to transition him back home. There were only three fairly simple goals—simple for you and me—that Henry had to meet in order to come home. The photograph that so distressed us was of Henry after he had been self-harming. I cannot describe the level of damage that he had done to himself. He had been bashing his head in PMH. He could not see. He had awful bruising around his head and his eyes were just big, puffy, red, swollen lumps. I did not even know whether the child was alive; I could not really tell. It was a still photograph, but it was so distressing, particularly for Jordyn, who has two young daughters of her own. She was very distressed to see that this child had got into this situation. The long-term plan that Henry's mum and dad have worked out with the hospital and caseworkers is for Henry to go back home. That is what they want, but he has to meet these three goals: he has to be able to wear clothes all day, he has to be able to sit at the table to eat his meals and he has to use the toilet. I might say that he was doing these three things particularly well before he was hospitalised for 100 days. He was hospitalised because of pain that was undiagnosed by the places where he went and he had to be checked, so he had to go to hospital. None of those three goals have been met. Henry's dad visited him twice a day in hospital. He had breakfast with Henry every morning and came back in the afternoon and had tea with him as well. These are not parents who do not genuinely want their son to come home. He is their child; they want him home. Henry cannot achieve the three things that he has been set to achieve in order to come home.

Henry's parents tell me that they have been pushed to relinquish their parental responsibilities for Henry. I find that appalling. I understand the reason for this is that if Henry comes under the provisions of the Department for Child Protection and Family Support, more finances will be available to support him, but in order for him to be accepted by DCP, his parents understand that they have to relinquish him, and they are not prepared to do that. I do not blame them. Ultimately, they want him home. They believe that needs to be done in a considered and planned way and at a pace that is best for Henry. I am advised that the Disability Services Commission consider that the current arrangement with Nulsen is not sustainable in the long term. I am deeply concerned that if the department insists that he has to return home before he is ready, it will have a detrimental effect on Henry and his younger brother, who is also autistic. His younger brother is terrified of Henry coming home at the moment. This will affect the whole family of course. On behalf of Henry's parents and Henry, I ask that the department look closely at not ceasing emergency funding on 5 March. Henry's parents want the funding to remain in place for a longer time, maybe 12 months, until Henry can meet those three criteria so that he can come home. I went into the detail of that family's case because it is a really good example of the crossover between the health system and the mental health system and where gaps occur. It can be shattering for a child to be in that state and for parents to be told that he has to come home because the state will not fund his stay at Nulsen, that it will not support that because it is too expensive. When will a health service provider for a health service area be established in an area such as mental health to look at provisions around mental health and at the linkage of systems so that there are transitional arrangements that simply make sense for children and their parents?

I am very happy that the Child and Adolescent Health Service will continue because it is an absolutely crucial service. Children aged zero to three years are the backbone of our society. If we do not get it right for children

aged zero to three, then we will have missed an incredible opportunity to save our health system and a lot of grief for all the other systems down the road. Getting it right when a child is aged between zero and three means delivering child health nurses, making sure that the system is in place to support zero-to-three early years interventions, making sure that parents who need diagnoses for weeny babies get that diagnosis early so that they have the maximum opportunity to have a child's standing assessed and provide the right diagnostic tools to help them grow the best they can.

In the preventive health area my colleagues have mentioned something that again is an interesting area that perhaps the minister might consider when he establishes health service providers in not necessarily geographic areas, and that would be in the preventive area around alcohol and drugs—illegal and legal drugs. We in this house talk on many different occasions about the impact on our society of both legal and illegal drugs. There have been some massive steps and massive positives around cigarettes and the management of that through great institutions such as Healthway and the interventions that Healthway has put in place to promote non-smoking. When we look at alcohol, which has a far greater impact on our community and a negative impact on the health budgets, there is every reason to consider having a board, the job of which would be to look at the impact of both legal and illegal drugs on our community, because the multiplier effect of the damage done by alcohol is astronomical. I know the minister is very aware of the impact of methamphetamines and other illicit drugs at the moment. Some of the attention on other drugs has faded away, but they come and go. At the moment we are talking about ice and the dreadful impact of that drug, but who is to know what drug might come up next week that requires a different strategy and how those substances will influence the provision of services in health and the sorts of services we want to purchase. Of course we want to purchase services that address alcohol and illicit drugs, and of course we must do that, but do we have a system in place already that does that effectively? That is a question I would like the minister to consider.

Within the Health Services Bill debate I also wanted to ask about consumer representation. The Health Consumers' Council has been slogging away for a long time to be the voice of consumers in the health system. I would like to double-check with the minister that in fact no consumer representative or patient representative is currently specified to be involved in this board. I think that is a great failing.

[Member's time extended.]

Ms L.L. BAKER: It is a great omission in this legislation. If we are going to specify the number of people on a board—six to 10—and if we are going to specify that the board comprise three health professionals, two of whom must be practising, someone who cannot be an employee of the department or the Mental Health Commission, with terms no longer than three years and a maximum of nine years, and a $20 000 penalty for not disclosing material personal interests, then the minister is missing a golden opportunity by not specifying the need for a consumer rep on the board. I remember from my days working in the energy sector that when we said the words "consumer representative" one of the great power companies would jump down our throats saying, "We have that. We've got a manager of consumer issues." That is not an appropriate way of having a consumer represented on a board or as a spokesperson. We do not take somebody employed within the system to represent the patients of a system or the consumers in the health system. We must have someone who is actually living the experience, and that is not hard to do. That is another question I have: how do we influence the workings of those boards?

I want to cover quickly two areas before I finish speaking about areas that might be justified for health services. One is the area of women's health. I went to see—I admit quite some time ago—the women's health centre, and I think I have said in this place before that at that time I watched a presentation about the WA women's health strategic plan. I do not even know if a women's health plan is still being produced by the state. I have not seen anything or read any reviews or seen any outcomes from it. At that time I was watching the strategic plan being worked through and at the end of the presentation I was dismayed to hear that whilst we had a strategic plan, there was absolutely no way of following up on whether it was being implemented or whether resources were even being allocated to getting things done. It is no good having these things unless there is some activity around them and outcomes that relate to them. In this health service area, women's health is clearly an area that could come under a board of that nature.

I am sure it is no surprise to anyone that I would raise the issue of Aboriginal health as something that should be the subject of a special health services area. If we do nothing else with this kind of governance for health, surely looking after our first-nation people would be paramount. We are hearing very, very sad stories about the level of suicide in Aboriginal communities. When I heard with some great distress about the suicide last week, I rang Fred Chaney, whom all members would know. He had just stepped off a plane from a reconciliation Aboriginal Australia gig in the eastern states—he is very seldom in this state. He is a good friend and mentor of mine and I wanted to know what he thought about that dreadful incident. At that time he was not aware of what had happened but he was dismayed to learn that such a young child had thought that the only way for the future

was no future. When we have profound statistics around poor health in our Aboriginal communities—the level of substance abuse, poor nutrition and the like—then surely Aboriginal health should be covered specifically in every single board in some kind of strategic plan or, I would argue, it should warrant a separate focus and its own board. Those were the two areas that I wanted to highlight specifically.

In closing my short comments about this I want to also refer to a subject that members of the Liberal Party in the upper house have brought to my attention in the past and in my role as the Chair of the Joint Standing Committee on the Commissioner for Children and Young People in Western Australia. An upper house member brought to my attention some three years ago issues around media images, digitalisation of images and their impact on children. The dreadful problems that arise from psychological damage, such as anorexia, come from children who see images, whether it be young men or young women, and think they need to live up to that. They end up with an eating disorder; the statistics around this are quite horrendous.

I was recently made aware of Marilyn Krawitz's work on the issue of legislating models for body mass indexes and photoshopping images. I will quote a few pieces from a recent research paper that she released last year. I do not know if anybody in this house has had the chance to see it, but I have sent it to my upper house colleague so that he can have a look at it. She starts by talking about the National Advisory Group on Body Image in Australia, which created a voluntary industry code of conduct back in 2009 that informs people who work in fashion media and advertising industries about actions they can take to improve the public's body image. Of course, there is a very clear link between health and body image so I am not going to go into any detail to prove that link as it is completely obvious. A few years later, in January 2013, the Act Limiting Weight in the Modelling Industry came into effect in Israel. The paper states —

> *Known as the Photoshop Law, it requires all models in Israel who are over 18 years old to have a body mass index of 18.5 or higher.*

Body mass index is a common formula to calculate a person's weight-to-height ratio. In this research, Marilyn goes on to talk about eating disorders as a category of mental illness: an eating disorder characterised by obsessive thoughts about food or body weight. Approximately 10 million women and one million men have this disorder worldwide. In 2012 Mission Australia surveyed over 15 000 Australian youth and found that body image was one of the top three topics that trouble them. Approximately one in 100 adolescent Australian girls suffer from anorexia nervosa. It is estimated that 10 per cent of Australian young women and one per cent of Australian young men between the ages of 14 and 24 suffer from eating disorders. They are the second most likely cause of Australian young women being admitted to hospital. The social and economic cost of eating disorders in Australia in 2012 was approximately $69.7 billion. By extrapolation it is usually 10 per cent for Western Australia, so $6.9 billion. From an economic perspective, this government should realise how much money it can save if we looked at a photoshop law similar to the Israeli law. It would not be something that would be able to be implemented solely in Western Australia; it would have to be implemented by other states as well. Ideally, it would be a national law, but I am not seeing the issue being discussed nationally. The thin body image is perpetuated through photographs of models that are photoshopped to make models appear thinner and more attractive. Media images showing models who are unhealthily thin and photoshopped damage psychological health, particularly for women but for men too, because they may believe that these images are in fact real, that that is what they should look like. I have spoken in this house before about this disorder and I have encouraged our previous children's commissioner to look at this issue.

In relation to the Australian code that I referred to earlier, the former federal Minister for Youth, Kate Ellis, brought that code on board and recommended initiatives for the government to take to improve Australians' body image. That code, whether it is working or not, is not mandatory so there is no opportunity to hold the industry to account for what is happening to children. It is a voluntary, not a mandatory, code. The code does not give any penalties for businesses or people who do not follow it. A photoshop law, or some version of it, would be very beneficial in this state and in Australia because it would mean that we could start to hold the industry to account. We could put penalties in place if the industry was not delivering on the promise to not digitalise images into completely unrealistic versions of what the human body should look like. I am not saying that that should be a board that the Health Services Bill 2016 should establish, but I am saying that in terms of the number of issues facing Western Australia around wellbeing and a healthy lifestyle and reducing the impact of the health bill into the future, it is one of the things that should be looked at as it will be very interesting to see how the funder–purchaser provider model is established within the Department of Health to cope with this. I would also recommend that the contracting policies that are in here perhaps need review in light of what has happened in Health recently around contract management. The Department of Health had one of the most sophisticated contract management regimes in state government when I was the director of policy and planning in the government's contract management area, some years ago now. It had one of the most sophisticated and well-resourced systems. My guess is that that has been substantially reduced and I would not be at all surprised if

there was some impact from a reduction in full-time equivalent employees on the way Health failed to manage those contracts and ended up with a $14 million blowout.

In conclusion, I think this has been a long time coming. I am sorry that we are just not quite in a position to recommend that we support the bill's passage. It is very close but it probably needs a bit of a discussion with a few other agencies that are impacted by this.

MR M.P. MURRAY (Collie–Preston) [8.58 pm]: I wish to add to the debate on the Health Services Bill 2016 probably along very similar lines but overall from more of a country perspective. Something has concerned me for some time not only under this government, but also under a Labor government. It is about the theory that we can wind down smaller country hospitals and put them into major regional centres. That affects people with trauma—broken arms and legs and that sort of thing. Hospitals that had a catchment area of what once was about 40 kilometres around the hospital have now reached out to about 70 kilometres to provide those services. It is certainly a worry for many, many country people. Once a person goes into hospital, how do they travel, how do others get down to see those people, and how do they check on their welfare? That in itself causes problems at Collie Hospital as it does at Bunbury Hospital. I certainly understand that sometimes with operations or treatment a person may have to travel a distance, but when they are turned away at the admissions area or accident/emergency because they cannot get an X-ray or basic services, it is a concern. Although this issue is not as bad as it has previously been as it has dropped off in recent times, it is still happening and recently it was about X-rays. People were going to the hospital, which is the normal place to go after someone falls off a motorbike and breaks their arm, and were being told, "You can sit there or come back Monday, or you can go to Bunbury." I do not believe that is good enough for any rural town with a population of around 9 000 people. I could understand that in areas where 500 people live, but even then the travelling they would have to do would be a concern.

The other issue related to distance is childbirth. People have been told, "No, you can't have your children in Collie Hospital; you have to have them in either Bunbury or Perth because your weight is a bit high." I understand the reasoning for doctors being very reluctant to take on issues such as that—the hospital might not be able to cope if there is an emergency. The doctors do not want people to go elsewhere because they do not have the skills, but they need a government commitment to install equipment that allows overweight people to have their babies in the Collie region. In recent times several people have said to me, "I don't want to have my baby in Perth or Bunbury. Why can't I have it in Collie?" The doctors say that there is a shortage of facilities and specialist care for those women. I believe that no matter where people live, they are entitled to some specialist care. It should not be available only in Perth, Bunbury, Mandurah and possibly Busselton; they are the major centres where people have children. I do not think that is fair on anyone in any community, especially members of the community who would like to visit the child after its birth. Those sorts of special moments are being taken away. The minister said that it was about dollars, safety and care. If the facilities were there, the minister would not have to say that. In recent times they have been taken away. It is not as though we are asking for them; we are asking for them to be reinstated to what they previously were.

Another major concern is how we deal with people suffering from drug problems. Of course, my family's history in that area has been quite well publicised. I am still getting calls from people saying that they want to take their child, who is probably in all sorts of bother, to hospital. The child is saying, "I want to go to hospital; I want to get off this problem." I can name many people who have reported this to me. But when they get there, they are told, "There's no psychiatric nurse or people who specialise in drugs issues. We'll call the doctor and he'll give you a drug"—I believe it is valium or something like that; I cannot say that that is exactly what it is—"We can book you in on Monday or Tuesday of next week and then we'll be able to talk to you." But, unfortunately, this issue does not allow people that time. Specialists must be available to assess and talk to those people immediately because the window of opportunity is very small. If members think any person with a drug problem can wait two days, they are miles out of the park. There are minutes, maybe hours, and that is about it. Sometimes the time frame is only an hour. I have been there, and I know that. I have failed at times to say, "Righto, jump in the car; we have somewhere to go", because there was nowhere to go. There was nowhere to go other than the outpatient department to be seen by a nurse who would say, "I can book you in to see your doctor on Monday." I am not criticising this government; I am criticising the system overall. I do not think we have put enough effort into providing a white door or something like that so that if someone comes in with drug paranoia, saying that they want to get off that drug, in they go and they do not upset the people in the hospital waiting room with trauma, broken arms, broken legs or general belly problems or whatever. They would then be hived off and processed through a system and given the help that might assist them to move forward from their problem of drug addiction or whatever it might be. When they come into the outpatient department, generally later at night, they get very emotional and sometimes need security to look after them because they do not believe anyone cares. It is not that at all; people care, but there is nowhere for them to immediately go. Again, I am not pointing a finger at anyone because this is a very widespread thing, but I think this Parliament should be

looking at how we can make the door, as I will call it, available for that person who arrives with their mum, dad, brother, sister or sometimes only a friend, saying that they need help. I have had the phone calls in the middle of the night and people have said to me, "I've been to the outpatient of X hospital, and they've told me the psych nurse has seen him and he's okay, so he'll be all right to come back on Wednesday." Although I have not seen a suicide over that, I recently heard of a father and son who suicided over a 12-month period because they just did not get that help. They were difficult to manage; they were difficult to work with, but the gate was never open. The door was never open for those people to go through. Yes, doctors are busy; there is no doubt about that and I am not criticising them at all. It is about funding specialised mental health services that are available 24 hours a day. As I say, the window is very, very narrow when those people have a change of heart and a change of mind. If they do not have that service straightaway, the craving has them back on the street within hours—not days, hours. Just maybe if we had those services available, we could cut a few of those off, reduce the suicide rate and probably dramatically reduce the crime rate within our communities.

Having talked through our family issues and worked with people on that, that was one of the things I said I would raise. I will move on now because the emotions will start coming. Before I do, I say—I will have a drink of water first—with great pride that my daughter went through the system and is now 11 months clean.

Members: Hear, hear!

Mr M.P. MURRAY: Many people would not have recognised her when she was up here for dinner at the last sitting. It has really, really showed me that things can happen. She has done it by herself, to be quite honest, other than dad yelling and screaming and doing many other things. The person has to want to get better, and that door needs to be open for them to go through. Thank you to Cyrenian House. I will wrap that up and move on.

Another issue that has arisen in the south west is dialysis problems. A family I know has a genetic disease and in time they will need kidney transplants or will need to be on regular dialysis. They went to the Bunbury Hospital and said that they wanted to get on dialysis, because for a kidney transplant—the minister can correct me on this—people have to have very clean blood. They were told, "Well, you'd better get off work and move down to Perth". Thank goodness, after questions and some publicity, that advice was reversed because the money was then made available for this family. Not only do the two brothers have this problem, I think one or two of their children have the same problem also, where their kidneys grow to the size of small rockmelons and they have to have them taken out and, if they are lucky enough, have a kidney transplant. But to have that transplant their blood has to be very, very clean, so they have to be on dialysis all the time. When they were told to give up their jobs, one of them was working in the mining industry and would go every so often to get his blood cleaned. For him to give up his job and move to Perth meant enormous cost to the family; the family is in Collie, the father is in Perth getting his treatment, and to me it would not be such a big issue to have more dialysis machines around the south west. I work with different people in the Collie area and the community at one stage said, "Righto, we'll buy the dialysis machines for Collie." What happened? The hospital rejected it because it did not have people who were available or willing to train them to use the dialysis machines. I think that is a sad state of affairs and something that the minister should look at very closely.

We have seen some remarkable improvements in this area in the Kimberley, especially with Aboriginal people. I have been following that, and I heard from the minister the other day about how that has improved. Although the Kimberley is a long way away, so is the 200 kilometres from Perth hospitals to the south west. People in the south west in places like Collie should have access to dialysis machines on a regular basis, or even home dialysis for treatment. I am not sure about this, and again I will stand corrected, but I believe that in the Kimberley there is a dialysis bus that goes around. Why could we not have the same thing in the south west? I do not know how many it can treat and how many hours it takes—please bear with me on this—but if we were able to pick up two, three or maybe four people in a day in a bus-type situation, I am very sure it would be cost effective and very well received in all south west communities, including not just Collie but also Bridgetown, Boyup Brook and Darkan. People out in those communities could be serviced by a bus-type situation, if that is possible in technical terms, but if it is happening in the Kimberley, why could it not happen in the south west?

Another problem I am seeing at Collie Hospital is a change of rosters. People have been put off but people who want to work only three or four days a week are being asked to work longer hours. They do not really want to, but they feel obliged to because there is a shortage on the roster system. That means that the people who are helping out are often women who are very close to retirement age who say, "I don't mind doing three days a week, but I don't really want to do five", but because of the way the system works, they have been asked to do the four or five days—any extra days—to fill up those gaps because people have been put off. It means the hospital does not have to pay for total workers' compensation and all the things that go with that when there is another part-timer. Again, when people drop out, they find it difficult to find workers who want to work full-time—possibly partners and those sorts of things—in the smallest communities. They are very concerned about the way that has been handled to reduce costs by reducing people's hours, but the service will be reduced as

well. It also means that they are obliged to go there on a day that, normally, they would maybe babysit for their children and meeting other sorts of social obligations that, again, help in smaller communities so that parents can go to different jobs.

I can say that there is a problem at our Collie Hospital, having spent a couple of nights there. I do not think I have told the minister previously, but I had to go there when I was pretty crook, to say the least, on—you would not believe it—the coldest night of the year, and the air conditioning was not working. That is an ongoing problem in Collie Hospital; it has been going on for probably the last five years. The only thing worse than the air conditioning in Collie Hospital is the television sets. Well, we can put up with the TVs, but believe you me, the place was so cold that night that the nurses were wearing gloves to do their job, and it was a disgrace to the system—an absolute disgrace. For years we have been asking for an upgraded air-conditioning system that can provide comfort for all people working there and all the patients. I had up to five blankets on, trying to keep warm. I think that night it was minus four degrees, and it does not matter how many blankets there are if there is no warmth in the room. It was terrible, but to see those nurses working in those conditions was just wrong, totally wrong, and it is time that the old system was thrown out. Although it may be cost effective, I do not believe the standard is up to scratch.

[Member's time extended.]

Mr M.P. MURRAY: Another thing I must talk about in respect of country people in the hospital system is the patient assisted travel scheme. Thank goodness, minister—this is a pat on the back—that in recent times I have not had many complaints. Although I have complained in this place, at the same time I do not have a problem in saying that some things are working out there, because the complaints are not coming in, so I would like the minister to take that back to the PATS people and thank them for sorting out the problems, and I know that doctors also have a major part to play in this, so that country people do not have to go through the pressures of PATS. However, in many cases some of the accommodation costings are a bit low; some of those costings are, I think—I will again stand corrected—only $60 a night for overnight accommodation, and we all know that you will be battling to buy fish and chips for $60 nowadays, let alone a bed in a hotel. That is something that has to be adjusted, but the scheme has tidied itself up and is working very well, in my view. Others may have a different view on that, but I certainly do not have problems with it, and I want to say thank you to those people.

Another issue that has come up that I have asked questions on and have spoken to the minister about is a bit age-old, but I still believe it has to be brought up: the issue of aged care in country hospitals. At times there can be up to five or maybe six people in hospital who should not be there because they are aged-care patients, but because there is nowhere else to go, they have not been accommodated in an aged-care facility, so the state pays for it. I know aged care is a federal issue, but while the state is paying for those people, they could go into respite in other areas if the state were to pay for it at, I believe, about one-third of the cost, instead of the state picking up the full amount of them being in a hospital. The average, I believe, is about $1 200 a day for a patient to be in a hospital, while the aged-care people would be clapping their hands and jumping with glee if we were to pay them $300 a day. I do not quite understand why the minister will not take that job on and look at it and say, "Yes, there's a huge saving for the state hospital system", but then moves over to the federal system. I cannot quite understand that at all. Not only that, it accommodates those people who should be in an aged-care facility and not in a hospital. We have people like the runners and people like that who have mental problems, and it meant that at one stage in the Collie Hospital they had to have a security guard on the door to keep one person in. That is astounding. That patient could have been taken to a secure facility for about a third of the price of what it cost to keep him in the hospital. The minister should look at that closely because if this is happening right across the board, it would certainly help with the state's budget problems to some degree. Evidence suggests that the use of hospital beds for aged care is happening at not only Collie Hospital, but also other hospitals. That is something that could be fixed and fixed quite easily.

I am happy to say that the minister's press release the other week addressed the issue of delayed moneys for Collie Hospital, and finally work is being done on the hospital building itself. My concern is that the work to the building is mainly about office space and not about the people who use the hospital's comfort zones. I will again use my experience. When I went into the shower, which is quite ancient, there were no hooks to hang my clothes and towel on. It was a bit daunting to say the least, and when I grabbed hold of the shower and turned on the tap, everything fell off the wall. It was difficult to wash some parts of my body, to say the least.

Dr K.D. Hames: Where was this?

Mr M.P. MURRAY: It was in Collie Hospital.

My argument is not about what people have decided to do there; rather, the moneys that have been allocated are not enough to do a full makeover and I believe the hospital needs a full makeover. Yes, everyone is entitled to a reasonable office, but the government should look at hospital wards as much as anywhere else. My experience

in there was not very nice. I froze to death, I could not hang up my clothes and I slopped around the water on the floor. I know the maintenance guys personally and they said that they were really struggling to keep things up to scratch because the building is so old. As soon as they fix one thing, something else needs fixing. It is about the age of the place. It really does need a major overhaul to get it up to scratch. I suppose it had to happen, but I watched on with some annoyance when certain small hospitals in the state were completely refurbished with moneys of between $20 million and $30 million. Collie Hospital will receive a piddling $7 million, which will be spent on creating office space.

Dr K.D. Hames: Seven million dollars is still a lot of money.

Mr M.P. MURRAY: But it is far different from what Manjimup hospital got, which was $30 million.

Dr K.D. Hames: I know, but when we came to government, there was only $12 million or $13 million for the whole of the country health service in the budget. That was it.

Mr M.P. MURRAY: Do not argue with me about that, because prior to that, 10 hospitals—I have argued this in caucus—got money and the rest did not. When the Liberals come to government, there was a chance to follow that on and go right throughout the state. That did not happen.

Dr K.D. Hames: It was only two hospitals—Katanning and Merredin. They were the only hospitals that had funding in the forward estimates when we came to government.

Mr M.P. MURRAY: What I am saying is that prior to that, 10 hospitals from the top end all the way down received money. Believe me, I am not fudging the figures on that one.

Dr K.D. Hames: It was not very much and that is the point. We have put in hundreds of millions of dollars.

Mr M.P. MURRAY: But there comes a time when hospitals of that age cannot keep battling on. The minister says that $7 million is a lot of money and I agree with him, but it is nowhere near what was invested in Manjimup.

Dr K.D. Hames: I wouldn't mind having that, I can tell you.

Mr M.P. MURRAY: I think there is a little bit of political bias going on here. Manjimup hospital seemed to get quite a bit of money, as did Katanning Hospital and Narrogin Hospital. But the hospital in the Labor seat that happened to be in the middle of those electorates got stuff all. The minister should not tell me he did not go tick, tick, tick, cross.

Dr K.D. Hames: The Department of Health determined where the funding went.

Mr M.P. MURRAY: What a handball. Come on; the minister is at the top of the tree, not the bottom! I know he is retiring, but do not expect us to believe those furphies.

The point has been made that although $7 million will do X amount, it is certainly not enough to ensure that Collie Hospital will be up to the standards of many other hospitals in country areas. There is something that I do not understand.

Dr K.D. Hames interjected.

Mr R.H. Cook: It should all go to the Kim Hames retirement fund.

Mr M.P. MURRAY: That is right; he is on the old scheme!

In my wrap-up, what is a feasible distance to travel to a central area? I am talking about Bunbury. Is 60 kilometres from Collie to Bunbury too far? Is travelling 70 kilometres from Boyup Brook to Bunbury too far to see a specialist? If it is too far, we must look at taking a specialist out to the people one day a week. We have talked about this many times in here. I get complaints from people about having to travel to see a specialist. In some cases, I ask people what the real issue is—their health or whether they are too tight to pay the money to get the treatment. Of course, they jump up and down. It really comes back to how far away should a hospital be to service people. I thought about that because when I went to Edith Cowan University for a meeting one night, I asked what its catchment area was. I was told it was 50 kilometres, so I assumed that discounted Collie. I was told yes, it has something to do with government policy. I hope that is not the case.

Dr K.D. Hames: It is 70 kilometres; it used to be 100 kilometres.

Mr M.P. MURRAY: It used to be 100 and now it is down to 70; righto. Thanks for that, because I believe that some people are a bit soft on it because they think that 60 kilometres is too far. But if a person is dying from a disease, 100 kilometres is not far, to be quite honest.

Dr K.D. Hames: I'm worried about you. I reckon you've got a crook back. I've been watching you standing there.

Mr M.P. MURRAY: No; it is where the kidney was removed and the big bulge is hanging out the side. I think the doctor must have been a bit like the minister—a bit rough and he did not sew everything back up! I had a bit of trauma there, but I am travelling very well, so much so that I will stand again and give you hell about health over the next few years. Thanks for listening. I am not just complaining. I am outlining the issues in my area.

MR B.S. WYATT (Victoria Park) [9.28 pm]: Members will be pleased to know that I do not intend to speak for long tonight. I will make a few comments about the Health Services Bill 2016, which is not an insubstantial piece of legislation and which has been debated for some time today. I will not take as long as I otherwise would because of a recent government decision about maternity services at Bentley Hospital, which is in my electorate. It will fall just outside of my electorate after the redistribution conducted by the Electoral Commission, but it will still service and has serviced for a long period people in my electorate and a much broader area. It is a fantastic hospital; indeed, today I presented a petition to the house signed by 150 or 160 seniors who live in a seniors' village who want to access Bentley Hospital more efficiently, but who do not have a public transport service to Bentley. I presented that petition on behalf of those seniors. That is just one example of not only the hospital itself but also the pushback in the community about the government's intention to close Bentley maternity services and effectively take those services to Fiona Stanley Hospital contrary to government decisions and an announcement made by the Minister for Health in conjunction with the local federal member for Swan, Steve Irons, about commitments made to not only the services within Bentley Hospital, but also members of the communities who so value that hospital.

As I said, I will be brief. I want to take members back to 7 March 2012 when, in the lead-up to this point, there was discussion and doubt around the future of obstetrics services at Bentley Hospital. That was in the lead-up to the opening of Fiona Stanley Hospital. Conversations were very much around whether we would lose obstetrics services at Bentley when Fiona Stanley opened, which had been rumoured for some time. In a piece in the *Canning Examiner* by Kate Murphy on 7 March 2012, the minister effectively put this doubt to bed by saying, and I quote Dr Hames, the Minister for Health —

> "As we moved forward we talked a lot to the local community, particularly to Steve Irons, as the federal member and the mayor and there was strong support for continuing to retain that hospital in the future," he said.
>
> "I have said that if they continue to support the Bentley obstetric service and if the number is getting close to the 1000 that are needed, we will reconsider and re-invest whatever dollars are required to bring that up to a high-quality obstetric service.

That assuaged the community's initial concerns about the future of obstetric services at Bentley Hospital. Indeed, the article goes on to mention how Mr Irons went on to save obstetric services at Bentley Hospital. The government's methodology has been to effectively cast doubt about the future of Bentley Hospital by asking, "Do you really want to start the process of having children here and drawing on the services of Bentley maternity services when, in the end, you may not get to deliver the babies here?" We then found last year—there were long conversations and doubts last year—that, quite extraordinarily, a report effectively suggested that Bentley Hospital's maternity services were unsafe. The intent of the report was to cast broad doubt in the community about the safety of Bentley Hospital. I was particularly perturbed by that because, although the report states that the hospital is "potentially"—that is why the wording was so cunning—unsafe, of course, a mother or a pregnant lady's decision about where they will have their baby will be affected if there is any doubt about safety, which will undermine the credibility of that hospital. This goes back to November last year and the shadow Minister for Health then put questions to the minister about this. The Minister for Health said that he did not think there was a safety issue, but that it was the right decision. I will quote the Minister for Health —

> It is the right decision. A brand-new facility is 10 to 15 minutes down the road. We will work very closely with staff at Bentley Hospital who are upset by this decision to make sure that we facilitate their continued participation in antenatal and postnatal services at Bentley Hospital—and the introduction of a midwifery service, as well as ensuring that necessary staff are at Fiona Stanley Hospital to provide the service that we need.

Despite the report making the allegation of potential safety issues at Bentley Hospital, in his response, the minister said that it was actually about staffing because he could not get the staffing that was needed for obstetric services at Fiona Stanley. Fiona Stanley Hospital did not just appear on the scene; there was a long period of planning and development, and construction. We knew that there was going to be demand for the services. Back in 2008, I recall that the government made the commitment to Royal Perth Hospital. It therefore also took on the consequence of that, which was staffing those facilities. At no point in 2012, when Mr Steve Irons and the Minister for Health said that if Bentley Hospital gets 1 000 births a year, they would not only save it but also upgrade the facilities, did they say that it was subject to staffing capacities at Fiona Stanley Hospital. I never

heard, "If Fiona Stanley can't do it, we're going to move services out of Bentley Hospital and move those staff down to Fiona Stanley because that's really the easiest thing for us." Then what happened, of course, is that the local community voted with their feet after the 2012 commitment by the minister and Mr Irons. For a number of consecutive years, and again there was a burst this year, there were well over 1 000 births a year. That triggered the justification that the minister should be not only retaining those services but also upgrading the facilities at Bentley Hospital.

Mr R.H. Cook: Which we can fully expect in the budget.

Mr B.S. WYATT: That is right, member for Kwinana.

An extraordinary community pushback then happened, like there was back in 2011–12. I have a large file that I intend to go through during private members' business at some point during the lead-up to the budget when there will be much more substantial time to go through a lot of the statistics that I have been given, both through the hospital and from questions through the parliamentary process. However, I will not have the time for that tonight and neither is it necessary because of the government's welcome backflip on this. I want to make the point that families who use the obstetric services at Bentley Hospital are not from Bentley; they are from the entire south eastern suburbs of Perth. Indeed, a number of families from the wheatbelt are using Bentley Hospital and had used Bentley Hospital for previous deliveries. The hospital services a very broad geographical spectrum of Western Australians who are having babies. The diversity of the families who are giving birth at Bentley Hospital is important. They are a hugely diverse community. Nowhere was that more highlighted than late last year, just before Christmas on 22 December, when page 1 of the *Canning Times* had "Baby what a milestone: thousand babies born at Bentley". Again, that was another year that triggered the 1 000 births that the minister said would justify not only retaining services but also an upgrade. I want to read a small part of Pia van Straalen's article —

> THE 1000th baby of 2015 has been welcomed at Bentley Hospital—a bittersweet arrival for the maternity wing, which is set to close next year.
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> On December 11, Joseph Florence Manickam arrived at 7.33pm, measuring 51cm and weighing 3.135kg.

The minister was gushing about this and he congratulated the staff at Bentley Hospital for their fantastic work. There is a fantastic photo of the parents, Florence and Annie, with baby Joseph, the 1 000th baby to be born last year at Bentley Hospital. They were then still under the clear impression that 2015 was the last full year of maternity services at Bentley Hospital. If members look at that family, it is very reflective of the community that utilises Bentley Hospital. There is an incredible diversity of Muslim families and there is a wonderful doctor in particular; I will not name her because I do not want vengeance wrought by this government upon that doctor, but I am sure that the Minister for Health knows who I am talking about.

Dr K.D. Hames: We met with her the other day.

Mr B.S. WYATT: She is a fantastic doctor. When I am moving around the community, it is very rare for people to come up to me and talk about the service provided by a doctor. That is reflected in the midwives at Bentley Hospital. If a birth is not going to be complicated, people want to be able to deliver their babies close to their community and where they live. A lot of the people who are utilising Bentley do not have two cars. They do not have the capacity to simply flit around Perth's suburbs during that time, when mum and bub are in hospital and maybe dad is home with another child, and simply connect that easily, as though they are at Fiona Stanley Hospital, for example. The public transport services are not what they should be to aid the transition in the event that the government proceeds with the closure of Bentley Hospital. I do not have the 2013–14 statistics here, but I will read in them over the coming weeks, of the countries where the mums who were delivering babies in Bentley Hospital were born. That is an extraordinary story in itself. I do not have it in this file; it is in a file I left back in my electorate office, but it sets the story of the services provided and the nature of the patients receiving those services. Similarly, a significant number of Aboriginal mums give birth at Bentley Hospital. The average number of Aboriginal people in Bentley and surrounding suburbs is higher than the average metropolitan number. As a result, we see high numbers of Aboriginal mums there who highly value the service provided and the elders they have forged relationships with to aid the birth of their children. When we take those sorts of services away from the suburbs of Perth and try to isolate them in big centres such as Fiona Stanley Hospital, it makes it very difficult for people who are broadly from a lower socioeconomic background to access them. Fiona Stanley Hospital does not have anywhere near the visiting midwifery service provided at Bentley Hospital. The statistics for November 2015 last year alone highlight that at Fiona Stanley Hospital, there were 60 visits from the visiting midwifery service but in Bentley, a significantly smaller hospital, there were 181 visits during that month. There are a number of months on this list, but I will not spend the night reading them all in.

I am very pleased with the minister's decision to defer his decision on withdrawing maternity services from Bentley Hospital. I note his decision to revisit that decision in 2018. I and the community will take any win at this point because I am sure that that 1 000 mark will be delivered year after year and by 2018 we can then upgrade it, shadow Minister for Health, to meet the current government's commitment for 2018. I have written to everyone who signed a number of petitions over the years, saying that this is a great result from the efforts made by members of my community to make it crystal clear to not just the government but also Mr Steve Irons that they hold him to account for this result. They want him to stand up and ensure that the services committed to are retained. That has been a great result with the government's backflip, but I certainly note the initial arguments made maybe not by the minister, but certainly in the report put out to justify the closure of maternity services around safety and the fact that the minister said, "Well, it was logical to close Bentley; it's old and Fiona Stanley needs the staff, so we'll move everyone down there." I am glad it is no longer logical and the government does not think there are any safety issues at Bentley maternity services, and I am glad those services will be retained there. Members should not think for a minute that this is something the government had not acted upon and was not going to proceed with. The maternity services transmission and integration communication plan was done. The government certainly knew how it would spin the plan in the local community and it had been doing that in the lead-up to what was going to be the closure in June 2016.

I want to thank all the members in my community who participated in the campaign to save maternity services at Bentley Hospital. It was a broad-based campaign from people throughout, not just my electorate. Constituents from the electorates of the member for Cannington and the member for Belmont signed my petition and, indeed, constituents from the next electorate down, which I think is the member for Gosnells' electorate, also signed my petition. It is a great outcome. I am pleased the minister has reversed his decision to close the maternity service at Bentley Hospital for at least the short term, until 2018. It is something I will continue to fight for, particularly as we move towards the 2017 state election. I will make sure that every member of my community knows that if they re-elect these guys, Bentley maternity services will certainly be gone.

MR D.A. TEMPLEMAN (Mandurah) [9.47 pm]: I always find myself as the last speaker for the opposition, usually late at night. I am happy to make a contribution to the Health Services Bill before the house this evening. There is no doubt that it is an important bill. The bill was introduced and read a second time by the Minister for Health. There are a number of clear implications regarding the bill's content. I acknowledge that it obviously seeks to reform the governance of the Western Australian health system. In the minister's second reading speech, he refers to it replacing the Hospitals and Health Services Act 1927 and he makes a range of explanations of various parts of the bill. He also indicates the establishment of health service provider boards of governance, which is of particular interest.

I will not speak for very long but in his response I am keen to hear him, I suppose, not allay fears but perhaps briefly map out what this bill means to the Peel region hospital services. As the minister is well aware, there is the Boddington Hospital, the Murray District Hospital in Pinjarra and the Peel Health Campus in Mandurah. The services in the other local government authority of Waroona tend to be delivered through Harvey Hospital and through Murray District Hospital. I want to talk about Murray District Hospital very briefly shortly. In terms of emergency and high-level needs, the Peel Health Campus seems to be the focus for those hinterland, if you like, communities. I understand the health service needs of those people who live in the Serpentine–Jarrahdale shire are focused on Armadale–Kelmscott Memorial Hospital and Fiona Stanley tertiary hospital. I have said in this place that I have never and will never proclaim to be an expert in health service delivery, but as members in this place will very well know, the Peel Health Campus has had a very chequered history over its 20 years of operation. With the Peel Health Campus opening, which was an expanded Mandurah hospital in 1996–97, it was under a private contractor, contracted by government to provide public health services. There is no doubt that under the original contractor, a whole range of issues were associated with its operation. I think history will show that under the former contractor of the Peel Health Campus, it was a chequered history. I think both parties in government would certainly agree that it was quite a rocky relationship. I acknowledge that has changed with Ramsay Health Care taking over the contract coming up to, I think, two years ago —

Dr K.D. Hames: I think it's longer.

Mr R.H. Cook: It's more than two years.

Mr D.A. TEMPLEMAN: It has gone very quickly then. It is more than two, because it was not long after the 2013 state election, so it is over two years ago. I will be absolutely up-front. When Ramsay Health Care took over, it did a number of important things. One was that it worked very hard and very quickly to restore some morale amongst the staff in the hospital. Indeed, it implemented some very simple and some more complex measures to address some significant staff morale problems. I think that was successful. That renewed confidence can also be sheeted home to Dr Margaret Sturdy, the CEO, because of her capacity. I have a great

relationship with Margaret Sturdy. I must admit, it is probably the best relationship that I have had with any of the CEOs of the hospital. There were some with whom I had a good relationship, but, as we know, under the previous contractor, there was almost a revolving door of CEOs at the hospital. In that respect, there has been greater stabilisation of the hospital in the last three years. The hospital still gets complaints. I know that the minister still gets ministerials. I write to the minister sometimes on some things and he has constituents raising issues with him, but by and large there has been a vast improvement. That has been very important. That change in confidence is welcome.

I have mentioned this in this place before. Maybe it is my naivety or lack of understanding of the hierarchical structure of delivery, but I keep questioning what the ultimate plan will be for Peel as we move forward, and particularly as population growth continues. As members know, if the Perth and Peel@3.5 million population projection is to be supported, understood or believed, we will be looking at having a significant population. We already have one, but it is going to be significant as time goes on.

Dr K.D. Hames: Isn't 130 000 proposed for Mandurah?

Mr D.A. TEMPLEMAN: A population of 130 000 is forecast for the City of Mandurah but then there is that big growth between Mandurah and Pinjarra. The 90 000-odd that is expected —

Dr K.D. Hames: I thought that was part of it.

Mr D.A. TEMPLEMAN: For the Peel in total it is a population of 300 000 in the out years. It is significant. This means that the population will continue to increase. It will, of course, continue to concentrate probably in two main areas—one is the Shire of Murray to the east and the other is the continued densities and growth in the City of Mandurah itself. That will mean that we will have a population that, by its demographics, will have its own peculiarities, as it does now. The minister and I, as members for the area, know that we have a high number of seniors in our population and that the area is a hotspot for lifestyle diseases; there is a high prevalence of those diseases. The area features prominently in the statistics relating to the number one, two, three and four killers or contributors to ill health—diabetes, kidney failure et cetera—because of the nature of the population and also the socioeconomic basis of that population. As I have said to the minister in this place, this is not a criticism of him but an opportunity to very clearly articulate what the plan is.

It is almost universally understood that when the Reid report was conceived, developed and launched as the basic blueprint for our system in the early 2000s, Peel did not feature prominently—Peel Health Campus did not. In fact, in many respects, Peel Health Campus was almost sitting out by itself in terms of what its existing, future and long-term future would be for service delivery. I do not know why that happened; I have no idea and I am not really interested, because it does not matter. The fact is that it is now time to very clearly articulate what will be the future of that hospital and all the other health services that should be delivered locally but currently are not. I know that we have suffered over the years because we have found it difficult to attract specialists to the region. It is still very much a drive in, drive out centre for a number of specialist areas. That is something that has happened and is historic. We need to continue to try to attract service providers, doctors and specialists; it has not been an easy feat. However, what I am concerned about is how we articulate a comprehensive plan that fits in with what is delivered. We are part of the South Metropolitan Health Service, and we have been for two decades, I think. I am not even sure when we were a country board or whatever it was previously. It may have been in the early 1990s or late 1980s. We are part of the South Metropolitan Health Service essentially. The minister and I know that quite often the criticism is that we are tacked on the end bit of the South Metropolitan Health Service and therefore there are services that should be provided or could be provided but things get difficult. We need a clear health plan. I have been directed previously to the clinical services framework as an example. I understand what that all means, but I think we need a designated plan that articulates to our population exactly what it can expect to be delivered locally and what it can expect cannot be delivered locally or will not be delivered locally for whatever reason. One of the challenges is to clearly explain that.

We could talk about the situation with the patient assisted travel scheme as an example. PATS has been a to-and-fro experience whereby a significant part of Mandurah was once covered by PATS but, as we know, now very little of Mandurah is covered by PATS. Most of the area that is covered by PATS is the southern suburbs of the minister's electorate.

Dr K.D. Hames: I am not convinced that Mandurah was ever PATS. It used to be 100 kilometres in the past and then we brought it back to 70, so some of my electorate is now covered.

Mr D.A. TEMPLEMAN: Yes, but some of mine was, too.

Dr K.D. Hames: We brought it back largely to deal with Northam, which was just far enough away but it needed to be covered for some things.

Mr D.A. TEMPLEMAN: Yes. I suppose my argument has been that for some people, PATS is still a viable option because of the nature of the population. It is always argued back to me that we have a train line link to the new Fiona Stanley Hospital and the Murdoch private hospital, but the minister knows very well that we have buses that leave the community health buildings in Mandurah every day packed with cancer patients and people who have heart appointments in the tertiary hospitals et cetera. They are packed every day. I sometimes see the buses when I drive up here.

I think we have to come to an understanding of exactly what services are going to be delivered and will be delivered in the future, and how that fits in with the overall plan. That is what is concerning me about this. One example is the new health service provider boards of governance. What I would like the minister to answer in his second reading response is where our region fits in with the new governance board that will be established as the South Metropolitan Health Service. I want to know what the minister envisages the local community that we represent will have when the new health service provider board is established. I assume that the board will have some community representation, or we will want a broad cross-section of representation, but will we be guaranteed that at least someone from our area will have a spot or the opportunity to be on that board and how might that come about? Secondly, what will that do to the operation of the Peel Health Campus, given that it is a privately contracted entity? What will be the relationship between the South Metropolitan Health Service board of governance that is going to be established and the Peel Health Campus's operations and/or board structure, because a community board of advice still operates? I am interested in knowing what that relationship will be and what the logistics of that will be as proposed in this bill? That is an important question, especially when the minister is articulating to the communities that we represent exactly what this bill and the structures associated with it will mean for our particular populations.

[Member's time extended.]

Mr D.A. TEMPLEMAN: I am also interested to know what this plan means for Murray District Hospital. As the minister well knows, Murray District Hospital once had its own accident and emergency department and used to deliver babies. In fact, my wife was delivered at Murray District Hospital. It provided a suite of services that were traditional for a number of regional hospitals of that size and that nature a long time ago. However, as the minister is well aware, things have changed and, effectively, limited services are now provided at Murray District Hospital, including palliative care–type services and allied health services. I am sure that many in Pinjarra and the Shire of Murray would love to see the return of an accident and emergency department and a suite of enhanced services at that hospital. I am asking what this legislation and this new governance structure is going to mean for a hospital such as Murray District in the long term. As the minister knows, over the years both the Labor government and this government have spent money on Murray District Hospital. I remember when the minister opened the mental health service at that hospital a couple of years ago. I think that is important, and to a lesser extent—not because it is not important but because I think it is part of another district—is the Boddington Hospital. I assume that Boddington Hospital is a country hospital that is not —

Dr K.D. Hames: — part of WACHS.

Mr D.A. TEMPLEMAN: Yes, so it is not within the bailiwick of the south metro model. I would like the minister to provide a general feel of what this bill will mean to the Peel Health Campus, and Murray District Hospital in particular, and to explain what the big plan is for Peel in the long term. I am aware that a contract at the Peel Health Campus is due for renewal in 2018.

Dr K.D. Hames: It concludes by 2018, but it is under negotiation now.

Mr D.A. TEMPLEMAN: I know that is probably commercial-in-confidence, but again that is an important milestone because we know that Ramsay Health Care has a $70 million-plus proposal for expansion, and that is obviously tied to what happens in the negotiations on the existing and the next contract for services. I would be interested in knowing what the minister is able to tell me about the progress of contract negotiations. Whatever happens in terms of the contract, whether it is Ramsay Health Care or another provider that expresses interest? What are the essential needs? My understanding is that the contract allows Ramsay the first bite of the cherry. The minister would know this as well: I hear very regularly about the existing accident and emergency department. The capacity of that was expanded a number of years ago but my understanding is that its volumes are now —

Dr K.D. Hames: It is definitely overcrowded.

Mr D.A. TEMPLEMAN: Absolutely. The minister would hear this in his electorate office, I am sure—I hear it all the time, including intelligence from some people who work there—about people being ushered into various waiting areas because it is very busy —

Dr K.D. Hames: I think it was designed for about half the number they are getting now.

Mr D.A. TEMPLEMAN: I assume that part of the contract renewal will include what might happen in terms of the expansion of that. If we were to further expand the accident and emergency department, there are some issues about its configuration. Whenever I am shown through the existing accident and emergency department, I cannot see how it could be expanded to double or whatever is required. My understanding is that the volumes have hit 50 000 or more. I am not sure what the latest figures are. In terms of presentations, it certainly exceeds what it is able to respond to or provide. We need to know the exact plans for accident and emergency and when the next contract will be signed with the provider.

There is talk about Ramsay's proposed expansion costing in excess of $70 million. I think it is much more than that now, in dollar figures. What would that mean in terms of the ultimate build? As the minister knows, the Peel Health Campus site is a significant land area. It stretches to Teranca Road to the east. From a mental health perspective, when Jim McGinty was the health minister there was consideration for what were then called step-down beds for mental health patients or people with mental health needs. That, of course, went by the wayside.

Dr K.D. Hames: There was no money in the budget when we arrived.

Mr D.A. TEMPLEMAN: There won't be a crumb left when we arrive in March next year!

Was the member for Eyre the Minister for Mental Health before Minister Morton?

Dr K.D. Hames: Yes.

Mr D.A. TEMPLEMAN: The former Minister for Mental Health was considering this because there was some money for step-down beds, but the model changed. More of a community model was delivered. That is why a number of units, including in central Mandurah in my electorate, were provided for people with mental health needs. That still comes back to the grand plan. What is the grand plan? What will it look like for the people of Mandurah and Peel into the future? The Ministers for Health and Regional Development were at the launch of the "Peel Regional Investment Blueprint: Vision 2050". I asked Mr Paul Fitzpatrick, chairman of Peel Development Commission, who was at Parliament House tonight for the Western Australian Tourism Commission event in the courtyard, where health featured in the blueprint, and it does not. Probably my only criticism of the Peel blueprint is that health does not feature in it. I know it is an economic document, essentially; however, it is probably one of the most crucial aspects of the future development and/or future delivery of quality of life and all those things associated with quality of life for our region and for our region's population now and into the future. I think that is a downside of the blueprint. It is a glaring, if you like, omission that health and health plans do not feature.

Interestingly enough, this government, through the royalties for regions program, has put a lot of money into health. There have been a number of hospital upgrades or designated units being built and support has been provided for professional health service providers. All that has happened, but none has come to our region within the context of our hospital —

Dr K.D. Hames: No, because I think it has always been expected that the state government will fund that out of consolidated revenue or in partnership with the private sector—one or the other.

Mr D.A. TEMPLEMAN: True, but I think the option of exploring some legitimate claim on some royalties for regions funding for health provision has not been taken. I will give the minister a classic example in my remaining three minutes. There is a mental health program that they are desperately trying to find funding for through GP down south—I know the minister has talked to Eleanor. It is Eleanor Britton's mental health program. They are looking for about $300 000 over three years, or it might be a bit more, to deliver mental health support to young people in particular. That will not be delivered through consolidated revenue, but it is an opportunity —

Dr K.D. Hames: We don't fund private organisations through royalties for regions funds, and they are.

Mr D.A. TEMPLEMAN: No, but royalties —

Dr K.D. Hames: We only fund not-for-profit organisations through taxpayers' money.

Mr D.A. TEMPLEMAN: I do not know whether it could be claimed that it is not not-for-profit. Honestly, I think the minister needs to look seriously at that program. They have a fundraiser coming up in a couple of weeks and at the moment they are madly going around trying to raise funds. They are not going to fundraise that money to deliver that program, yet we know that on the evidence—they have banged on the door of the Minister for Mental Health, the Minister for Health and they have been to me and Andrew Hastie, the federal member—the program stacks up. The business case stacks up —

Dr K.D. Hames: I helped fund it early on.

Mr D.A. TEMPLEMAN: Yes. So we have a business case, a designated and understood need, and kids in Waroona, Mandurah and Murray who we know can be helped by this particular program, yet we cannot seem to find any money for it. I am saying that I think it is a legitimate call on royalties for regions because it has happened in other regions in the state. I know we have this blurred problem with boundaries and whatever, but I think that is a legitimate call on royalties for regions funding. I will leave it there because I will run out of time, but I am really interested to hear the minister's response to the second reading debate. I assume we will go into consideration in detail at a later date.

DR K.D. HAMES (Dawesville — Minister for Health) [10.14 pm] — in reply: I thank members for their contributions. It is disappointing that they are not supporting this bill because every member who stood and spoke about the bill—there were not many—has been pretty supportive of what is in the bill, the legislation and what it intends to achieve. Those who have not been supportive have been asking questions about what it will do. After we had described what it will do, I would have thought that would have been the direction they wanted to go in, particularly the member for Girrawheen. I wish the member for Armadale had been in this place to listen to the member for Girrawheen's speech because she was very strongly supportive of the direction the bill will take us. The member for Armadale was asking where the bill will take us and what is in it for us. The member for Girrawheen provided the answer, so I do not need to. The shadow Minister for Health made the point that this is good legislation, but in the wrong place and at the wrong time. I do not know what the right place and the right time is, but it is 18 months after —

Mr R.H. Cook: When you have been able to manage your finances in a competent manner.

Dr K.D. HAMES: That is the whole point of the bill. The bill is a tool to assist us in managing the finances. Let me remind members how the bill started. It was started by a former acting director general of Health, who said to me that we have significant problems with governance. I was aware of that, because we have gone through a few DGs, and there is a huge amount of pressure with the current system of governance. I am at the top, giving policy directions, getting on top of everything that needs to be done, and particularly responding to complaints that come directly from patients or from members of Parliament about the management of patients, and putting that back on the department, and there is then one single person who has to try to disseminate that throughout the whole health system, with 45 000 people, and try to better manage what happens with the provision of health services. There was a huge issue about how we could make that governance better. Therefore, the former acting director general put to me that we should set up a task force to look at what other states were doing, and I agreed to do that. The members of that task force were Peter Conran; the Treasurer; Rebecca Brown; and one other person whose name escapes me for the moment. That team looked at what other states were doing, particularly New South Wales, Victoria and Queensland. At the time, two of those states were Labor states, and they were strongly supportive of the role of health service boards.

Remember, the Labor government abolished the health service boards and made me, as the Minister for Health, administer the board for all those hospitals. I have to say that was enjoyable, because under one of the previous director generals, when I wanted to find something out, he would say. "You're the minister and I'm the DG, and really that's my job, not yours", and I would say, "Yes, but I'm also the board, so you will tell me what's going on and give me detail about the day-to-day running of the show." That was very handy, and it gave me, as the minister, enormous power. Therefore, I will be giving up a fair bit of power in this change to the legislation. I had a lot of hands-on control of the day-to-day operations through the health system, particularly dealing with issues about individual patients. The member for Girrawheen made an excellent point. She said that when she was on the board of Sir Charles Gairdner Hospital, that gave her and the team of people direct and hands-on control about issues that came up in that hospital that needed correction. However, she then made the point that that would be much better done on a regional basis rather than on an individual hospital basis. The problem we had with the previous boards is that they were hospital-based; they were silos; they had different computer systems that could not talk to each other; and they ran their own budgets. That meant that the government would find out, two weeks before budgets were due, that Royal Perth Hospital, for example, was $100 million over budget. That $100 million would be about $500 million nowadays, and, suddenly, there it was. That is why these boards caused problems in the past. I accepted the decision of the previous Labor government to get rid of those boards. The then Metropolitan Health Services Board that was standing behind that, under Mr Andrew Weeks, was not well regarded by all and sundry.

That team looked at the operation of health service boards in other states and found, as the member for Girrawheen said, that devolving responsibility so that it is closer to the people who provide the service is a much better way to run a health service, and having a board with a team of people of very high calibre, particularly people who have been senior either in the health system or in running private sector companies, and who have a huge breadth of experience, will provide a much better outcome for people in the regions. That is not just better financial management, but better management of day-to-day problems and individual complaints, particularly

coming out of clinicians within the hospital system. Clinicians are complaining now that they talk to bureaucrats within the hospital but cannot get their voices heard. The changes in this bill will provide a much better opportunity for them to have direct access to their boards and say, "This is not working, and these are the changes that we need." Again, we heard from the member for Girrawheen about two clinicians who could not get on and the board made a decision around that to solve the problem. Those are the sorts of outcomes that I expect to see as a result of putting these boards in place. When the member for Armadale asks how this will benefit his electorate, it will benefit him in two ways. Firstly, Armadale will be part of the east metropolitan region, so we will have a board whose total focus is on Royal Perth Hospital, Armadale–Kelmscott Memorial Hospital, Bentley Hospital, Midland Public Hospital and Kalamunda Hospital. That will be a clear focus on the board's catchment and management area for a large population that is a bit different from the rest in that it sits to the east of the city. Before, most of those hospitals were included in the South Metropolitan Health Service, which already had a huge responsibility all the way down to Peel, including Royal Perth Hospital, which is a major tertiary hospital, Fiona Stanley Hospital and Fremantle Hospital. This takes that responsibility away from the south metropolitan board, and that is part of the answer to the member for Mandurah's question. The benefit for Peel is that it will have a board that does not have to worry anymore about Armadale, Bentley and Royal Perth Hospital. It can focus on the southern area and make sure that the service provided there is of a very high quality.

The issue then becomes partially about funding. The member talked about cuts. I would remind him that there have been no cuts and that the budget has gone from $4.6 billion when we came to government to now $8.2 billion. The increase that has gone to the tertiary hospitals in the current budget is 4.5 per cent. The problem we have had is that all the hospitals are operating over budget. There have been no cuts put in place. They have been told to stick to their budgets and the reason they are over budget is that in the reconfiguration they ended up with too many staff compared with other hospitals around the state. Their funding is activity based, so they are funded according to the service they provide, and they were spending far more than the funds that were being allocated for the standard of service they were providing, so they have to cut those numbers back to be equal to all the other hospitals—it is no great onerous task—throughout Australia. That is what they need to do, and it has been difficult for them and it is not their fault because, partially, demand has grown significantly, but they are not the ones who have employed all the different staff throughout the hospital system. It partly is because of the reconfiguration that has downsized services at Fremantle Hospital and Royal Perth Hospital, and they have ended up with more staff than they require. When we are doing a transition, part of the problem is that we have to keep two hospitals open at once, still providing a service up to the last day at one and then suddenly it all has to be provided at the next, so in effect we have to have two lots of staff to manage the transition, which has never been easy.

It has been a difficult time, but we are now 18 months after the opening of Fiona Stanley Hospital. By the time the legislation is passed the new change will start on 1 July, providing the legislation gets through. That is 18 months after the opening of the hospital and nine months after the opening of Midland. That is going very well. It is under a lot of pressure, with a lot of people going there, but nevertheless it is going very well. That gives time for those things to change, and this is designed to improve the governance. When the member says that they are under stress and under pressure and that now is not the time, now is exactly the time, because this is designed to relieve some of the pressure they are under by having people with much more hands-on control and more linkages into the problems the hospitals face, and the capacity for much more improvement. There is nothing that frustrates me more than getting letters from patients talking about things like the lady on television that the member for Fremantle spoke about, who was left laying for a day in a soiled bed. That is totally unacceptable management, but how do I as minister control that? When someone puts in a complaint, it is a retrospective complaint, so the issue has already happened. What do hospitals do to stop it in the future and make sure things like that do not happen again? I am sure, in this instance, it might have been a couple of staff, someone under pressure, extra patients coming in, rushing around and something happened and went wrong. Inevitably it is when something goes wrong that something like that happens, because nobody would deliberately do anything like that. But at the end of the day we have a million people going to our hospitals, into emergency departments and directly to the hospitals, and similar numbers coming through outpatient clinics. That is a huge number of people. The quality of service provided is excellent and many opposition members have accepted and said that it is an excellent service, but it does not mean that things do not go wrong. Sadly, Fiona Stanley Hospital is copping all the flack, but it is no better or worse than any of the other hospitals in the system. They have things that go wrong as well. It has almost become fashionable for Fiona Stanley Hospital to be the one that cops it and the media are now even asking me whether it annoys me that every time something goes wrong at Fiona Stanley Hospital it suddenly becomes front page news. It annoys me and it certainly annoys the staff as well.

Unfortunately, some people in the system have taken advantage of that and this so-called "listen to the clinicians" who are making the complaints. If I listened to them, we would not have the East Metropolitan Health Service and I would seriously annoy the Australian Medical Association and all the people it represents and all the doctors and clinicians at Royal Perth Hospital. If we had not kept Royal Perth Hospital, I think I would have seriously annoyed all those same clinicians and now the opposition as well, who support the concept of keeping it. So we have some work to do to fix these things and members, particularly the shadow minister, made a lot of contributions about those. There are just a couple of points the Deputy Leader of the Opposition made that I think I need to cover, although in consideration in detail we will cover a lot of those things. The member referred to things that he is concerned about, such as the workforce and transferring the workforce. We have made sure that that is in place. They can transfer across and there is no loss of conditions.

I am aware that the department went through a lot of consultation. I do not have the details of that and we can perhaps cover that more in consideration in detail, but I know it consulted a lot of people. It certainly consulted the unions. Someone mentioned that the unions did not know it was coming. They were all consulted right at the end. At the end of the day, when government makes a decision, it puts a proposal, and this is just to change governance. So it is about the structure of governance within Health. The government makes a decision: it goes out and talks to people about what those changes will mean. One point the deputy leader made was about the community representative. A couple of members made that point. We do not have a designated community rep. We have only a small number of positions that are designated. There is no issue. Any government can make that decision to put on a community representative. I do not think it is a bad idea to do that. The deputy leader also talked about making sure that boards cannot enter into outsourcing of contracts, and that is true. I know the member has been reassured about that, but just to reiterate that reassurance: it is not there.

I think that has covered the comments largely that the shadow minister made. Most members did not talk about the bill. They talked about issues of health within their areas, and that is not uncommon. The member for Armadale said that we are bringing in a bill to try to not fix governance, and not fixing the day-to-day health problems, but that is exactly the point. That is what the bill is for—to fix the governance so that we can fix the day-to-day problems of Health. That is what it is all about. I think he seemed to miss that point.

The member for Mirrabooka covered some things about consultation and other issues that I know she will raise in consideration in detail. It was great to see that the member for Girrawheen is very supportive of the bill and I think she might have preferred that it be supported by the opposition. Again, the member for Maylands talked about a consumer representative.

The member for Victoria Park talked a lot about Bentley Hospital and the change in position. I said that if they had 1 000 deliveries there, I would review it, and I did review it. It was well down the path of a decision being made to transfer it, but I looked at those services and I was extremely convinced by the doctors at the hospital, the general practitioners who are doing a third of the up to a thousand deliveries; by the midwives there, who were extremely dedicated; by the fact that very few of those midwives wanted to transfer to Fiona Stanley Hospital because they were loving it where they were; and that Fiona Stanley Hospital, in my view, did not have the capacity to access enough midwives to cater with those additional staff.

It was interesting seeing the shadow Minister for Health—I know that this is what is done in opposition—claiming credit for himself and the public about the change in decision, but I can tell the shadow minister that I had virtually no contact whatsoever with the public about this issue. The member said that there was a huge outcry —

Mr R.H. Cook: I didn't claim it for myself at all.

Dr K.D. HAMES: The member suggested that members of the public had an influence on my decision. To have had an influence on my decision, they would have had to contact me to make their unhappiness known, and nobody did. Nobody came to me and asked me not to do it, other than Steve Irons when we had a meeting in the past. The decision was made by myself.

Mr R.H. Cook: So it was more about saving Steve Irons' arse than it was concern about community outcry.

Dr K.D. HAMES: He had been told we were moving down the path of transferring. He was not happy; nevertheless, that is what I told him we were doing.

Mr R.H. Cook interjected.

Dr K.D. HAMES: No, I was not protecting his butt. I can tell the member that it was the people who were working at the hospital who helped change my mind; that is, the doctors, the special doctor obstetrician to whom the member for Victoria Park referred—I think it was him—and the midwives. Also, having looked at what Fiona Stanley Hospital was able to provide, I did not think it was appropriate. The decision needs to be looked at

again in two years. I can say that we were instrumental in saving Osborne Park maternity hospital. You guys were going to close that. I objected and Jim McGinty did a backflip. It is now operating as a great hospital. I looked at the surrounding suburbs and listened to arguments from the staff about the sorts of patients who go there. There is a very strong ethnic community. I was getting feedback from some of the midwives about those who could not afford to pay for parking at Fiona Stanley. In fact, some women caught a bus to get to the hospital while they were in labour. Those women said that it was a much better service than the services provided where they had come from. A lot of them were refugees who had come from places with very poor health conditions and to them Bentley Hospital was an amazing hospital with a great community atmosphere and great support. I hope that when the decision is reviewed in two years, the next Minister for Health will look at not just the economics of where it is best to have those patients, but the community aspect. In going out, I can now say that there is a great community service to be provided by a community hospital that does obstetrics. That is something that everyone should keep in mind. Whoever makes the decision in two years' time should sit in a meeting with the clinicians before making up their mind after listening to people in the Department of Health who say that it is more efficient because it is a big hospital. Remember that services are better provided close to home. We do not necessarily need in a level 5 obstetric unit, which is what Fiona Stanley has, delivery of level 3 care, which is basic deliveries. A woman having a baby is a normal event and does not always need higher levels of care. Community care is a great way to provide that level of service. That should be borne in mind in the future.

I cannot say that I thank members for their support, because they do not support the bill. I thank them for their comments that were largely in support of the bill, with some expression of surprise that they are not supporting it because of some view that it is not the right place and time. To some extent, I think this is opposition for the sake of opposition. Nevertheless, I commend the bill to the house.

Question put and passed.

Bill read a second time.

Leave denied to proceed forthwith to third reading.