PUBLIC HEALTH BILL 2014

Consideration in Detail

Clause 1: Short title —

Mr R.H. COOK: Obviously, the short title of the bill is not a fundamental part of the debate, but we have used the term "public health" rather extensively—particularly extensively in some of the contributions to the second reading debate—and people relate public health to hospitals, the funding of health and so on. They are not the terms in which we know it in this bill. The short title of the bill perhaps frames, or mis-frames, the views of a range of people when they refer to this bill. We will shortly get to the objects and principles of the bill. The principal objective is to promote and improve public health and wellbeing. I guess this is the nub of the issue, and for me —

The ACTING SPEAKER (Mr N.W. Morton): Member, just to clarify, we are on clause 1, which is the short title of the bill. You are talking about objectives and principles.

Mr R.H. COOK: I was just saying that they inform our views about what the short title of the bill might be.

The ACTING SPEAKER: I am not trying to be difficult; if you could just return to the debate.

Mr R.H. COOK: I understand. The wellbeing of the community and how we improve preventive health measures, reduce injuries and so forth is signalled as the principal aim of the bill and, indeed, that is the context that we have been talking about. Therefore, it falls into the domain of public health. In common parlance, as the member observed on a number of occasions when some members got a little wayward with their speeches, public health tends to encompass a broad field. Could the minister explain why we are calling it the Public Health Act and not something such as the "Public Health and Wellbeing Act" or some of the words that we now see in common use in reference to these sorts of issues?

Dr K.D. HAMES: Yes, the debate was difficult along those lines. When we said to members, "You are not talking about the bill", it was pretty hard to argue when that is their perception. Public health means anything to do with public health. I made that point quite a few times. The members for Bassendean and Mirrabooka had a defence that could have been used. Once they used that defence, I shut up, because they were sort of right. We have to have local health plans and state health plans and there is really nothing stating that a local health plan cannot address issues relating to health, including public facilities, even though that is not the general concept of public health. Really, there is no reason we could not have called this the public health and wellbeing plan. I do not think that would have taken away from the perception that it is about public health and therefore hospitals. Since we have had the current title for 100 years, I do not see anything wrong with having the same name for another 100 years.

Mr R.H. COOK: The current title is the Health Act, not the "Public Health Act". Were other titles considered in workshops and discussions on this bill?

Dr K.D. HAMES: Member, there is no particular reason. Other states have done other things. New South Wales calls its health legislation the Public Health Act, as does the Australian Capital Territory; in the Northern Territory, it is the Public Environmental Health Act 2011; in Queensland, it is the Public Health Act; in South Australia and Tasmania, it is the Public Health Act; and Victoria has the same name that the member is suggesting—the Public Health and Wellbeing Act. To be honest, I do not think that it matters a lot what the title is. Obviously, there is variation. It is what is in the legislation that is the critical issue.

Mr R.H. COOK: I appreciate the minister's answer acknowledging that some other states use the word "wellbeing". I know this may sound trivial to the casual listener to Parliament, but it is important. I quoted the City of Perth health plan that states that it is about the health and wellbeing of the community. Nowadays, I think there is a greater acceptance that health means not only hospital processes, but also the absence of ill health and the wellbeing measures that go hand in hand with that. If we are to craft a piece of legislation consistent with modern thinking and approaches to health, particularly in the areas of preventive health and other public health issues, surely the notion of wellbeing must be considered as part of the language that we use.

Clause put and passed.

Clause 2: Commencement —

Mr R.H. COOK: I referred to clause 2 in my contribution to the second reading debate, particularly part 16, which refers to the exemptions granted by the minister. A large focus of our discussion was on the granting of exemptions to the state in relation to public health compliance. Part 16 is to come into effect on the same day that the bill is assented to, as detailed in subclause 2(b). Is the minister therefore saying that those departments and so forth that have not been exempted at the time the act is assented to will fall outside the act and be in contravention of the act?

Dr K.D. HAMES: I have a response I could have made in my second reading reply. The member for Kwinana also expressed concern that part 16 of the bill would come into operation on the day following royal assent and that the exemptions would not be subject to any public scrutiny. The intent is to bring part 16 into operation at an early stage, prior to the commencement of any substantive obligations provided by the bill, to ensure the early consideration of the new requirements imposed by the bill on the Crown. The Department of Health intends to consult closely across government to inform and educate people about the obligations imposed by the bill. All exemptions must be made publicly available.

Mr R.H. COOK: In this context, we have no way of understanding how it would work on day one of this act coming to life. We are flying blind in some respects. Does the minister anticipate that on day one he will be knocking on government department doors to inform them of their requirements under the act or will the minister issue a blanket exemption and then pull back from that?

Dr K.D. HAMES: I certainly will not make any blanket exemptions. I think I went through that in my second reading reply. We can go back to how the Halls Creek case came before me. The Halls Creek environmental officer put in a notice to the department, I guess, that a Department of Aboriginal Affairs house should be condemned. In fact, it took the department to court in the end to say that that house should be condemned, but the case lapsed because the Crown could not be bound. Someone needs to initiate an exemption. It may be that a local council or an Aboriginal community or someone on behalf of an Aboriginal community—for example, a land corporation—will bring to the department's attention that a government department, say, has a house that is not fit for human habitation or a sewerage issue that does not comply with the Public Health Act. The government department will be required to fix that under the normal requirements of the act. Only if it seeks to not have to do that, it will then have to come to me, as Minister for Health, with a proposal for exemption. I will then consider that proposal and make the decision, firstly, whether it should be exempt—I can tell the member that the department will have to be pretty smooth to convince me to make it exempt—and, secondly, if it is exempt, the methodology of that exemption. I will be advised by the department on how that should be created and in what sort of time. Of course, that will be mitigated by whatever funds it is able to get to do the work, if it is a massive amount of work. It is an individual thing. I am not going to suddenly tell the Department of Housing that I will give it an exemption to fix all the sewerage problems across the state, and I will give it five years to do it. I do not even know what they all are. However, the department will be made fully cognisant of what is in the act and the act says that the department is bound by the act, unless it gets an exemption. So it will have to do its own estimates but if it does nothing, I am sure people will complain.

Mr R.H. COOK: In the context of that, let us say that the bill travels through this place and it is proclaimed on 30 June. The minister then gets a letter on 1 July from, potentially, the Kimberley Land Council, the Halls Creek council or someone stating that they want to draw the minister's attention to the shoddy state of housing on Aboriginal Lands Trust lands. That would be on day one. What happens if the minister gets 20 of those sorts of letters coming through the door on day one? How would that be managed? I am not trying to dig into part 16 here, but I am keen to understand how, once the bill is assented to or proclaimed, those exemptions will work.

Dr K.D. HAMES: From day one, there is a transitional period when all the conditions of the current act still apply. That period is three to five years. This will give an opportunity for people to bring all those things up to standard.

Mr R.H. COOK: Just to be clear, we are talking about part 19, "Transitional and savings provisions". In part 19, clauses 299 and 311 will come into effect straightaway, so it is those particular provisions that will allow the minister to manage the process in the interim over a three to five-year period. Is that correct?

Dr K.D. HAMES: There are transitional provisions for the entire bill because something like 47 regulations have to be brought into effect, which is a substantial body of work. I know that we have waited 100 years to get the bill; we have longer to wait to get all those things done. Infectious diseases is one of the first provisions that will be brought in—that comes right at the front. The last one will be environmental health. So, there will be a time before conclusions are brought to those specific communities.

I will just read out how the bill will be implemented. The Public Health Bill and the Public Health (Consequential Provisions) Bill 2014 will be implemented in conjunction with each other and with required subsidiary legislation in a staged manner. Implementation will occur in three broad stages over the course of a three to five-year period following royal assent. The first stage of implementation will involve the proclamation of all those provisions that are necessary to achieve consistent terminology across the bill, the Health Act and the range of other acts that refer to the Health Act. The second stage of implementation will facilitate the application of the framework provided by the bill to notifiable infectious diseases and related conditions, prescribed conditions of health, serious public health risks and public health emergencies. The final stage of implementation will facilitate the application of the framework provided by the bill to all environmental health matters. The commencement of the new provisions in the bill will be timed with the repeal of the

equivalent provisions under the Health Act, the commencement of new subsidiary legislation under the bill and the repeal of the existing subsidiary legislation under the Health Act.

Mr R.H. COOK: Clear as mud!

Can the minister describe in general terms how the transitional regulations in part 19 would differ from the substantive regulations that would be in place? I assume that the minister would be making exemptions under the transitional regulations. My apologies—I am just a bit confused about how the transitional regulations will come into effect on day one and how that will impact on the way the minister does exemptions and so forth.

Dr K.D. HAMES: The transitional regulations are the standard things that deal with the timing of when things come in. It is not until a substantial component comes in for which people can seek an exemption that I can prescribe exemptions. Until then, the existing legislation remains in place. We have operated on that for 100 years. It is certainly by no means ideal in forcing local governments and state government departments to do things, but we have to say that, for the most part, they do it pretty well. Government departments do go out and address public health issues now within the community under the current act.

Clause put and passed.

Clause 3: Objects and principles —

Mr R.H. COOK: This is, I guess, the part of the Public Health Bill 2014 that excites me, because it talks about the aspirations of the legislation. There is a lot of discussion in this clause about disease management and things of that nature, and there is a reference to injury. But I wonder why injury is a form of preventative health. Does it have greater prevalence in relation to this bill? What is the role of injury management in the overall public health framework?

Dr K.D. HAMES: The advice I have is that there is a large number of other acts that deal more specifically with injury. So, there are relationships within the Public Health Bill, but there are also other acts, such as the Occupational Safety and Health Act and the road safety act, that deal specifically with injuries.

Mr C.J. TALLENTIRE: In looking at those objects and principles, as the member for Kwinana has said, there are many commendable features, but I am looking for some indication that the Chief Health Officer has the power to override poor decision-making. We touched on this in our speeches during the second reading debate. We are all aware of occasions on which local government makes a particular decision about the location of a liquor outlet or a fast-food outlet or whatever, but despite the community frustration about the poor outcome of having such an outlet in a particular location, such as near a school, there is no capacity for the Chief Health Officer to override that decision-making. I note that the objects mention things like "promote" the provision of information, and "encourage" individuals to plan. The language is very soft. There is nothing in the bill that provides the additional teeth that I think we should be looking for when it comes to important decision-making. I guess the bill does need to include the term "decision-making powers" to provide the capacity to override the poor decisions that might have been made when health considerations have not been properly gone into.

Dr K.D. HAMES: I direct the member's attention to clause 7, which provides six different mechanisms by which the Chief Health Officer might give directions to local government.

Mr C.J. TALLENTIRE: My comments were not restricted to the work of local government. We know that there are many state government agencies that try this on as well.

Dr K.D. Hames: You need to read the clause. Subclause (1)(b) states, "is unable to reach agreement with the local government".

Mr C.J. TALLENTIRE: The minister has directed me to that, yes.

Dr K.D. Hames: It all relates to local government.

Mr C.J. TALLENTIRE: That is precisely my point. We do not want the Chief Health Officer's capacity to be restricted to local government. We want the Chief Health Officer to have the capacity to override poor decision-making at the state government level as well. It may be a decision that is made by a planning authority, not the local government, but it may be a poor piece of policy in relation to—to use something that is quite topical—the number of hospital admissions that have occurred in the last 48 hours of people with respiratory illnesses who are struggling with the smoke impacts. Why could the Chief Health Officer not make some recommendation or decision about the suitability of certain times of the year and certain climatic conditions when it comes to prescribed burning? So, I am not restricting my comments at all to local government. I am asking, minister, why we do not have additional capacity for the Chief Health Officer to override poor decisions made at the state government level as well.

Dr K.D. HAMES: At the end of the day, those things are up to cabinet, when proposals come through to cabinet for things like prescribed burning. The Chief Health Officer has the opportunity, through me, to make

submissions. But we are not going to have a case where the Chief Health Officer is able to override decisions of government or decisions of ministers.

The ACTING SPEAKER: Member for Gosnells, just wait until I give you the call, because I was about to give the call to the member for Mirrabooka. You are obviously very enthusiastic.

Mr C.J. TALLENTIRE: It is hard to see, Mr Acting Speaker, and that is the nature of this chamber. It is the layout of this chamber that makes it difficult.

The issue is, then, that we are not providing our Chief Health Officer with a degree of independence. I think the minister is saying that in fact the Chief Health Officer is in a role that is subsidiary to him as minister and that he or she does not operate independently and is not in a position to give independent advice and make independent recommendation. Is that the case, minister?

Dr K.D. HAMES: Yes. The Chief Health Officer has always, in all jurisdictions, been subsidiary, if we like, to the Minister for Health. That has always been the case and we are not planning to change that. But I have to say that the Chief Health Officer often gives independent responses, particularly to submissions, and his department responds. In fact, when he does a response for cabinet that I do not agree with, I still put it in.

Ms J.M. FREEMAN: In subclause (1), paragraphs (e) and (h), a term is introduced that was not in —

The ACTING SPEAKER: Sorry, members, but can we keep the noise to a minimum. I am struggling to hear the member on her feet.

Ms J.M. FREEMAN: That is all right, Mr Acting Speaker; I can be louder if you want.

When I look at the 2008 draft bill and the 2014 bill that is before us, certain other health conditions have been added in the definition. Does that include things such as obesity, alcoholism or depression, because one would have thought that fits into "other public health risks"? I would not have thought that pregnancy would be included, because that is not a condition of health as such —

Dr K.D. Hames: It is a healthy condition!

Ms J.M. FREEMAN: It is a healthy condition, yes; that is right. I was thinking that maybe it is women's health, but I would have thought that would come into the general "public health and wellbeing" aspect in paragraph (a), because again it is not a condition of health; it is a condition of wellbeing.

Debate interrupted, pursuant to standing orders.

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