HEALTH PRACTITIONER REGULATION NATIONAL LAW (WA) AMENDMENT BILL 2017

Declaration as Urgent

MR R.H. COOK (Kwinana — Minister for Health) [4.16 pm]: I move —

> That in accordance with standing order 168(2), the Health Practitioner Regulation National Law (WA) Amendment Bill 2017 be considered an urgent bill.

This bill has an element of urgency about it. As members would be aware, the Health Practitioner Regulation National Law is based upon a national agreement between Australian governments. In most jurisdictions, this law is changed by an amendment to the legislation in the host Parliament, which in this case is Queensland. Subsequent to that, all other jurisdictions that have delegated their authority on this law to that Parliament automatically change their laws as a result. We, however, have a different approach.

Mr P.C. Tinley: Because we're WA.

Mr R.H. COOK: Because we are WA. I have never received a particularly good explanation of why that is the case, but it is what it is.

Mr C.J. Barnett: It's called sovereignty.

Mr R.H. COOK: That is right. I understand that there are sensitivities around sovereignty. For the purposes of this law, we do not surrender any sovereign rights. Parliaments undertake this entirely under their own authority.

Under this legislation, we subsequently move to mirror the legislation that will be changed in the Queensland Parliament. That legislation is currently making its way at speed through the Queensland Parliament. The urgency on our behalf is to move to make sure that our statutes mirror the national statutes so we do not fall out of the national regulation scheme. As members would be aware, one of the key aspects of this bill is to establish the profession of paramedics as part of the national scheme. The bill will also strengthen governance arrangements and improve the information provided to complainants or notifiers at different stages, as well as a number of other amendments. Because these changes will take place nationally, it is important that we are in lock step with the other states in the nation. I understand that expressions of interest have already been called for membership of the Board of Paramedicine. As a result, I am very keen for this legislation to move through this Parliament quickly so that this state will remain in concert with the other states of Australia.

I understand also that after the bill has passed through this place and goes to the other place, it is likely to be referred to the Standing Committee on Uniform Legislation and Statutes Review. The national scheme has already been subject to analysis by the uniform legislation committee. This bill makes only simple amendments to the national scheme. Therefore, there is good precedent for this bill not to be referred back to that committee. However, I understand there is a view that because this legislation establishes a new board, it will need to be referred. The consideration of this bill by that committee will take some time. That puts further pressure on this place to pass this legislation with some urgency. I therefore ask members to support this motion to facilitate the changes that have been agreed to the national scheme.

MR W.R. MARMION (Nedlands) [4.21 pm]: The Opposition will not oppose the motion that the Health Practitioner Regulation National Law (WA) Amendment Bill 2017 be considered an urgent bill. However, I make the point that basically all this motion will do is speed up by one day the process of getting this legislation through both houses of Parliament.

I wish to comment on a few points that were raised by the minister. Firstly, yes, we understand that this amendment bill is currently going through the Queensland Parliament. I want to thank the minister for the letter that I received today explaining why this bill should be considered an urgent bill. One could also argue that this bill could have been declared urgent when it was introduced by the minister. I guess it is swings and roundabouts.

The minister has not mentioned why this Parliament cannot simply adopt the Queensland legislation. Members in the other house hold the very strong view that any legislation that relates to Western Australia should be passed by the Western Australian Parliament. That is the history behind why this Parliament seeks to adopt its own legislation. The principle is basically that we need to preserve the sovereignty of this state, as the member for Cottesloe has mentioned. Some people agree with that and others do not.

I note that an important amendment in this legislation, particularly for Western Australia and South Australia, is the provision with regard to birthing practices. This provision seeks to restrict the care of a woman during the three stages of labour to a registered midwife or registered medical practitioner. That is another reason that this bill needs to be dealt with urgently. The minister also made the point in his letter to me about the Standing Committee on Uniform Legislation and Statutes Review. That is something that this house obviously has no control over.

Mr R.H. Cook: That's right, member! No-one has control over the other place!

Mr W.R. MARMION: I would not want to even suggest anything in this house because it may influence the decision made by the other house.

Mr P.C. Tinley: Say one thing and do the opposite!

Mr W.R. MARMION: That could be the case, member for Willagee!

We need to be a bit careful about what we say about that process, because it is up to the other house. The opposition is happy to support the motion that the bill be considered an urgent bill.

Question put and passed.

Second Reading

Resumed from 16 August.

MR W.R. MARMION (Nedlands) [4.24 pm]: I am the lead speaker for the opposition on the Health Practitioner Regulation National Law (WA) Amendment Bill. I want to begin by thanking the minister and his team for organising two briefings for me on this bill. Those briefings were very helpful. I also thank the minister for the answers to the questions that I put to the team on Thursday, which were delivered today.

In considering the implications of this amendment bill for the current act, I contacted Paramedics Australasia, which represents paramedics in Western Australia and is based in Melbourne. I had a very good conversation with Peter Jurkovsky from that organisation. I was told that Paramedics Australasia is very supportive of this bill and that paramedics have been pushing for some 10 years for their profession to be declared a medical profession under the national scheme.

Given that another important part of this bill is to split the nursing profession into nursing and midwifery, I thought that I should also contact the Australian Nursing Federation, so I put through a call to Mark Olson. I did not get to speak to Mark, but I did leave a message with his secretary, who said she thought it was very important that he did speak to me.

Mr R.H. Cook: It's no reflection on you, member!

Mr W.R. MARMION: I gave his secretary my mobile number last Wednesday and, unfortunately, he has not got back to me. I have not spoken to Mark for some time, but the last time I spoke to him I do not think we left on bad terms. I assume the ANF does not have a problem with the bill, because I am sure Mr Olson would have phoned me back very quickly if that was the case.

With that brief introduction, this is a bill that we fully support. This is not a controversial bill. I must say as an engineer that the bill is well put together and very logical. I could not follow one part of the bill, but I got the answer to that this morning in my second briefing, and I will mention that a bit later. Therefore, I congratulate the people who put the bill together. The bill goes a long way towards improving the current system because it adds paramedics to the national scheme and splits nursing into two professions.

It is important that I give a bit of background about the national law so that it is recorded in *Hansard*. In March 2008, the Council of Australian Governments agreed to the intergovernmental agreement that was the basis for the establishment of the national scheme. The national law, which implemented the national scheme, commenced on 1 July 2010, with commencement in Western Australia a few months later, on 18 October 2010. The initial scheme included 10 health professions, and that has now been expanded to another four health professions.

It is also important to record in *Hansard* that the purpose of the national law is to ensure that the community can have confidence that health practitioners who provide treatment and care meet a national standard based on safe practices developed by the board of each of the professions covered by the national law. The national law consolidated 74 acts of Parliament and 97 separate health professional boards across eight states and territories into one single national scheme. That has been highly beneficial for the health profession. I congratulate all the health ministers across Australia, in particular Kim Hames, the Minister for Health in Western Australia at the time, for working together to bring in the national law in 2010.

The national law obviously increases the mobility of health practitioners working in Australia by removing the necessity for them to be separately registered in each of the different jurisdictions. That is the major purpose of a national scheme. It also improves protection in the health system by ensuring that any health practitioner who has been found to have committed misconduct can no longer practise undetected in another jurisdiction. That is another important aspect of the national law. It also enables significant improvements to health workforce information and planning due to the availability of accurate data on each of the 14 professions operating within it. Basically, it captures data on each of the professions. That is the national law as it stands. Today we are starting the process in the Assembly of approving 117 amendments to the national law as outlined in the Health Practitioner Regulation National Law (WA) Amendment Bill 2017.

What are the main issues and key reforms in the bill? Firstly, as I mentioned, one of the key reforms in the bill provides for the national regulation of all paramedics, including the establishment of the Paramedicine Board of Australia. Currently, paramedics, who are predominantly ambulance drivers, are not covered by the scheme. As I mentioned before, they have been pushing to be part of the health practitioners scheme for some 10 years. Another important aspect of this legislation is that it builds on a review of the 2010 act by the Council of Australian Governments. A former director general of the Western Australian Department of Health, Mr Kim Snowball, was engaged to review the scheme, as was required under the act. Mr Snowball came up with a number of recommendations, and I thank the minister for providing me with some more specific information on the recommendations over lunch. Primarily, the recommendations—I think there were 33—from Mr Snowball went to COAG, and the recommendations that COAG agreed to are part of the amendments in the bill we are looking at today. Some recommendations will be deferred and will form part of another bill that will be brought forward by COAG when there has been further consultation. I think COAG did not agree with six of Mr Snowball's recommendations, while some have been deferred for further consultation.

The current complaints process of the various boards was one of the key areas that Mr Snowball identified to provide more efficiency by the boards, and that is fairly important. Obviously, some of the boards receive more complaints than others, so Mr Snowball recommended that some of the professions' boards that do not receive many complaints, which makes them easier to manage, be amalgamated into an overarching board. I think the ministers at COAG might have thought it was a good idea, but, in my words, they probably did not want to upset some of the professions by not allowing them to have a unique board at this time. However, in the future, COAG ministers could agree to amalgamate, through regulation, some of the health practitioner boards for efficiency reasons. That is a very good idea, because some of the boards do not receive a lot of complaints. Ninety-five per cent of the complaints are about doctors, dentists, psychologists and two other health professions—there were about five professions—and the other five per cent of complaints are about the other nine health professions. The bill has many clauses that relate to the ability to merge some of the boards through regulation down the track. Sometimes it will be a case of changing something from plural to singular or from singular to plural, and sometimes it will be a case of making a reference to the board relating to the profession rather than a reference to the profession's board. That is one of the key aspects of the bill.

Of course, another aspect of the bill is the recognition of nursing and midwifery as two separate professions, but they will still be looked after by the same board. The Nursing and Midwifery Board of Australia will remain the same; there will not be two separate boards. They have separate registers, so there is not much to do in administration around this amendment. It is important to recognise that there are about 30 000 registered nurses in Western Australia and about 3 000 nurses across Australia who have only midwifery qualifications, so it makes sense to separate both professions.

Another general aspect of the bill is to improve the complaints notification management process. That is quite detailed in the bill. To give a quick snapshot, there are some drawbacks under the current system with putting someone on notice that they can no longer practise. If there is an emergency situation and there is a need to stop a doctor from practising, there will be a process to fast-track that. There will be safeguards around that process to allow the practitioner to respond within, I think, 14 days. It is cleverly worded.

The other new aspect of these amendments is that there will be more feedback for the person who makes the notification. I will call them the person who makes the complaint, but "notification" is the terminology used in the bill. I have had experience in this area, as have probably all members of Parliament, and I am getting a lot more as the shadow Minister for Health. The amendments will allow the board to provide carefully considered information, while ensuring that Privacy Act conditions are not disrupted. The person who makes the complaint will be able to get notification about the action that is taking place and even the board's determination of the particular incident. There will be a feedback mechanism for the person who makes the notification to find out what happened to the professional. The bill also allows the practitioner to be suspended from undertaking some procedures. For example, a doctor might be told that he can no longer undertake certain procedures. It is amazing how much detail has been put in the bill. It is prescribed that the board has to keep a register and write against the practitioner's name the procedures they can no longer undertake. The board will have to notify all employers, volunteer organisations, companies and partnerships related to the health practitioner of any procedures they can no longer undertake. It is quite extensive indeed, and it means there has to be an amendment to allow the board to ask a practitioner to provide it with quite a lot of detailed information so it can have on record all the areas in which a person works or volunteers. I was very impressed with the rigour with which they have gone through all the possible scenarios. I guess that is due to Kim Snowball; he is a Western Australian who is making sure that his years and years of experience in the WA health profession and health department —

Mr R.H. Cook: I should also say that there's been experience, particularly in New South Wales, of people representing themselves as doctors but not having any qualifications at all.

Mr W.R. MARMION: That is the primary purpose of the national law. This legislation brings in a $30 000 fine for a lot of things. If a person holds themselves out as a practitioner and they are not registered, this particular legislation will make sure that they can be prosecuted. That is the primary reason each profession likes to have regulation.

I will digress to discuss paramedics. Obviously, the legislation has to set up a paramedics board. The process for doing that requires a transition arrangement. Once the bill has gone through the Queensland Parliament and our Parliament, the Australian Health Practitioner Regulation Agency can start to put in what I will call an interim board to get the process going. The board's job is to make sure that it has a qualifications scheme and framework set up for paramedics. It is similar to when the nursing profession in Western Australia went from combined in-house training and training under the Western Australian School of Nursing to requiring a degree for registration. Paramedics will go through a similar process. I have been advised that a degree qualification will be required in all states except New South Wales. There are three methods of qualifying as a paramedic. The first is through having a degree, and that is the way I have been told it will work in WA. Secondly, there is a grandfathering clause. Once the bill is passed, there will be three years for someone currently operating as a paramedic to make sure, on the rules and guidelines that might be set up by the new board, that they meet the qualifications. There is a third unusual method of qualifying that allows paramedics in New South Wales to get a diploma through the New South Wales ambulatory services. The legislation will allow that qualification to be recognised in New South Wales, which means that it will be recognised Australia wide. Those are the three methods by which someone can become a registered paramedic. In the interim process, the interim board will have to set up processes including the database and how everyone is to be registered, and then the new board will be put in place.

This legislation will allow different people to comprise boards. It allows for the chairman of the board to be a practitioner who is not necessarily from that particular —

Mr R.H. Cook: I'm not sure it is in this legislation, but we've made it quite clear, particularly in the case of the Medical Board of Australia, that we insist that that person is a doctor.

Mr W.R. MARMION: It does not do that—okay. I thought it was surprising. I thought that the legislation would allow non-practitioners to be part of the board, but today I read another document and I thought it said that the chairman of a health practitioners board could be from another health profession. I would like clarification because I was quite surprised when I read that somewhere. I understand that boards can have a number of people from the community, and I think that is a good thing to do as well. I am quite happy with the way that is set up, but I would like some clarification on whether someone can be chairman when they are not a practitioner from that particular board. The question could be whether they are a practitioner from another board, but, no—I would like some clarification on that point.

There are some technical amendments through the bill. I mentioned one that requires health professionals to provide information on all the areas and ways in which they work. The bill is quite clever in that a person cannot hide through a company or a partnership any areas in which they might work. People have to provide that information and I assume that there will be penalties. The minister might like to respond to that. If we find out that a doctor, for example, has hidden from the board an association with perhaps a volunteer organisation or a company he sometimes does work for in some capacity and he has concerns about that involvement and does not let the board know about it, but the board finds out later, is there a penalty for that particular health practitioner?

Mr R.H. Cook: For not informing the board about knowledge of a malpractice?

Mr W.R. MARMION: No. The board only asks a health professional to link all the areas in which they work. The legislation is very clever in that it specifies a range of possible constructs of organisations such as partnerships, which is obvious, but it could be that a person says they are a director of three companies and sometimes they do some work for that company, because they are a doctor and that company provides medical services. The way I read the legislation, all those areas are captured and a person cannot hide. If a health practitioner does not tell the board, it would not know that they are a director of a company that provides medical services. I am interested to know whether there is a penalty—I am sure there is—if that did occur.

Interestingly, I would like to get into *Hansard* that the whole board process is cost neutral. In New South Wales and Queensland, the complaints or notification process for health practitioners is done by the Queensland–New South Wales interstate system—whereas, the rest of us, including WA, are involved in the national scheme. When our practitioners pay their registration, it is handled by the national board and the practitioners' registration group—that is, the AHPRA. That is all handled nationally. The idea is that the process is cost neutral. A person's registration fee covers the administration and the complaints processes around each of the professions. It is interesting to see what the current registration fees are for the different professions. I might just read those out if

I can find the right piece of paper. The fees range a lot. It is probably not obvious but perhaps interesting that the highest registration fee is for a medical practitioner—doctors pay $724. I am going to read these figures into *Hansard* because I think they will be useful for future comparisons if there is any change. It is also an opportunity for me to read in the fees for the 14 professions. The first profession is Aboriginal and Torres Strait Island health practitioners, who pay $120 registration a year. Chinese medicine practitioners pay $579 a year. Chiropractors pay $566 a year. Dentists have three subgroups: dentists and specialists pay $628; dental prosthetists—they do prosthetics—$558; and hygienists and therapists pay $310. Then we move to doctors, who as I mentioned, pay $724 a year. Medical radiation professionals pay $180 a year. Nurses and midwives pay $150 a year. Occupational therapists pay $110 a year. Optometrists pay $300, osteopaths $376 and pharmacists $328. Physiotherapists pay equal lowest, at $110 year. Podiatrists pay $278 year and psychologists $449. As I said before, those fees reflect the cost of running the administration of the complaints process in those professions nationwide. I mentioned the data in the review. The five health professional areas that accounted for 87.5 per cent of registrants were dental, medical, nursing/midwifery, pharmacy and psychology. As I mentioned before, 95.5 per cent of complaints were in those five areas. The remaining nine professions account for 12.5 per cent of registrants and less than five per cent, in fact 4.5 per cent, of complaints notifications. That is useful to know.

The other important part of the bill that I think is a bit different in our legislation as opposed to that of the rest of the nation—it is the same in South Australia—is a clause dealing with births. It came out of a coroner's report in South Australia. The minister may want to elaborate on this later, but I believe there was a case of a midwife attending a home birth of twins. I was told in the briefing that there were cases of more than one homebirth involving twins, maybe two or three, in which one of the twins died. The coroner in South Australia recommended that restricted birthing practices be adopted. Although I am not sure that a coroner in WA has made a similar finding, I think a similar case occurred here, and as a result, both South Australia and Western Australia have done the same thing. Clause 38 in the bill provides for restricted birthing practices and that will see the insertion of new section 123A into the Western Australian act. The minister can clarify if I am wrong, but I believe that means only a midwife or a doctor can be involved in the three stages of labour—that is, a registered midwife or a medical practitioner. The three generally accepted stages of labour are the start of regular contractions until the cervix is fully dilated, the time when the cervix is fully dilated up until the time of the birth, and after birth, ending with the delivery of the placenta. I understand there are provisions in the bill to cover sudden, accidental or unplanned births, but, in the norm, the midwifery and medical boards will set up guidelines for what should be done during those three stages of birth. Under the guidelines set up by the board, if a midwife or a medical practitioner attending a homebirth is concerned about complications—although I do not think a medical practitioner would be doing a homebirth—they have an obligation to inform the person, who obviously will be a lady, that they will not participate in the birth. The member for Morley is laughing. I got it right, did I not? She must be a Saint Hilda's girl! The lady concerned can choose what she wants to do, but I have been advised that under the national law a health professional or a midwife is obliged to say they can no longer be of service.

Mr R.H. Cook: It is essentially in relation to homebirths. You cannot have a companion or a doula. Any plan has to be considered by a midwife or a medical practitioner. Obviously, there are circumstances in which there could be a student under supervision and all that stuff who could do it. And, as you say, there are times when there is the good Samaritan, who will be captured by that clause, who has to intervene because the baby has decided to come out. In the context of homebirth, I think it was particularly the case in South Australia where people are having homebirths with a doula—that is, a non-registered midwife, nurse or medical practitioner—and that was creating dangerous circumstances.

Mr W.R. MARMION: Following on from that, there would be a case of someone holding themselves to be a registered midwife, which is covered by the current law. That does not preclude what is happening now. I would have thought that such a person would not be able to associate themselves with that birth now.

Mr R.H. Cook: That is right.

Mr W.R. MARMION: This clause makes it abundantly clear. There are fines for anyone who holds themselves to be a midwife without being registered. I think the penalty is $30 000.

I was very pleased that I was provided with a copy of the amended act, with the amendments shown in blue and deletions in blue, so I could read how the clauses related to the current act.

Mr R.H. Cook: We were joking earlier, member, that I have been in Parliament for nine years and I did not know those things existed!

Ms J.M. Freeman: You did so.

Mr R.H. Cook: You never told me.

Mr W.R. MARMION: I could not have done consideration in detail without the marked-up act. When the minister gets to consideration in detail, he will find that everyone will be referring to the bill, and all it states in the bill is that something is deleted or added. That does not really help very much, because it cannot be read in context. The only way it can be read in context is by having the marked-up act.

Ms J.M. Freeman: I have known about it for nine years.

Mr W.R. MARMION: I know the member for Mirrabooka knows about it. She refers to things in other acts when she asks questions in consideration in detail.

Ms J.M. Freeman: Not anymore!

Mr W.R. MARMION: I know! I am surprised; I would have thought that the member for Mirrabooka would have made a fantastic minister.

One of the things I found out today when going through the marked-up act in order is that at section 113, the word "penalty" is cut out and replaced. That was not in chronological order in the bill. When I was going through the act, I was concerned that that amendment was left out, but I found out that amendments to section 113 and a number of others are dealt with under clause 97 in the bill. If that had been pointed out at the beginning, I would have given it a 10 out of 10; it got only a nine and a half out of 10.

I do not want to delay the house anymore. I have pretty well covered every substantive thing in the bill without detailing the different ways notifications are made. That process is immensely detailed and it is probably pointless to explain all the different applications available for someone making a complaint, except to say that the bill is extensive about the information that can be provided to a person making a notification. In conducting his review, Mr Snowball found that stakeholders were very disappointed about the lack of feedback and not knowing what had happened to their complaint, if anything. The amendments to the current act through this bill provide that a person making a notification can get information at any stage along the process without contravening the Privacy Act.

That is my summary of the bill. The Liberal Party supports the bill. I was surprised that the government made it an urgent bill when it could have been brought on tomorrow; however, everything in the bill is logical. It improves considerably the current act, particularly the complaints process, which was lacking. The bill will make the legislation far more prescriptive and outcome based in a resolution situation when a health practitioner is "impaired"—that is the word used in the bill—or experiences problems when providing services. After all, the safety of the patient is paramount. That is what it is all about. I am very pleased to sit down and support the bill.

MS A. SANDERSON (Morley — Parliamentary Secretary) [5.02 pm]: I, too, wish to speak on the Health Practitioner Regulation National Law (WA) Amendment Bill 2017 and indicate my support for the bill. The opposition spokesperson on health has outlined the provisions of the bill very well. The bill essentially provides for the uniform regulation of a number of health practitioners and, importantly, transferrable registration for health practitioners so that when a nurse moves from one state to another, their practitioner registration is transferrable. Paying a registration fee is costly. This is about people's livelihood and some of those fees are not insignificant, so it is important that, firstly, professional registration is recognised in other states and, secondly, people do not have to pay twice for professional registration.

I am going to focus on and speak to the midwifery aspect of the bill. I am sure my colleagues will talk about other aspects of the bill. Importantly, this bill also recognises that midwifery and nursing are two distinct health professions. It used to be that all midwives were previously nurses—that is, they had to complete a nursing qualification before doing midwifery studies. That is no longer the case. A number of institutions now offer specific midwifery training, which is fantastic because many people do not want to do nursing but want to go straight into midwifery, so the bill really acknowledges the changes and differences between those two professions.

The bill contains complaint management provisions, strengthens some disciplinary and enforcement powers in midwifery and introduces a prohibition order that can be imposed by the State Administrative Tribunal. The midwifery registration aspects of the bill have arisen out of a South Australian coroner's report, where there were some incredibly tragic circumstances in home births and an increase in what is described as "free birthing". I want to talk a bit about why I think that is the case and why I think the current system in WA does not support women having broad safe choices for birthing. The previous government was, and this government is, committed to providing those choices for women and it is important that they are implemented in our hospital system.

On 1 January 2011, the national maternity services plan came into effect. It was endorsed by all national health ministers during the time of the previous Minister for Health, Dr Kim Hames. I congratulate the former government for being part of the national maternity health services agreement because it was an important step forward in women's health and maternity care. Obviously, this government is continuing that commitment. Action 1.2 of the national maternity services plan states —

> Increase access for Australian women and their family members to local maternity care by expanding the range of models of care.

It states that under the plan —

> Women's access to care is improved through the provision of local maternity services. Locally-based care also facilitates the participation of the women's partners and families in the maternity experience. Services that can be sustained in local settings are particularly important in rural and remote Australia, where women and their families have limited access to the major centres of care.

The plan breaks this down. It is a very good plan and it really outlines the strategies and outcomes and the signs of success. It goes on to state—this is in 2011 —

> Australian governments facilitate increased access for public patients to midwifery and medical practitioner continuity of carer programs.

It then goes on to state —

> Jurisdictions develop consistent approaches to the provision of clinical privileges within … maternity services, to enable admitting and practice rights for eligible —

Now called "endorsed" —

> midwives and medical practitioners.

This agreement was signed by the previous health minister, Kim Hames. He stated at that time that it was a government priority. That meant that it enabled access of private endorsed midwives—that is, registered midwives—to public hospitals so they could admit their patients in a public hospital. That is very similar to the way obstetricians operate in public hospitals—they have admitting rights. If a person chooses an obstetric-led birth or maternity care, they go to their obstetrician and choose to have a hospital birth. The obstetrician will admit them under their care at a hospital—it may be a private hospital such as St John of God, or a public hospital. Those admitting rights—that pathway, if you like—is well and truly tried and tested and well used in the service. Obstetricians in the public sector are paid well to also provide care for patients who opt to be admitted as a private patient in a public hospital. That is a well-understood model and, rightly, the previous government accepted that that should be adopted for midwives in public hospitals as well.

According to the national maternity services plan, the indications of success in the middle years were —

> Jurisdictions use best endeavours to facilitate the clinical privileges, admitting and practice rights of eligible midwives —

Or "endorsed" midwives —

> Jurisdictions monitor the provision of consistent clinical privileges, admitting and practice rights for eligible midwives and medical practitioners.

It goes on to outlines the signs of success and states —

> Eligible midwives have the opportunity to access clinical privileges, admitting and practice rights in public health care settings.
>
> There is a consistent approach to the provision of clinical privileges, admitting and practice rights for eligible midwives and medical practitioners in all jurisdictions.

If those are signs of success, I would have to say that in Western Australia it has not been a resounding success and it has not been implemented in line with the national maternity healthcare plan. That is not due to lack of motivation at the political level from governments of either persuasion. Governments of the Liberal–National persuasion were motivated on this issue and the current Labor government is also motivated of this issue. The issue is that it is not being implemented in our hospitals.

I want to outline some of the experiences for private midwives and I want to put on the record, by way of full disclosure, that my last birth was with a private midwife in a public hospital. It was arduous and I had to fight tooth and nail at every single point to have the birth I wanted. I am just making it clear that this is something I feel strongly about and have a really keen interest in. I will outline some of the experiences for women and midwives who are private providers in hospitals. In 2011—some six years ago—the then Minister for Health said that this was going to be a priority and that health services needed to undertake a credentialing process. That was set up and many midwives have completed the process. However, it is important to note that this kind of access will relieve pressure on maternity hospitals. Essentially what happens is that one midwife does all the prenatal care and appointments, at home or at work, if that is where people choose. It means that people are not sitting in

King Edward Memorial Hospital for Women for three hours, clogging up the waiting room. I have done that as well. It takes the pressure off prenatal clinics, which are really bursting at the seams. After the birth of my first child in 2007, I was really shocked to go back to those clinics in 2015 and discover how much busier they were and by how much the wait times had blown out. They say to put aside three hours for the appointment, but when a woman is at the end of her pregnancy, she is going there every week. People have to work; people have jobs. People work right up to the end of their pregnancy. It is totally ridiculous and unworkable.

It is important to have access to private midwives who are Medicare rebated and nationally clinically recognised, so we are not talking about fringe elements; we are talking about experienced, registered midwives who are already operating in the public system and who can also operate in the private system. It relieves that prenatal care aspect and relieves maternity beds. If someone has certain risks and chooses to go to hospital, as I did, they go for a few hours. Rather than going through the whole rigmarole of hospital admission, there is a midwife and a birthing suite, and the person is there for as long as their private midwife assesses is safe. In my case, it was four hours altogether. I did the majority of it at home, went in, and left two hours after having had a baby. Under the public system, the person would be there for a lot longer and there would be a whole range of other things. I was well advised of all the information I needed and had full faith in my care providers, who had seen me from my early pregnancy. That relationship has been well documented as being one that will provide the most success in any maternity outcome. That single relationship with a midwife is very well documented—that genuine continuity of care.

There is lots of research demonstrating the significant savings to the health service, but also outcomes for women, their babies and their families. Women get the Medicare rebate for the birth, as they do if they go private, as well as all the pre and postnatal appointments. There is a gap. Publicly employed obstetricians are paid a yearly amount to provide care for private patients, should an escalation occur in a public hospital. Part of the issue we have seen is that despite numerous meetings and attempts by private midwives to get credentialing and admitting rights to hospitals, the parameters that are put around them are unworkable, so they essentially cannot admit anyone. There are two hospitals where they have admitting rights: King Edward Memorial Hospital for Women and Armadale–Kelmscott Memorial Hospital. Those hospitals have not properly gone through the private access model, which is the same model that obstetricians work under, but implemented for midwives. It is extraordinary to me that these barriers occur in our system. It has been a long-running policy of government to do this, but blockages at the health, hospital and management levels are limiting the choices that women have for their births.

Every woman wants a safe birth and it is incredibly unfair and offensive at times to single out women who choose a certain birth that may have certain consequences. No-one goes into these scenarios without all the information and, frankly, hospital births can be deeply, deeply traumatising. Hospital births have high rates of intervention and can be very traumatising. They can scare women off going back to hospitals. We have seen an increase in the free birthing movement, if you like, which is when no registered medical practitioners are present; rather, there are doulas, birthing partners, family and friends. Although I do not recommend that, having had a very traumatic birth in a hospital, I can understand it. To avoid that we need to provide better and broader models of care that will not necessarily lead to a cascade of intervention that has really negative impacts on women and their babies after birth.

The private midwifery model in its intended expression is in place right across Queensland. Queensland has implemented it fantastically. There are 10 sites in Queensland public hospitals that offer this model. It saves the health system huge amounts of money, and that is, in itself, motivating. It is also safe. Victoria is running a pilot program and is about to open another two sites. New South Wales has just opened its first site, South Australia has a site and the Australian Capital Territory has just implemented the model as well. I urge health practitioners in the Western Australian system to broaden their minds to this model because it is well documented across the world that this model is safe and provides better outcomes. It also saves significant amounts of money in the system.

We have a fantastic and amazing family birth system and centre, and I know many, many people who have used it. Labor made a very clear commitment that we would also open one at Fiona Stanley Hospital, which is fantastic. I would like to see a similar one around Midland; however, I suspect that St John of God, which now runs Midland Public Hospital, does not run midwifery-led care at all. I suspect that the contract we have signed with St John of God for 20 to 25 years would prohibit a family birth centre being opened and run out of that hospital. I would like to see access for women around the wheatbelt and the outer eastern suburbs to the family birth centre, because it is essentially one centre that is heavily utilised and, frankly, highly restrictive in its criteria, and women are risked out of the centre. A number of women who would, under other international jurisdictions, be eligible for homebirth or the family birth centre are being risked out, and that is even if they take medication regularly—antidepressants, for example. The family birth centre will not see women who are on antidepressants during their pregnancy. Show me many women in our community who are not on antidepressants. Those kinds of mental health issues are genuinely and constantly being treated, whether women are pregnant or not. In other jurisdictions, those women would not be risked out of the family birth centre.

[Member's time extended.]

Ms A. SANDERSON: I believe women's health is limited by a group of doctors in Western Australia. We take an extremely conservative approach. It is also extremely expensive, and it is a highly medicalised approach to childbirth, which is essentially a perfectly natural and normal process to go through. The high rates of intervention and caesareans in Western Australia have scared women. Many women are rightly scared of childbirth, because all they hear are the horror stories. All we really hear about is the pain or the cascade of intervention and the post-birth trauma. People rarely talk about their positive experiences, and in many ways it has spooked women. In my first childbirth I was terrified, and I took the approach of "give me everything early". It was actually the worst possible thing I could have done. I learnt from that and took a different approach the next time.

As a government, as a health department and as leaders in the community, we need to be empowering women about their ability to give birth naturally, take the pressure off the health system and provide those choices. At the moment we see a system controlled by a number of doctors whose idea is, it seems, "our care or no care". That is not what women choose, so they drop out of the system. They do not want that highly medicalised care. They have no other choice, so they free birth or they homebirth in unsafe circumstances. We need to stop that by providing much better choices for women. I am confident that this government will deliver that. I am very passionate about it, and I will not stop going on about it while I am a member of this place. The way we birth our children and how we feel about it afterwards, for many years to come, is fundamental to our wellbeing. I commend the previous government and this government for their commitment to this issue, and look forward to seeing it implemented in our hospitals.

MS L. METTAM (Vasse) [5.22 pm]: I would like to make a contribution to debate on the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. Given that the focus of this bill is largely on the healthcare system in Western Australia, it would be remiss of me not to mention the investment made by the previous Liberal-led government. It was quite extraordinary—$7 billion since 2008, accounting for the building or rebuilding of 61 hospitals and health centres across regional Western Australia. This is an extraordinary feat that also highlights what we were facing as a government in 2008. Since 2008 we have seen the construction of, most importantly, a new hospital in the electorate of Vasse. Busselton Health Campus is a $120 million futureproofed facility providing 50 per cent more capacity than the previous hospital, with 84 beds and expanded emergency services. In the 12 months since its opening, we have seen a 10 per cent increase in activity in the emergency department, and a 37.6 per cent increase in outpatient activity. This reflects the significant population growth over that time. The $7 billion investment in health by the Barnett government represented an 80 per cent increase over that of the previous Labor government.

I will move on to discussion specifically on this bill, but it is important to highlight a program delivered under the Liberal-led government—the Southern Inland Health Initiative. This program invested in not only new health infrastructure but also ensuring that doctors stayed longer in regional areas. That investment worked. Between 2008 and 2015 there was an increase from 35 per cent to 67 per cent in the number of doctors of doctors remaining in regional towns for longer. If this program is continued with the same level of support, I would like to see a focus on the larger regional centres such as Busselton, Bunbury and Geraldton, so that investment meets the level of demand. The point I am making is that there has been a significant investment in health infrastructure in response to the demands of a growing state, with an additional 450 000 people, and in response to the legacy issues that we faced coming in as a government in 2008.

There is no doubt that the Western Australian healthcare system continues to face a number of challenges, partly due to the fact that we are an ageing population, with a rising burden of chronic disease. There are also technological advances in health care and challenges with workforce shortages. All these challenges impact on the cost of health care. To meet these challenges, it is essential that we continue to invest in building a strong primary health sector that aims to prevent illness in individuals and in the community. The delivery of comprehensive primary healthcare services is dependent on having access to an adequate and sustainable workforce, including medical practitioners, pharmacists, nurses, physiotherapists, dentists, psychologists, chiropractors and optometrists, as well as Aboriginal and Torres Strait Islander health workers.

The term "accessible" does not have the same meaning as the term "equitable access". This is especially true in regional Western Australia, where rural and remote residents are challenged by not having the same access to the range and scope of primary health practitioners as residents of metropolitan Perth. That was a big focus of the investment in health that I spoke about earlier, in the delivery of those hospitals across the state and programs such as the Southern Inland Health Initiative. Irrespective of geography, socioeconomic status and cultural background, all WA residents have a right to access good quality health care, and professional and competent healthcare practitioners. However, there are low numbers of health professionals in our regional and rural communities compared with Perth. The challenge is to ensure that primary health practitioners are working across a range of different disciplines and in different locations and offering different services to meet the needs of our growing regional populations. It has resulted in poorer access to some services for many more remote regional communities.

This is especially true of paramedical and midwifery services in regional Western Australia. The title "paramedic" broadly describes healthcare workers who, as a key requirement of their role, provide intensive emergency clinical care outside a hospital setting. As emergency health service providers, paramedics in Western Australia are predominantly employed by the public ambulance service, St John Ambulance WA. St John Ambulance WA covers the largest area of any single ambulance service in the world—over 2.5 million square kilometres, or 33 per cent of the total land mass of Australia. There are 162 St John Ambulance locations operating in country Western Australia, serviced by more than 3 100 dedicated ambulance volunteers and 90 paramedics.

These volunteers travel more than two million kilometres across WA annually, transporting over 62 000 people, which is an extraordinary effort. In larger country areas, where populations and ambulance call-outs are high, career paramedics work alongside volunteer officers to provide this service. These locations include Albany, Australind, Broome, Bunbury, Busselton, Collie, Dawesville, Geraldton, Hedland, Kalgoorlie, Karratha, Kununurra, Northam, Norseman and Pinjarra. In addition, a team of community paramedics has been deployed across the state to provide training, and clinical and operational support for volunteer sub centres.

The 2013 Australian and New Zealand Standard Classification of Occupations identifies the tasks of ambulance officers and paramedics as including attending accidents, emergencies and requests for medical assistance; assessing the health of patients; performing therapies and administering drugs; resuscitating and defibrillating patients; transporting accident victims to medical facilities; instructing community groups and essential service workers in first aid; providing aero-medical services; and providing first aid and emergency medical care—the list goes on.

As public ambulance services evolve from a model of emergency treatment and transport, the role and scope of paramedic practice is expanding to better respond to the acute health needs of patients as well as to alleviate the demands on the healthcare system. Increasingly, paramedics are able to provide treatment that adequately resolves patients presenting issues without the need to transport them to a health facility. Paramedics with advanced levels of skill and training may undertake interventions once exclusively performed by emergency physicians or critical care nurses in a hospital setting. Advanced-skill paramedics include intensive care paramedics, critical care paramedics, mobile intensive care ambulance paramedics, retrieval paramedics and extended care paramedics. As paramedic practice is becoming more complex and much more sophisticated, it carries a correspondingly higher risk of significant harm when things can and, tragically, do go wrong. Although pre-hospital management by paramedics can be lifesaving and directly influence the long-term quality of patient outcomes, the expanding scope of paramedic practice increases the risk of death or serious injury attributable to a practitioner's impairment, incompetence or unethical conduct. The nature, frequency and severity of the risks by individual paramedics depends, in part, on their level of training, the extent to which they must exercise clinical judgement, and the nature and scope of their practice. Apart from regularly triaging and assessing patients, paramedics frequently deal with life and death situations in emergency conditions. In delivering out-of-hospital care, paramedics deal with patients who are particularly vulnerable and must often manage unconscious, incoherent or combative patients, sometimes in multi-casualty situations. Improperly performed, these risky activities or procedures can have catastrophic consequences for an individual.

Western Australians who live in less densely populated areas in regional Western Australia should not be disadvantaged in terms of reasonable access to mobile intensive care ambulance services and specialist paramedic expertise, which I have outlined. This is why the importance of initial training in high-risk paramedic activities and procedures, and the need for regular refresher training and continuing professional development for paramedics cannot be understated. This bill will establish the Paramedicine Board of Australia, which will be responsible for regulating paramedics with administrative and other support provided by the Australian Health Practitioner Regulation Agency, and manage the performance of those paramedics who engage in professional misconduct, are impaired, or practise in an unsafe manner. The bill also amends the national law to require people who use the title paramedic to be registered, ensuring that only those persons who are competent to practise are registered and can use the title.

In the time I have left I would like to briefly comment on another important part of this bill, which is the separation of the nursing and midwifery professions to clearly reflect that they are two distinct professions. There are significant benefits for women and babies who receive care through midwifery services, especially those living in regional WA. According to the Nursing and Midwifery Board of Australia, as of March 2017 a total of 395 midwives and over 2 900 nurse–midwife practitioners are registered in Western Australia. Those with qualifications as both nurses and midwives can simultaneously maintain registration in both professions. The specific amendment in this bill, which is modelled on a provision in the South Australian national law, is also included in the bill to restrict birthing practices to registered medical practitioners and midwives. This involves managing the three stages of labour, which are generally accepted as the first stage, which is the start of regular contractions up until the cervix is fully dilated, the second stage, and the third stage, which is after the birth of the

baby and ends with the delivery of the placenta. Birthing practices will be restricted to a health practitioner registered with the relevant national board—medical or nursing and midwifery. This does not prevent other nominated support people, such as a partner, being present during labour, provided they do not provide any clinical care during the three stages of labour except in an emergency, when an individual may support the woman until such time as a registered medical practitioner or midwife can take over that care.

Significant incentives to support homebirths and a midwifery system are that they provide mothers with choice, discourage unnecessary intervention and also cost the taxpayer significantly less. One of the challenges with the provision of public support for homebirths is the way they are funded through the health system; these patients are treated as outpatients and are not financially supported in the same way as those going through a public hospital. I recently met, and have had a few meetings with, representatives from Birth Circle in Busselton, a not-for-profit community group that supports women and families' choices in their own birth plans, about the need to extend the Midwifery Group Practice program into the Busselton region, which has a lot of support. The Midwifery Group Practice program supports both hospital births and homebirths; it provides mothers with choice, decreases unnecessary intervention, and significantly reduces the cost to taxpayers. In view of the success of the Bunbury Midwifery Group Practice, which offers both hospital births and homebirths as part of the public health system, consumers in the Busselton region want the same care option to be available to them. In light of this, we should encourage the implementation of a policy that provides equitable access in the public health service for women to engage the maternity services they seek, which should include midwifery-led care and homebirths.

MS J.M. FREEMAN (Mirrabooka) [5.39 pm]: I also rise to speak about the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. I thank members on both sides of the house for their contributions to this debate and for their recognition of the importance of national recognition of many of these professions, in particular paramedics and midwives, and the separation of midwifery from nursing. I put on record—I have done this before and I want to do it again—that I do not agree with the idea that we have a separate standalone law for Western Australia on these issues. I believe that that places us in a situation of lagging. We have that problem in Consumer Law at the moment. We lag behind Consumer Law because we have a practice of adopting federal laws. Consumer Law has been adopted throughout the nation, as one particular state hosts that legislation. There is agreement at the Council of Australian Governments, so that law never gets changed unilaterally. There is always agreement for that law to change; there is no capacity to change that law unilaterally. However, there is capacity for Western Australia to say, "No, we do not agree with that particular part." These national laws are not made in Canberra and they are not made by using the Constitution to override laws, as was done with the WorkChoices legislation under Howard whereby international powers were used to override Western Australian laws. These laws are made by consultation and with the agreement of all parties, unlike the Liberal Party, which clearly wants to secede and have completely separate practices. Having a national law that registers practitioners —

Several members interjected.

Ms J.M. FREEMAN: I am interested; did we deduce which way they voted? Member for Kwinana, did we deduce whether they were for staying or were for "WAxit"? Are they WAxit supporters or are they for staying?

Mr R.H. Cook: There are four honourable members in the chamber and I think the member for Dawesville is looking a bit sheepish at this stage.

Ms J.M. FREEMAN: The member for Dawesville is a WAxit: "Wax on; wax off."

That was not a mature debate. In these cases, when we look at national laws, we need a mature debate. A mature debate in 2017 is not about arguing for some sort of false sovereignty over these sorts of acts. I get the particular sovereign issues that members opposite want to maintain, but this is not one of them, and Consumer Law will not be one of them. While Western Australia continues to not adopt the national law as agreed to with a host jurisdiction, which in this case is Queensland, and duplicates laws, we are wasting money. Bureaucracies are working on these matters when they could be working on much more important issues in our health system to make sure that the system is responsive to our community needs, as they have to draft things and get us through this situation. That will never change, because it has been agreed to at COAG. We need to have a mature debate about what we look like in a Federation, and we should not look like this. We should not look like we are saying that we need a separate piece of legislation. I am not sure that my colleagues agree with me on this.

Mr W.R. Marmion: Proposed section 123A is a WA-specific section.

Ms J.M. FREEMAN: That could be agreed to by COAG. There is nothing stopping WA from having a separate piece of law around that matter. A perfect example was when a previous Minister for Health wanted to allow for a certain hormone treatment in Western Australia but was prevented from doing so because of the national poisons act. However, he found a different mechanism for that, if I remember rightly—I might be wrong and am just quoting that off the top of my head. I am suggesting that instead of having these immature, fallacious, idiotic, irrelevant debates about breaking up the country when we stand in this place, we should have mature debates about

how our legislation looks so that we operate properly in our Federation for the benefit of the community we represent. In this case, we are putting the practitioners first. These people have been waiting to get recognition. I congratulate the Minister for Health for declaring this bill an urgent bill.

I want to correct the member for Nedlands on the small point that only women have babies.

Mr W.R. Marmion: I worried about that when I went and got a coffee!

Ms J.M. FREEMAN: I want to alert the member to the fact that at the Isabelle Lake Memorial Lecture on 17 May, which was hosted by the Equal Opportunity Commission and the University of Western Australia, A.J. Kearns shared his remarkable story of his pregnancy and transition for the International Day Against Homophobia, Transphobia and Biphobia. Basically, he wanted to challenge people on what gender meant. Certainly, that is pretty challenging. In the media statement from the Equal Opportunity Commission, he is reported as saying —

> "When I was thinking about my own journey, and how it would be fairly unique, I felt that it was important to document that in some way; to show other trans guys that they could do this, and they could do it however they needed too," …

He told the audience about his decision to transition and then postpone his transition to give birth to his second child. The media statement also reports him as saying —

> "I think that the biggest misconception is that life after medical transition is magically completely fine, easy.

I point out to the member that in 2017, we should not succeed and that not only women have babies.

Several members interjected.

Ms J.M. FREEMAN: Secede. We should absolutely succeed, but we should not secede. I am sure that after the Treasurer presents the budget on Thursday, we will certainly be on the path to success.

I want to spend some time talking about paramedics. In particular, I will talk about the Independent Oversight Panel, the Phoenix Australia report and the independent oversight panel's report titled "Review of St John Ambulance: Health and Wellbeing, and Workplace Culture", which was produced in August 2016. Before I do that, I point out that paramedics have a high level of commitment. I have worked with paramedics. I was privileged to be the industrial officer for paramedics when I worked at United Voice. I know how committed they are to their profession, how compassionate they are in their work and how focused they are on patient outcomes. Sometimes this leads to a conflict with their employer because it does not see patient outcomes as the priority, and that is what paramedics always focus on.

As we have heard, the Health Practitioner Regulation National Law will register paramedics so that their level of education, skills and competency is protected. I want to give a bit of the history of this matter. The separation of paramedics and patient transport officers was introduced in around only the late 1990s, early 2000s. Before that, ambulance officers and patient transport officers were one and the same. An ambulance officer could attend an accident and administer acute care to people, and then come back to the station without the next callout being a high-level, high-stress and high-demand job. They could have a job such as going to someone's house and transporting someone to hospital. By separating those jobs into two occupations, we have effectively made the paramedics bear the brunt of continual stressors of work.

People in this place who have greater capacity to explain those experiences, such as those who have come through the police force or the fire brigade, would say that being able to have downtime jobs—they are still fulfilling the job requirements—is beneficial. The downtime is more pleasant; patients are chatty and appreciative and those times can be a relief from those highly stressful critical incidents that they have to deal with. That is not the case so much for paramedics. Not every callout for a paramedic is critical or an accident or a car crash or something like that. Some of them are called into houses where people have had episodes such as strokes or heart attacks, but every time they arrive, they know that they are on the frontline of someone being between life and death. That was not always the case. They could know that when they arrived, there would be a little old lady to pick up, put in the ambulance and take to hospital. She would be really appreciative and chat and probably offer them a cup of tea. I am not sure whether they would be allowed to have them, but she probably would offer them a cup of tea. There was a sort of release as a result. The separation of those two jobs was because St John Ambulance determined that it was not an efficient way of doing it. It really meant that it wanted to pay those patient transport officers less than it paid the paramedics. At first they were on the same agreement but the transport officers were a lower level. They never progressed to the paramedic level, whereas they would have previously because they were all trained in-house. At the same time or just a bit after that, training of paramedics was taken out of St John Ambulance facilities and put into university and professionalised. Basically, young people now have to do a year of university training and when they complete that year, even if they pass, they do an interview and then they come into

St John Ambulance. I am not even sure now whether they have to complete their degree before St John Ambulance will accept them.

Mr B. Urban: Yes.

Ms J.M. FREEMAN: They do now. Previously, when it was introduced, all they had to do was their first year and then St John Ambulance would take them in for their second and third year and they would be paid and used as a patient transport officer so they would get used to the job. Now students have to complete their degree, I am reliably told by the member for Darling Range. That must have an impact on the wellbeing and health of those workers when they are dealing with those critical incidents. It is really interesting to see that there are now two separate enterprise bargaining agreements and they do separate negotiations. St John Ambulance is constantly trying to undermine the conditions of the transport officers. I raised in the house recently that it is also trying to reduce the income protection insurance coverage, which has been an important inclusion in the enterprise bargaining agreement since the late 1990s. Whether St John Ambulance will have the same success with the paramedics is yet to be seen. The paramedics are on the frontline and have a larger capacity for bargaining, but there is a real sense that the transport officers have been left behind, despite the fact that they do really important work in our community by transporting patients.

As the first responders, paramedics are inherently exposed to traumatic incidents throughout their careers, over and above routine workplace stressors, because of this separation. There cannot be a mix; it is very much channelled into one. It is clear and it makes complete sense that the continual exposure to trauma frequently results in negative trauma response, burnout, anxiety and depression. It can develop into conditions such as post-traumatic stress disorder. In some instances, trauma responses have led to cases of intentional self-harm. There have been concerns about the number of suicides in our ambulance service, and the reports that we have before us show that.

[Member's time extended.]

Ms J.M. FREEMAN: I want to talk about post-traumatic stress disorder. When I started working in the union movement, PTSD was considered to be non-existent. It was not recognised and it was very difficult to deal with. Any stress claim is notoriously difficult under the workers' compensation scheme. We can thank Graham Kierath for that. As a result of reforms to the Workers' Compensation and Injury Management Act 1981, under the section covering stress claims, people have to meet thresholds. Someone who thinks their employer should have treated them well and that stressed them is excluded from a stress claim.

Mr S.A. Millman: Section 5(4).

Ms J.M. FREEMAN: I thank the member for Mount Lawley. I remember section 5(4) well. There are two other ways to exclude someone; one is a pre-existing condition. Post-traumatic stress disorder was often argued to be a pre-existing condition. I have told this story in the house before, but there are new members here and I would like to share this story. One of the ambulance officers whom I represented in a workers' comp claim was one of the first responders to an incident in which a gentleman held at gunpoint a police officer in the old police station down the end of Adelaide Terrace. The man was holding the police officer hostage and he came out of the building. Subsequently, it was found that he no longer had the gun. He came out of the building and he was, in the words of this paramedic whom I dealt with, mowed down. Bullet holes in the side of the WACA wall showed where he had been shot, and was killed. All these coppers were standing there with guns ready to fire and the paramedics had to go in and see whether he was dead. They went in to check whether he was dead or alive. When someone is hit by that many bullets, their body twitches—supposedly. I did not know that. She said that as she walked in, all she could think was: if he is alive—they clearly wanted him dead because they have shot enough bullets around—what is going to happen to me? She walked up and he twitched. She dealt with it and he was dead. Something like seven years later, another incident happened; she had to deal with a critical incident and she started having flashbacks about this situation. She went on sick leave and the employer, St John Ambulance, did not accept her claim. I do not necessarily blame St John Ambulance in a lot of workers' comp claims, because often it is handed to a lawyer. The employer is insured and the insurer stands in their shoes. Stress claims are notoriously difficult. Post-traumatic stress disorder was a relatively new illness and so I blame the insurer and the insurer's lawyers for not having compassion in this instance.

Sitting suspended from 6.00 pm to 7.00 pm

Ms J.M. FREEMAN: Before the dinner break I was talking about something very tragic indeed. I am not going to go back over it. Suffice to say, the issue was post-traumatic stress disorder. There is a need, especially for emergency service workers and first responders, to ensure that the threshold for post-traumatic stress disorder and stress claims is not as arduous as it currently is. The member for Mount Lawley and I were fondly reminding ourselves of the three clauses that were introduced by Graham Kierath, the then Minister for Labour Relations, all those years ago when he changed the wording from "material" to "significant". The amazing thing about changing the contribution of the workplace to stress from "material" to "significant" has meant that many people cannot get

workers' compensation. Just in finishing this story about this very tragic situation for a paramedic who had classic signs of post-traumatic stress disorder—it was when people were still debating how that operated and worked—the insurer went back into her history and delved right back to the point of finding out that she had issues as a child in terms of a sexual assault and then brought that up as being one of the reasons the workplace incident would not have materially contributed to her situation.

Mr S.A. Millman: Disgraceful!

Ms J.M. FREEMAN: Completely disgraceful, member for Mount Lawley. That was one of the most tragic situations I have been involved in. Clearly she was having those images and nightmares because of this particular incident. Suffice to say, we fought very hard for her to get covered by workers' compensation. Unfortunately, she was not successful in her claim but, as insurers often do, she was offered some paltry agreement in exchange for waiving her rights in the future. I do think that is a big issue for paramedics. We are now looking at them as professionals. If we have separated that capacity for first responders to have other work that can take them away from trauma and stress, we really need to go back to our workers' compensation system and ensure that they are properly cared for and recognised.

I want to talk about some of the outcomes of the "Review of St John Ambulance: Health and Wellbeing, and Workplace Culture" report by the Independent Oversight Panel, which was released in August 2016. In the chair's foreword, Neale Fong said —

> … paramedics … are particularly vulnerable to developing posttraumatic stress disorder in the course of their working career. The risk is more than double the general population and is higher than for police officers or firefighters. Additionally, exposure to traumatic events is a specific risk factor for suicidal ideation and suicide attempt.

In a chapter right at the back of the report—it is a really weighty report—the Independent Oversight Panel reviewed all the different submissions it received, including the University of Melbourne's Phoenix Australia Centre for Posttraumatic Mental Health report. After it had looked at that and at the evidence and witness evidence it received, it stated —

> There appears to be a link between length of service and less recovery time between incidents and higher levels of burnout and posttraumatic stress symptoms. Moreover, experienced staff are expected or feel they are expected to cope better and as a consequence were more reluctant to express their distress. It highlighted that managerial staff may have tended to be less alert to the needs of these experienced staff and the early warning signs of difficulties in this group.

The report goes on to state —

> A significant issue that arose through consultations was the lack of career pathways or alternative roles for paramedics who cannot continue to work in on-road roles, due either to psychological injury or physical injury or capacity.

I thought that was really interesting, because in my time working with paramedics who had injuries, retraining and redeployment was always an issue. There was a real sense that this was the job that they did and they would have to leave the service because there was nothing more they could contribute. Now that we have paramedics who are nationally recognised and nationally accepted, we need to start thinking about how we use these highly trained paramedics in a greater system than just our ambulances. I put that challenge to the minister. I think that sometimes we limit them to just being in ambulances. The report states —

> The lack of awareness of the evidence by St John was perplexing … of psychological illness in its own workforce …

It goes on to state that there were quite serious problems in the workplace. The report identified that it was a toxic and dysfunctional workplace that was also rife with bullying. That does not surprise me. In 2000, when I worked with St John Ambulance, it did not even have a chaplain. Paramedics would witness quite serious events. I have said this before, but there are new members so I am happy to tell this story again. I dealt with a paramedic who had attended a murder–suicide. He had gone to a car where a bloke had gassed himself and his children. He attended that. He came back to the station and his station manager said, "So, you're good?" and he went, "Uh, yeah." He was not good. He went home to his own family. He was traumatised by it, but there was no-one to speak to. It was a really bad situation. I came in to work with people on a workers' compensation situation, which is not where people want to end up—we want to prevent that illness—and I could not believe that they did not even have a chaplaincy. The report states —

> Chaplains are an important part of care in an organisation, serving as counsellors, coaches and confidants, and offering non-denominational emotional and spiritual care. There should be no confusion between chaplaincy support and the importance of psychological care directed and provided by qualified mental health professionals. Psychological care should not be seen as a chaplaincy responsibility.

I believe that. I understand that many of the recommendations may have been supported. They are still being looked at. It would probably be worthwhile for us to find out how that report has been addressed. I note that recommendation 24, "Reporting to the State", was not adopted. Recommendation 24 states —

> It is recommended the contract between the State and St John incorporate agreed key performance indicators relating to psychological risk and care of the workforce.

Neither the previous government nor St John Ambulance agreed to that. I think that is worthy of consideration by the current government.

I would like to conclude on a positive note. St John Ambulance has agreed in its recent enterprise bargaining agreement negotiations to include paid domestic violence leave of 10 days.

MR K.M. O'DONNELL (Kalgoorlie) [7.10 pm]: I rise to speak on the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. Firstly, I would just like to make a comment to my learned friend the member for Mirrabooka. I take it she is a lawyer.

Ms J.M. Freeman interjected.

Mr K.M. O'DONNELL: I thought she was from the way she speaks.

Several members interjected.

Mr K.M. O'DONNELL: There is nothing about seceding. We are not seceding in any way, shape or form. Some people bring it up.

Ms J.M. Freeman: Not succeeding!

Mr K.M. O'DONNELL: Yes, succeeding!

I dare say that at the Labor Party conference, there were probably people with outlandish ideas too.

Ms J.M. Freeman: Not quite as outlandish as yours.

Mr K.M. O'DONNELL: No, but when Hon Norman Moore, our president, saw the term WAxit on the screen, he said, "Sounds very painful", and it would be!

Mr D.R. Michael: It is, let me tell you!

Mr W.R. Marmion: Too much information!

Mr K.M. O'DONNELL: Yes.

I go to the amendments to the Health Practitioner Regulation National Law, commonly referred to as the national law. The national scheme for health practitioners ensures that the states' and territories' standards are brought into line. This approach brings benefits, including smoother transitions of employment between states and territories, increased workforce competence, improved communication systems on the disciplinary history of employees and an overall better participation between the jurisdictions. A single registration that is recognisable across all states and territories is best practice and removes the confusion for employees who wish to relocate. It also assists in cases in which staff shortages occur in a particular location, allowing a seamless process for employing health practitioners from interstate. It allows new staff to relocate and commence duties without the delay of state-specific registrations and other local requirements. Removing these barriers can also encourage these professionals to consider movement between the states and territories. Encouraging this movement can be beneficial for skill sharing, whereby experienced health practitioners from locations of culture and other unique circumstances go on to share their knowledge with health practitioners in other locations.

Australian policing has experienced challenges in the past, with recruitment drives being made more difficult due to some of the states' and territories' initial academy training for recruits not being compatible with one another. This resulted in slower transitions for those relocating—actually they had to go through the academy all over again—and a loss of time in retraining or upskilling required for each new recruit, all at significant cost. Currently, regional areas such as Kalgoorlie have difficulty attracting suitably qualified professionals in a range of sectors. In some cases, in order to meet the community need, professionals are brought across from the other states and territories to undertake short and long-term contracts. This can present a range of issues due to the inconsistencies between the jurisdictions with qualifications, registrations, skills, laws and complaint management systems. In some cases, these inconsistencies can lead to problems that develop in the workplace. It is important for states and

territories to have a national system for notifications of disciplinary action of an employee. Without this communication, as we have seen previously, an individual who has been dealt with through a disciplinary process for malpractice has been able to practise in a different jurisdiction following an incident without being identified. There is nothing worse than a doctor being prosecuted or disciplined in Western Australia and then just starting to practise in the next state. Bringing this into line across Australia is fantastic. I wish these provisions could be pushed across to people not attending court in all states. Now, when they do a runner to another state, they get away with it, and they just move on. It does not matter what they have done in Western Australia, they just get away with it by living in another state.

The national regulation of paramedics under the national scheme is an important move towards recognising the skills and level of responsibility of paramedics, with paramedicine now to be viewed as a registered health profession under the scheme. The regulation of paramedics ensures community trust, the maintenance of professional standards and, most importantly, the safety of patients. Patients treated by paramedics are sometimes the most vulnerable and in some cases are unable to consent to their treatment. For this reason, it is paramount that paramedics meet high standards of knowledge, skills and ethics in their practices. St John Ambulance paramedics are highly trained and are required to meet and maintain the standard. Community trust is important, and it is essential for St John Ambulance and similarly qualified paramedics to undertake their duties effectively and safely. The regulation of paramedics and the standards required of them will assist in maintaining this community trust. The regulation of paramedics will also address the issue of a tendency for some private operators to use the term "paramedic" when they are not necessarily qualified to an appropriate standard. This situation has always presented a danger, with those individuals undertaking healthcare activities putting patients at risk. These national regulations are good protection for everyone to ensure that only the right individuals are able to identify as paramedics through the newly introduced protection of the paramedic title. The national law coming in, with consistent accreditation and registration standards, and including amongst other things codes, guidelines, national registers, notification requirements and complaint processes, is a very good thing.

I now wish to say that I strongly support this bill. I agree with the independent review, after three years of the act's operation. As the member for Nedlands said, 33 recommendations were put through to the Council of Australian Governments at the last review and a majority of them were accepted. Paramedics do a very good job in our community. I have no doubt that many times my friend from Darling Range would have assisted paramedics in various incidents. In the goldfields, paramedics can end up in the bush attending incidents, and there are many incidents when they call police to assist. A lot of the time they are dealing with people who are intoxicated. The paramedic is trying to help the person, but the person turns violent and so do his or her friends. I have assisted paramedics in driving the ambulance long distances. Back in the 1980s there was no such thing as two paramedics. There was one; he drove the ambulance and when he got to the scene, he hoped someone was there to drive the ambulance back. It was not our job as police, but we stepped up and had no hesitation in doing so.

The member for Mirrabooka mentioned post-traumatic stress disorder amongst paramedics, and she is spot on. I would like to bring something to the attention of the member for Mandurah. Paramedics, police, fireys, medical practitioners and all these other people need stress relief, and in the regions they need an arts centre. The arts centre would help with the stress levels coming down by allowing people to attend various functions, so they need one.

An opposition member: That was a scintillating segue.

Mr K.M. O'DONNELL: Did it come in all right?

Mr D.A. Templeman: That was the most outstanding example that I have ever seen in this Parliament.

Mr K.M. O'DONNELL: Does the minister think it will help?

Mr D.A. Templeman: I think it's going to be very helpful.

Mr K.M. O'DONNELL: I thank the minister.

The member for Mirrabooka talked about post-traumatic stress disorder. It does not affect only paramedics, but they have been highlighted in recent years, with quite a few of them taking their lives. Suicides are not isolated to paramedics. Police officers, too, commit suicide because of the things they see. Many times a person does not know whether they are suffering from post-traumatic stress disorder. I have mentioned before in Parliament attending a spearing in the desert. I believe I would be one of only a couple of police officers in history who would have actually stood 12 inches or 18 inches from the person being speared—not just once, more than a dozen times. I did not realise the stress I was under at the time. I took it in my stride and accepted it as part of the job. About 18 months or even two years later, a journalist from the eastern states wanted to talk to me about my story. When I had finished telling him about it, I collapsed in my seat and went like jelly. I have heard the term "taking a weight off your shoulders" and in that instance, it did. I mentioned it to my doctor—he was a friend of mine—and he said

that I was suffering from stress but I had no idea that I was. For anybody who is under a lot of pressure, I recommend that they talk to someone. This applies to not only police officers, but also paramedics. I have attended road crashes, suicides, people holding rifles to their heads and death by burning; we had to break limbs just to get the person in a body bag. I attended an aeroplane crash out Leonora way and I was one of the first people on the scene. People tend to think plane crash debris would go out quite a long way but this plane went straight, nose first, and there was hardly anything left of it. It just went straight in—boom! It was horrific. As a parent, I know that there is nothing worse than walking through a scene to try to find some identification and picking up a shoe and there is a foot in it. At road crashes, there are helmets with heads in them. Not everybody can handle it and it does not mean people are good or better than others if they can handle it; it is just that some people handle it differently. If anybody sees these things or is involved in them for their jobs, I strongly recommend they talk to someone, whether it is a colleague or anybody else, just to get it off their chest.

Sorry, Madam Deputy Speaker, I did not mean to talk for so long. I also commend midwives.

Mr W.R. Marmion interjected.

Mr K.M. O'DONNELL: No, I said that I would not keep going.

Mr D.A. Templeman: No, you should; you're doing well! Keep going.

Mr K.M. O'DONNELL: All right; I will talk for just a bit more.

Nurses and midwives—is it midwifery?

Mr B. Urban: Midwifery.

Mr K.M. O'DONNELL: Those ladies do a very good job in our community.

Mr W.R. Marmion: There are men as well. Janine's not here, but she would pick you up on that.

Mr K.M. O'DONNELL: I am sorry; I apologise. Men and women midwives do a fantastic job and I am very glad to see that midwives are not being forced to do all those extra studies if it is not required. It is no good training midwives as nurses if they have no interest in it. I thoroughly commend midwives. Like the member for Nedlands, I commend this bill to the house. I would even sit on the Minister for Health's side to push it if members opposite needed the numbers.

MR B. URBAN (Darling Range) [7.23 pm]: I stand to talk on the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. It is quite important and I will go into a number of issues that the member for Kalgoorlie raised. It is quite funny that two ex-police officers will speak one after the other so I hope that my war stories will be a little bit different from his. I promise not to talk about crash helmets with heads inside them!

Mr K.M. O'Donnell: You just did!

Mr B. URBAN: Is that the same as my joke about the penguins and the icebergs? Remember the joke I mentioned we had in court when we had to say words that we were not allowed to say and if someone got one in, they got a Mars bar from their mates? I do not have one of those tonight, but I managed to get iceberg and penguin in my inaugural speech, which I sent to a judge in the United Kingdom who used to play the game with us. I did manage to get that in and I might manage to get another Mars bar off him on this occasion!

I want to talk about paramedics. I think it is very important for paramedics to be included in the national scheme. That will mean paramedics are registered in all Australian jurisdictions and will be required to meet the registration requirements. This is very important for a number of reasons, and it was raised by the member for Kalgoorlie. If a paramedic comes to Western Australia from a different jurisdiction, whether it is Australia—it could be New South Wales or South Australia, for example—or South Africa or the United Kingdom, they still have the same qualifications. If they left those jurisdictions with a medical condition or their services were no longer required because of other things, it is quite important to have that on a database. I will go into some war stories about paramedics in a little while. Paramedics provide frontline services. In my view as a former police officer, they serve many of the same purposes as police officers. They attend quite a lot of incidents whether or not they are needed. If there is a disturbance somewhere, ambulances are always called there, whether or not they are needed. The issues that paramedics have to deal with are similar to issues that police officers have to deal with. If members listened to my inaugural speech, they would know that I said that post-traumatic stress disorder is an important issue and it is prolific throughout the police and emergency services, which I will talk about in a moment. It is amazing, member for Kalgoorlie, how we, as ex-police officers, were spat at; I was spat at with blood at one stage and I had to take the blue pill. I have been stabbed in the back three times. I got a busted nose —

Ms M.M. Quirk interjected.

Mr B. URBAN: Yes, that is just since I became a member of Parliament!

I got a busted nose. I have been punched countless times. I have been kicked. I have been kicked by other police officers by mistake. I have been bitten by a police dog. This was all in the execution of being a police officer. It amazes me even more that this is also the case for paramedics. I have seen paramedics turn up and be spat at and abused, both verbally and physically. They are spat at with blood. They are syringed. I saw a paramedic in Armadale held up by a syringe. This was just because they were doing their job. That is what I am trying to say. These people go out to do a day's work and they need to go home after they have been doing the right thing by people. It is amazing how paramedics particularly are there to help people but they are abused. People who are mentally impaired, drunk or high as a kite on drugs always seem to attack paramedics. For some reason, they are the soft target, and I do not understand why. One of the many things that comes into my head is that they are scene guards. A lot of times, paramedics turn up first to a scene, whether it is a car accident, a death or a crime scene. They are the scene guards and can give police a briefing on where they have walked and everything else, can they not, member for Kalgoorlie? It is amazing how they do that. They are also psychologists. They try to talk people out of jumping off a ledge or try to talk people into making the right decisions or getting some sort of help for their mental state.

Paramedics are caseworkers or care workers because they also try to assist people who are having an episode in whatever form, whether it is a psychotic episode or a medical episode. Believe it or not, paramedics are also first aiders. I will tell a story in which back in the United Kingdom, a paramedic had to open somebody up and he was the only one there—in Stevenage in Hertfordshire. He asked me, "Can you help me try to get his heart going again?" I think I had been a copper for about four years at the time and said, "What are you talking about!" Gloves were optional at the time so in I went with my hands to try to get a heart going. That is what these people have to do. This is what happens. I will talk about the post-traumatic stress disorder side in a moment.

[Quorum formed.]

Mr B. URBAN: *The Medical Journal of Australia* published a paper entitled "Occupational injury risk among Australian paramedics: an analysis of national data". It states, in part —

> The risk of serious injury among Australian paramedics was found to be more than seven times higher than the Australian national average. The fatality rate for paramedics was about six times higher than the national average. On average, every 2 years during the study period, one paramedic died and 30 were seriously injured in vehicle crashes. Ten Australian paramedics were seriously injured each year as a result of an assault. The injury rate for paramedics was more than two times higher than the rate for police officers.

Under "Conclusions", it states —

> The high rate of occupational injuries and fatalities among paramedics is a serious public health issue. The risk of injury in Australia is similar to that in the United StatesIt frightens me if that is the case, because I have been out with paramedics and police in the United States. It continues —
>
> While it may be anticipated that injury rates would be higher as a result of the nature of the work and environment of paramedics, further research is necessary to identify and validate …

We will talk about other states in a minute.

A 2015 article stated —

> **New figures reveal one police officer, paramedic or firefighter is taking their own life every six weeks, and experts warn frontline emergency workers are not getting the treatment they need.**

In Australia between July 2000 and December 2012, 110 police officers, paramedics and firefighters died by suicide. Of the 110 deaths, 62 cases involved police officers, 26 involved paramedics and 22 involved firefighters. An actual pattern is shown across all the agencies. A firefighter was quoted as saying, "I was treated like a liability." Being a former police officer, I can say that that is how we felt. I note the member for Burns Beach is over there. That is how police officers and paramedics feel they are treated by their agencies.

Another article states —

> SJA —

St John Ambulance —

> was described by the Independent Oversight Panel's report as having an element of culture that "can only be described as toxic and dysfunctional".

That was also in the 2015 report by Phoenix Australia.

I now refer to the recognition of qualifications. I note the member for Kalgoorlie's earlier comments about police officers from the United Kingdom. Even though we were at a certain level, we had to do a further 16-week course to be firearms trained and trained in the way that WA operates. It was quite remarkable considering they took us on with the qualifications we already had. That is no different from St John Ambulance paramedics. Paramedics are really well trained and very experienced. They have great qualifications from jurisdictions around the world. It amuses me that there is no national register for paramedics.

Like most other police, paramedic and firefighter jurisdictions in the world, black humour is used when debriefing. Our debrief would be in the canteen at the end of the shift. We might have one or two extra beers or, more to the point, we might take the mickey out of each other, which is predominantly what it is about. It is a little bit of pressure relief. In the late 1980s, the 1990s and the early 2000s that was the only way that any of these emergency services had that sort of pressure release. I suppose it was counselling. When I was in Stevenage, the paramedics and the fireys would come along. When I was in Armadale, the paramedics would come to the police station at the end of the shift to talk about any issues that we had. It surprises me that paramedics are in the position that they are in.

I want to talk about some of the other issues that paramedics have to deal with. They are constantly on the road dealing with injuries and fatalities and dealing with family members. I want to talk about what happened to Wes Ackerman when he was on duty as a paramedic. His ambulance was being driven along Mundijong Road in October 2016. Mr Ackerman was the front passenger in the ambulance. They were on a call from Serpentine–Jarrahdale station at the end of Jarrahdale Road. As they were heading along Mundijong Road towards Duckpond Road, a car coming from the opposite direction hit them head-on. It floors me how Wes survived. It is amazing how he survived the accident, which was shocking to say the least. He is not the only paramedic or ambulance officer this has happened to. Many ambulances around Western Australia have been involved in accidents at intersections. All they are doing is either taking somebody to hospital or attending an emergency call-out. It surprises me the number of road users who do not hear the sirens. It was reported in May 2017 that the driver of the car that hit Mr Ackerman's ambulance was under the influence of amphetamines at the time. That has actually gone to court now. Mr Ackerman is on the road to recovery. I would like to pass on my best wishes to him. He was around the Serpentine–Jarrahdale station for quite some time with the rest of the guys there. He was a member of our community. Most people knew him. It was quite a shock to see that he was injured in the way that he was, but he is on the road to recovery.

I have talked about the paramedics who help police officers, whether they have been involved in car accidents or whether they have been stabbed or assaulted. Paramedics are a helping ear to them. They are also there as an aid and to reassure them. This is what we all forget. We should be able to do this. I will not take much more time. If anyone has any problems that they would like to talk about, Lifeline Australia is available on 13 11 14. I fully encourage them to do that. It is a great organisation. Everything is treated in confidence. I want to pass this bill. It will be good.

MR Z.R.F. KIRKUP (Dawesville) [7.40 pm]: I rise to support colleagues on this side of the house and speak to the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. I take this opportunity to thank the opposition health spokesman, the member for Nedlands, for his comprehensive brief in the typical style of an engineer. The member for Nedlands is meticulous in his process of deconstructing a bill, and I thank him for his efforts in briefing me and the party room on what is a very important piece of legislation. Of late I have taken an interest in health bills because not only are we in this place being asked to vote on something that is quite literally enabling legislation for delivery of life-saving services, but also I find the Department of Health very well placed to draft some exceptional legislation. This is uniform legislation that reflects a Council of Australian Governments resolution that has been drafted across the Federation, and unlike the member for Mirrabooka, I always enjoy that Western Australia proudly, separately stands to have its own —

Mr R.H. Cook: Yes, but how separately?

Mr Z.R.F. KIRKUP: Still within the Federation, Deputy Premier!

Mr D.A. Templeman: You want different colour uniforms, don't you?

Mr Z.R.F. KIRKUP: I always enjoy that we adopt our own sort of tweak on uniform legislation, and I think it is good to have a Western Australian focus. Well done to the Department of Health for some fine drafting on this legislation. I think it has been worked on by some very solid individuals.

The member for Nedlands advised that this bill will make some important reforms to the delivery of health services in our community. Reading the legislation gave me time to pause and reflect on the efforts of the previous government in the delivery of health services. I think all in this place know—even though some opposite may criticise us—that the Liberal-led government completely revolutionised much of our health system. We know that nearly every single part of our hospital network has been changed for the better compared with what the

Liberal Party inherited in 2008 from the previous government. As the member for Vasse has already discussed, there has been an 80 per cent increase in the operating budget of the Department of Health. It is up to $8.6 billion now, which is a significant increase on what we inherited from the Gallop–Carpenter governments. I understand that the health system is now funded to cater for more than 628 000 inpatient episodes of care, more than one million treatments in emergency and more than 2.5 million services delivered in outpatient or community settings. The Liberal Party is often criticised by those opposite for spending too much, but to me an 80 per cent increase in the health budget for an unprecedented level of delivery of health services is money well spent.

I have talked about the lack of investment from those opposite when they were last in government. During the 2008 campaign, when I was the manager of key seats for the Liberal Party, we ran silent ads asking what the previous government had done and achieved, and people could not say; they were silent. It was fantastic. Internally, our party polling showed us that they had lost faith in the previous government to deliver health services because it had not kept up infrastructure to meet the ongoing and increasing demands in our community. Ambulance ramping was rampant right across Perth, and there was, I think, a total ignorance of people's concerns about the health system. As was splashed across the front page of *The West Australian* many times, it was a system in crisis.

Additionally, the Liberals, unlike the previous Labor government, actually started construction on Fiona Stanley Hospital. That was $2 billion well spent, I think. It was a marked change, because when Labor was in office last, as I said, the community view was that it did not do enough in health. I remember that, again, during the 2008 election, the Liberal Party got a tip-off from the then Leader of the Opposition's office saying that the Labor government had rushed to start work on Fiona Stanley —

Ms S. Winton interjected.

Mr Z.R.F. KIRKUP: Member for Wanneroo, I always enjoy it when we are here in the chamber together. I really do.

Ms S. Winton interjected.

Mr Z.R.F. KIRKUP: No, the member for Wanneroo cannot.

Ms S. Winton interjected.

Mr Z.R.F. KIRKUP: In the Leader of the Opposition's office at the time we —

Ms S. Winton interjected.

Mr Z.R.F. KIRKUP: The member for Wanneroo can; she can see the record levels of investment spent during that time.

Several members interjected.

The DEPUTY SPEAKER: Members, it is the practice of this house under the standing orders that if you ask someone to accept an interjection and they say no, we accept that and wait for our turn to stand and then comment. So, member for Dawesville, would you like to continue.

Mr Z.R.F. KIRKUP: So, worried at the time that the Labor government had actually got its act together and had for some reason started construction on Fiona Stanley Hospital during the campaign, we sent a cameraperson down there to see what was happening with the extensive works program that had been undertaken. We were expecting to see hundreds of workers or something like that breaking ground on Fiona Stanley, but we saw a solitary tractor on the site going back and forth. Apparently, that was enough for the Labor Party to fulfil its commitment during the election that it would commence construction on Fiona Stanley.

Mr D.A. Templeman: It was a very shiny tractor!

Mr Z.R.F. KIRKUP: It was a very shiny tractor—brand-new, member for Mandurah!

Mr W.R. Marmion: A D3.

Mr Z.R.F. KIRKUP: There we go—another engineer's comment from the member for Nedlands!

Mr B. Urban interjected.

Mr Z.R.F. KIRKUP: There we go. This is great! I am clearly being schooled by at least three members on heavy machinery being used on hospital sites.

In addition to the $2 billion we spent on Fiona Stanley while in office, there were significant investments right across the board, with $360 million spent on building Midland Health Campus, not too far down the road from where I went to high school. That was a fantastic change for Midland —

Mr D.A. Templeman: Were you still in high school in 2008?

Mr Z.R.F. KIRKUP: I was four years out!

Several members interjected.

Mr D.A. Templeman: I thought you were doing work experience —

Mr K.M. O'Donnell: Yes, work experience!

Mr Z.R.F. KIRKUP: As the member for Kalgoorlie reminds me, that is happening right now!

In addition to the $360 million spent on Midland Health Campus, there was $12.1 million for a new paediatric ward in Joondalup, $3.3 million to add 500 new car bays at Osborne Park Hospital, and I think regionally—as I am a proud regional member—there was a strong focus for me —

Mr D.A. Templeman: Haven't you had that conversation with the member for Kalgoorlie yet?

Mr Z.R.F. KIRKUP: I have tried! I have tried to school the member for Kalgoorlie!

Mr D.A. Templeman interjected.

Mr Z.R.F. KIRKUP: I would, member for Mandurah. We will take him to a back room somewhere and see whether we cannot help compel him as to the importance of our regional status.

But I digress. When the Liberal Party was in government, it spent $170 million to completely rebuild the then Albany Hospital, which I know is of importance to the Speaker and which was, again, promised many times by the previous Labor government. It was great at making recurrent election commitments, but not so great at putting them into motion. I was with the state's twenty-ninth Premier, the member for Cottesloe, for the opening of Albany Health Campus. It was fantastic. It was a great shame that we could not get that built earlier. I think the Speaker would agree that Albany regional hospital has helped significantly and markedly improve the welfare of his city.

Regionally again, in addition to the $170.4 million spent on Kalgoorlie regional hospital, there was, as the member for Vasse said, about $120 million for Busselton Health Campus. There was $59 million for Kalgoorlie regional hospital, $41 million for Onslow, $31.3 million for Esperance, and $26.8 million for Carnarvon, wherever the member for North West Central is. Some of this legislation will directly relate to the work of the previous Liberal government, which progressed works to replace a number of remote and regional Aboriginal health clinics across regional and remote Western Australia in communities like Jigalong, Noonkanbah and Bayulu. As I reflect on the provision in this legislation for the reform of nursing services, I am immensely proud of the former government's record on helping deliver these Aboriginal health clinics that are so critically important to these communities.

The member for Vasse stated that 61 hospitals or health centres were built or refurbished by the previous government. I think that is a fantastic outcome for Western Australia, and there is little wonder, in that case, why in 2015 the Australian Medical Association said that the Western Australian health system was by far the best performing within the Federation. As I look through these achievements, and as proud as I am of the previous government's record, I see that the Minister for Health has inherited a system that may have operational issues, but there will never be the same level of infrastructure investment required by this government for some time.

Ms M.M. Quirk interjected.

Mr Z.R.F. KIRKUP: There can be no doubt, member for Girrawheen, as we look at this bill and the provision of services for paramedics, nurses, midwives and clinical services, that they are now being delivered within world-class facilities—facilities built by the former Liberal government in communities that had been ignored for years and years by those opposite when in office. While we look at the extensive Liberal Party investment, I will take the opportunity to talk about the delivery of health services in my own community of Mandurah. Mandurah has an ageing population that is increasing in number. As I have said before in this place, the district I represent has the highest number of aged people in Western Australia, with 22 per cent of people aged 71 and above. That means that my community, and certainly the community of broader Mandurah, is heavily reliant on our hospitals and on the provision of services by health professionals such as paramedics, who are among the professions dealt with in this bill. In addition to the ageing population, an increasing number of younger people are moving into the broader Mandurah community, with many young families establishing themselves in the northern part of our city. More than 85 000 people now live in Mandurah.

In all reality, although the previous government invested heavily in our health system, Peel Health Campus has not been kept up to pace. Not a week goes by when people do not contact me, mention it to me when I am doorknocking, or tell my team when they call people, that their number one issue is getting into or getting treated at Peel Health Campus. As proud as I am of the Liberal Party's investment in health, I wish it had done a lot more for our local hospital. No significant infrastructure investment has been made in our hospital for the better part of two decades, and in the meantime the population of Mandurah has grown markedly.

Mrs M.H. Roberts: Wasn't the former health minister in your seat?

Mr Z.R.F. KIRKUP: I will never defend the lack of action or attention to Peel Health Campus—by any government, I might add—since the 2004 Reid review. The Reid review focused heavily on the delivery of services in the southern metropolitan area out of Fiona Stanley Hospital and in regional areas out of Bunbury, yet since 2004 it has completely overlooked Peel. The Reid review has enabled governments since its release to practically ignore the Peel community. That is not good enough. Peel Health Campus is in desperate need of investment.

Mrs M.H. Roberts: The previous health minister, Arthur Marshall, put the children's ward there.

Mr Z.R.F. KIRKUP: That is exactly right, member for Midland. That was done by the first member for Dawesville, Arthur Marshall.

Mr D.A. Templeman: May I interrupt?

Mr Z.R.F. KIRKUP: Of course.

Mrs M.H. Roberts: Why can't I interrupt?

Mr Z.R.F. KIRKUP: Because he is far more reasonable!

Mr D.A. Templeman: I actually do not disagree with what you are saying. The last major investment was actually done by Jim McGinty with the doubling of accident and emergency and the expansion of the dialysis centre. The problem is that they have already been outstripped by demand.

Mr Z.R.F. KIRKUP: Does the minister know what year that was?

Mr D.A. Templeman: It would have been 2005, from memory.

Mr Z.R.F. KIRKUP: So not two decades yet, but certainly a long time ago. I appreciate that point, member for Mandurah. I was a one-year graduate of high school at that point.

Mr R.H. Cook: This is like a Mandurah lovefest going on here.

Mr Z.R.F. KIRKUP: It is always feel the love, Deputy Premier, when it comes to Mandurah!

As I have pointed out, Peel Health Campus is in desperate need of investment. Ramsay Health Care is delivering great management of that hospital. However, Ramsay needs more funding. A sustainable health review is underway, and I welcome this government's commitment to that review. That review will inevitably look at the services that are provided to the Peel community. I join with the member for Mandurah in encouraging people in our community to make a submission to that review so that they can help shape the future delivery of health services.

Mr D.A. Templeman: I am writing most of it!

Mr Z.R.F. KIRKUP: The minister and me both!

However, I suspect that any submission to the review will help shape only the medium and long-term delivery of services to our community. I do not think it will resolve the increasingly desperate situation at Peel Health Campus. To give members an idea of that desperation—a word I do not use lightly, member for Wanneroo—I would like to share some figures to help paint that picture. Peel Health Campus now has fewer medical staff than it had at this time last year. The time taken for a patient to be seen and treated under the four-hour rule has blown out. At this time last year, it was at 85 per cent. It is now at 65 per cent. Staff at Peel Health Campus are being spat on and assaulted at an alarming rate, to the point at which private security contractors have contacted my office to say they would like to provide security services in addition to the services that are already being provided because they have been present at the accident and emergency department and have seen how bad it is.

In answers to questions that I have asked in this place, we have established that at Peel Health Campus the median waiting time for urgent colonoscopies is 52 days. Only public patients at Osborne Park Hospital and St John of God Bunbury Hospital have had to wait longer for a colonoscopy, and only by five days. The median waiting time at Bunbury hospital is only eight days. Urgent category 2 colonoscopy patients at Peel Health Campus have a median waiting time of 126 days, and category 3 patients have a median waiting time of 398 days for surgery. That is the longest waiting time of any public hospital in our state. Patients in Bunbury have to wait 71 days for a category 3 colonoscopy and patients in Mandurah have to wait 398 days. The emergency department, in which no investment has been made since 2005, as the member for Mandurah has pointed out, is overloaded and now has one of the longest surgical waitlists in the state. There is a high reliance on the use of over-census rooms. Since I raised this issue locally in the *Mandurah Mail*, a number of people have come to me with their stories and experiences about Peel Health Campus. One patient told me that she was admitted to the emergency department, very ill, at 1.00 pm on Monday, 14 August. I say this anecdotally, because I know from my close relationship with the former member

for Dawesville and then Minister for Health that sometimes people get their times blurred. She told me that she had to wait two hours to be triaged—so the five-hour rule was met—and it then took another two hours to get scans done. She was finally seen by a doctor at 11.30 pm. Ten and a half hours is too long for a patient to wait in a world-class health system. Unfortunately, this is not a unique story. I have tried where possible to balance the need for patient confidentiality with prioritising the need to highlight the issues in our local hospital system.

I am told that Ramsay Health Care would be well placed to spend over $1 million on Peel Health Campus to meet the demands of our community if it was given the security and certainty of a long-term contract to continue to operate at Peel Health Campus. Although I know, minister, that it is too late for budgetary submissions from this side, I pray and my community prays that there will be more money in the budget for investment in our hospital. However, if there is not, I sincerely put to this place that a review needs to be conducted into Peel Health Campus. Our hospital is in crisis. That is another word I do not use lightly. The lives of people in Mandurah are being put at risk. This is not a political issue. This is not an issue that I have gone out and beaten the government about, which is something that we can all do from time to time. This is an issue that I would like to get resolved with this government. It is vitally important that we ensure that the people of Mandurah are afforded the same world-class health care that is offered in Kalgoorlie, Albany, Bunbury, Joondalup and Murdoch.

Mrs M.H. Roberts: Surely the reason that has happened is because they had your government for eight and a half years?

Mr Z.R.F. KIRKUP: Again, minister, I am not seeking to politicise the issue.

Mrs M.H. Roberts: It is hardly our responsibility. You were in government for eight and a half years.

Ms S.E. Winton interjected.

Mr Z.R.F. KIRKUP: Member for Wanneroo, I came so close to finishing! I enjoy hearing the member's interjections from time to time. However, the member's interjections would be best placed at another time and not on such an important issue as Peel Health Campus.

I thank the house for the opportunity to speak on this bill. I join with the opposition in supporting the passage of the bill and the important reforms that will come with it. I commend the bill to the house.

MRS J.M.C. STOJKOVSKI (Kingsley) [8.00 pm]: I rise tonight to make a brief contribution to the Health Practitioner Regulation National Law (WA) Amendment Bill 2017. As defined by Paramedics Australasia —

> A Paramedic is a health professional who provides rapid response, emergency medical assessment, treatment and care in the out of hospital environment.

That is a significant departure from what a paramedic was in the 1950s and 1960s. Over the last 60 years, the role of paramedics has evolved from that of ambulance driver or stretcher bearer into the competent, technical technicians of today who solve clinical problems in out-of-hospital settings. With this increase in the scope of paramedic duties, there has also been the formalisation of education and training requirements. These two things combined have resulted in the community perception that paramedics are a professional organisation. Paramedics are very well represented and are a trusted profession. Unfortunately, the profession that we pursue in this place was rated 49 out of 50 in the 2014 *Reader's Digest* annual poll of trusted professions. The same poll has put paramedics at the top for a number of years running. Paramedics promote and maintain high standards of health care and guarantee that they are accountable for their professional conduct. A 2014 research paper into community perceptions of the professional status of the paramedic discipline proposed the idea that they be recognised as professional paramedics who must be competent, moral, idealistic and altruistic and maintain community respect and trust.

When I prepared for my speech tonight, I was quite surprised to learn that paramedics are technically not considered a professional career, because community perception is that the paramedic discipline reflects all the values with which we associate it. The research paper to which I referred reads —

> **Community members' perception of the paramedic discipline as a profession**
>
> *'I think they are very professional.'*
>
> *'You expect them to be professional because you are putting your life in their hands.'*
>
> *'They've got a huge responsibility ... because they've got your life in their hands.'*
>
> *'You'd like to think there's a level of standard they maintain and they are struck off or disbarred or something when they fall short of that requirement, I think it would be fairly important that a standard be maintained.'*

That is why I think that this particular piece of legislation is relevant to the community's perception of a paramedic. This legislation will raise the standards to meet the expectations of the Western Australian community. The same

research paper looked at a number of focus groups that assumed that paramedics were already a nationally registered body for a variety of reasons, including that they performed lifesaving tasks, they are highly skilled and educated and they wear a uniform. Traditionally, vocational training for ambulance drivers has been replaced with tertiary qualifications. However, standards and course content are not uniform across Australia. This is another reason that this legislation is so important not only for Western Australia, but also across Australia.

I move to the ability of registered paramedics to move from jurisdiction to jurisdiction, which links back to the idea of consistent training across the states. Notwithstanding our colleagues on the other side of the house who hope to remove us from this great country, the ability of people to move around in our great country—to move to Victoria or New South Wales and then to Western Australia—is something that we as Australians hold dear. The ability of paramedics to do that is hampered because their registration and skills are not immediately transferable if they move to a different state. This legislation will avoid that issue, while also maintaining standards for education and training across the states.

I turn to midwives. For me, personally, a very important part of my journey as a mother were the midwives I engaged with during my pregnancies, labour and postpartum care. I take a moment to reflect that the drive to separate the professions of nurses and midwives is not new. I refer to the *British Medical Journal* of 14 December 1859.

Ms M.M. Quirk: Your dentist should update the literature in his waiting room!

Mrs J.M.C. STOJKOVSKI: He probably should.

James H. Aveling laments the push at the time to class midwives and nurses together, and writes —

> A midwife practises upon her own responsibility, without the aid or interference of any medical man.

Please remember that this was written in 1859 —

> She is selected and engaged by the patient, and is under the control of no hospital or institution.

As it was at that time. It continues —

> A nurse is usually chosen by the medical attendant … Or supplied by an institute.

He continues —

> A nurse's duty is to carry out the instructions of the medical man to keep him informed of any changes which may take place in the patient, and to apply to him when in doubt or difficulty.

I find it somewhat strange that we are still debating the issue of the separation of nurses and midwives. In my opinion, midwives perform a specific function, which includes medical assistance during pregnancy, birth and postpartum care. But they also perform holistic care of patients, infants and family members. In Australia, particularly in Western Australia, caesarean rates have been on the rise. An article from November 2013 reads —

> With caesarean rates at some Perth hospitals above 50 per cent, there is concern some women may be pressured into undergoing the surgery without fully understanding the risks.

I admit that caesareans can save the life of both a mother and child, but the high rates in Western Australia could indicate a desire or push by doctors for medical intervention for whatever reason. It also may be the result of a lack of knowledge about other options. Having given birth to two children and experienced two very different births, I understand the rise of the desire to give birth more naturally. During the birth of my first child, my daughter, I was determined to have a natural birth. For those who know me well, I am a very strong-willed person. I was not going to be dissuaded from having no medical intervention during the birth of my daughter. I liaised with my midwife to strongly put forward my case that I was not going to have a pethidine shot or any other shot. I was not going to inhale drugs and I was not going to have an epidural. I did not want to do it. To understand my desire for this, we have to step back 18 months to two years from then, when I was forced to undergo numerous IVF cycles to get pregnant. My desire to do it naturally was probably to prove that I could do it. It was something I wanted for myself. My midwife understood this; she took it on board. She was there with multiple things that I could do to ensure that I did not have to go through another medical procedure. Six years later after many, many more IVF cycles, I fell pregnant with my son. I was very thankful but also still determined to give birth naturally. I had done it once and there was no reason I could not do it again. However, my son proved to be slightly uncooperative. The pain became unbearable. My midwife knew that I still desired to give birth as naturally as possible. She worked with me and gave me a variety of pain management techniques to employ to see whether I could get through it. At the same time, my obstetrician encouraged me early in the labour to allow for further induction via medical delivery of syntocinon to progress my labour more quickly. Towards the end of labour, he was very encouraging that I have an epidural. It was my midwife who provided me with non-medical options. In the end, I was not able to withstand the pain. I was given an epidural, but only when I was ready. It was a decision that I made with my husband to go for a medical option.

Like I said, I am a pretty strong-willed woman and I was very firm with the medical staff about what I wanted. Unfortunately, not everybody is as stubborn as me, and some may be persuaded to take an alternative route if it is being offered by a medical professional. It is for this reason that the separation of nurse and midwife is a very important distinction.

Finally, I am not coming down on my obstetrician by any means, because after I delivered my son he gave me some fantastic postpartum care. When I was required to go into surgery, he looked after me wonderfully. However, it was my midwife who looked after my two-hour-old son and my husband, who was handed a new baby to look after while his wife went into surgery.

I commend the bill to the house. The objectives of the bill are some that I can stand by wholeheartedly: recognising paramedics is essential to catching up with community expectation in this state and country. The separation of nurse and midwife is a no-brainer for me, but it is also essential for a holistic–care health system that we are striving for in Western Australia. I commend the bill to the house.

MR R.H. COOK (Kwinana — Minister for Health) [8.11 pm] — in reply: I would like to thank members for their contributions this evening, both passionate and technical, and very observant. The member for Nedlands opened the batting on this debate and provided us with some good background to the Health Practitioner Regulation National Law (WA) Amendment Bill 2017.

I want to acknowledge at this point that many people have talked about the importance of recognising paramedics as a profession. It is appropriate that we acknowledge the role of Hon Kim Hames, who was the state minister with carriage of the process to try to corral all the states to acknowledge paramedics. Originally, this was around about 13 or so professions. The law itself has the capacity to add on professions as it goes through. We went through Chinese natural medicines, because that was a fairly straightforward process, and both Hon Kim Hames and I were firmly of the view that paramedics should have been in the initial tranche of professions that were recognised. They were not, and obviously Hon Kim Hames then went about taking forward that process. As the member for Nedlands observed, it was 10 years in the making. Kim would often reflect to me just how frustrating the process was to try to get all the states to come in on it. As the member for Nedlands observed, New South Wales has a slightly different approach to these things, and in that we might have some understanding or background about why it was so difficult that some states just hung out there and would not put the process forward. As the member for Nedlands found out, the profession is passionate about this and it is a long time coming and an important development. As the member for Kingsley observed, most people in the community thought it already was a recognised profession. Paramedics perform an incredibly important part of our health-service chain. They wear uniforms and are called the single thing, so we would have thought there was a profession recognised as paramedics, but that is not the case. With the passage of this legislation, it will be the case.

As the member for Nedlands observed, the review, one of the dryer aspects of this legislation, was carried out by Kim Snowball, former director general of Health in Western Australia. He carried out a pretty comprehensive process. The fact that so many of his recommendations were accepted is testament to how comprehensive that process was. The member for Nedlands raised a couple of questions around the concept of one of the non-profession members of a board being the board chair. I understand it is section 33(9) of the act that disallows that. That was a point that we communicated very strongly to the Australian Medical Association here in Western Australia that we did not believe it was appropriate. The member is right; it is a good idea to have community members on those boards. Part of the problem of these boards sometimes is that they just shine a light to themselves and see themselves in the mirror. From that point of view, it is important to have other perspectives on those boards to make sure that they continue to meet community standards and requirements.

In relation to penalties—apologies for the paraphrasing—for a medical practitioner not informing the board that they are practising as a medical practitioner even though they have not directly signalled it, we think that is captured under the notification aspects of the legislation, or what is called holding out—that is, not providing enough information to the board. The member for Nedlands at that point also raised a question around the actual penalties. I wanted to bring his attention to the communique from the Council of Australian Governments Health Council meeting of 4 August this year. The actual legislation is from the March meeting, which was held on 24 March. The communique from 4 August has taken the issue around penalties further. With the chamber's indulgence, I will read it. The communique states —

> Health Ministers agreed to proceed with amendments to the Health Practitioner Regulation National Law (the National Law) to strengthen penalties for offences committed by people who hold themselves out to be a registered health practitioner, including those who use reserved professional titles or carry out restricted practices when not registered.

> Ministers also agreed to proceed with an amendment to introduce a custodial sentence with a maximum term of up to three years for these offences.
>
> These important reforms will be fast tracked to strengthen public protection under the National Law. Preparation will now commence on a draft amendment bill to be brought forward to Ministers for approval, with a view to this being introduced to the Queensland Parliament in 2018. The Western Australian Parliament is also expected to consider legislative changes to the Western Australian National Law.

I am sure the member for Mirrabooka would have appreciated that last sentence. The COAG Health Council continues to closely examine the legislation to make sure it is continuing to meet the needs. I must say that the Minister for Health in New South Wales was particularly strident on these issues because in New South Wales an individual held themselves out to be a doctor, undertook some quite complicated medical procedures and was in no way qualified for that. It is fair to say the minister wanted a penalty much stronger than three years, but we agreed that on balance that was probably the appropriate amount.

The member for Nedlands also talked about the incidents in relation to the coroner's report. It was, in fact, the WA coroner's report published in 2015 that outlined the importance for people undertaking homebirths. Under this law, all planned births will be under the supervision of either a midwife or a medical practitioner under supervision. The important thing about this is that although it is important for women to have choice, particularly those who want to have homebirths, we also have to guarantee their safety and, as a result, it has been decided that those births should always be under the supervision of a midwife or medical practitioner and that a doula or assistant is welcome but cannot undertake the procedure in the absence of a midwife or medical practitioner. Of course, there is the good Samaritan clause, or the "catch" clause, as I call it, for those circumstances in which someone is assisting an unplanned birth—in particular, for paramedics, who often find themselves in that situation. The clause provides appropriate protections under the law for those professions.

Referring to clause 97, member for Nedlands, and going back to the fines, I make the observation that under the next tranche of changes, there is the introduction of custodial sentences.

The member for Morley talked about choices for women and the national maternity services plan—an incredibly important development. She is right; I think we do need to pay respect to previous Minister for Health Hon Kim Hames, who did some good work in this space. Admitting rights for private midwives at public hospitals is one of our important objectives. I understand that it will be difficult. There are some very strong views on this in the medical fraternity, but it is an objective that we are determined to get on top of. In particular, choice for women is an important aspect of this government's policies. As many members will be aware, just yesterday the birthing centre at King Edward Memorial Hospital for Women celebrated its twenty-fifth birthday.

Mr D.J. Kelly: An outstanding facility.

Mr R.H. COOK: It is an extraordinary facility.

Mr D.J. Kelly: Both my kids were born there.

Mr R.H. COOK: The member for Bassendean would be surprised how many people have said to me that they were born there or their kids were born there. One of the first kids born at the birthing centre, a chap called Zerin, was there yesterday. I think it is fair to say that he has moved on a bit now from his early years—a strapping 25-year-old baby boy! It was a terrific function and incredibly chaotic with all the small babies there. I took the opportunity to remind the community that one of our policies in the election was to develop a similar facility for people living in the southern suburbs. We want to see a birthing centre developed at Fiona Stanley Hospital. They are great facilities because they allow women to have more control over the birthing process, usually under the supervision of a midwife, but if things do not go to plan, as in the case that the member for Kingsley just described, they have an opportunity to move quickly into a higher care facility and transition to higher medical supervision.

The member for Vasse talked about some of the recent investments in health infrastructure as well as the development of the work done under SIHI—Southern Inland Health Initiative—for the extension of GP services. We will have to come up with a name other than Southern Inland Health Initiative if we are to include Busselton in that group, but I take on board what the member said. She also talked about the importance of midwives and paramedics in regional centres, often filling the gaps of medical services left by others. I certainly acknowledge the work of volunteer ambulance workers, particularly in areas such as Vasse, where they continue to provide an incredible service with the support and under the supervision of community and professional paramedics.

The member for Mirrabooka described uniform legislation. I am not quite sure of the origins of these laws and why we do not concur with national legislation and allow it to be hosted in a host legislature. However, it is what it is, and I commend all members for the maturity that they have brought to this debate, understanding that it is

part of a national agreement, so for us to participate in the way we do is unique around the country. It is important that we also participate in it to make sure that we have national laws across the country.

The member for Mirrabooka, the member for Kalgoorlie and the member for Darling Range provided some great insights into the work that paramedics do, the very trying circumstances in which they work and the way we should support them better in their workplace. The member for Darling Range talked in particular about the role of first responders generally and how they can face incredibly traumatic and confronting experiences. I hope that the professionalisation of paramedics continues to drive better professional development and better understanding of and insight into the profession nationally, and that therefore we will be in a position to support them better in that role. Obviously, their unions play a very important role in advocating for the profession or for people in the workplace, but overall, we need to continue to develop our understanding of the profession, the standards we need from it and, of course, the ongoing training and professional development of these people in the field. A national professional board with oversight of paramedics will make a great contribution to that process. As the member for Kingsley observed, one of the important aspects of that is the transference of skills and qualifications from one health jurisdiction to another so that we can recognise them nationally and not have this absurd situation in which a paramedic registered in one state is not automatically registered in another.

The member for Dawesville made some interesting observations also around health infrastructure. If the member for Dawesville has an opportunity to speak about the previous member for Dawesville, would he please acknowledge the work that he did in the ongoing reform around health practitioners, the regulation of them and bringing in this national framework. As I said, the work that that former member did in bringing paramedic issues to this point was quite valuable and, as I said, he led that nationally. I understand the member's anxieties around the Peel Health Campus. I hear them also, he may gather, just a little bit from the member for Mandurah! For the benefit of Hansard, that was a large chunk of sarcasm because the member for Mandurah is unceasing in his advocacy for that hospital. We need to form a regional solution for hospitals that include Rockingham and the Peel and Murray districts to work out the best way to serve that community. There has obviously been a lot of population growth and expansion towards Pinjarra and south in the member for Dawesville's area. In the not-too-distant future, push will come to shove and we will need to have a much better perspective.

Mr B. Urban interjected.

Mr R.H. COOK: Darling Range is in the Peel, yes—it is further north than Kwinana, but somehow eligible for royalties for regions, even though Kwinana was not, but not to worry. Thank you, member for Darling Range.

I thought the member for Kingsley also made a great contribution in observing that many of the ideas that people have in their community around ambulance workers and paramedics in particular are ones that people rely on very heavily in their patient journey. Increasingly, we rely on paramedics to make critical clinical decisions on the spot or on the road that have a significant impact on a person's injuries and their recovery. From that point of view, it is extraordinary, member for Kingsley, that we are only now finding ourselves at this point in time. Innovation and medical technology will continue to play a role in our health services, and paramedics will play an even greater role as they bring devices and other medical technology to bear in their services in the lead-up to their taking a patient to a medical facility. The decisions they make and the actions they take will continue to have a significant impact on patient safety and outcome. This legislation is incredibly important to make sure, as the member for Kingsley said, that we constantly strive to meet community standards and continue to improve the profession and drive education and training and professional development to make sure we are constantly seeking to improve the lives and work of paramedics.

In conclusion, I thank all members for their contributions, in particular members who have shared their birthing experiences with us, not for any reason other than to demonstrate the important role midwives play in our lives and our health system. I thank everyone for sharing their personal experiences and I thank the opposition for agreeing to the urgency of this legislation and their commitment to support it.

Question put and passed.

Bill read a second time.

Leave denied to proceed forthwith to third reading.

Consideration in Detail

Clause 1 put and passed.

Clause 2: Commencement —

Mr W.R. MARMION: Clause 2 is about the commencement of the act. When I read this clause the first time, it did not make a whole lot of sense. Could the minister explain to me how part 2 will come into effect? Part 1 comes into effect on the day on which the act receives royal assent, but it is a rather convoluted way that part 2 comes

into effect. I would like the minister to explain why some clauses of part 2 are excluded. I guess it is a two-part question. I am happy to repeat it after the minister has answered the first part and has forgotten the second part, like I used to do. Under paragraph (b), part 2, excluding certain clauses, will come into effect on two different dates —

> (i) if the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (Queensland) section 3 comes into operation on or before assent day—on the day after assent day; or
>
> (ii) otherwise—on the day on which the Health Practitioner Regulation National Law and Other Legislation Amendment Act 2017 (Queensland) section 3 comes into operation;

Can the minister explain why there is a difference in those two parts? I will then ask another question.

Mr R.H. COOK: I understand that this is the simplest way to explain it, and it is not simple at all! My understanding is that it really depends on two scenarios. The first is when the bill passes in Western Australia and the second is when the legislation passes in Queensland. Some clauses will have immediate impact because they do not interact with the national legislation as such; others will have interaction with the national legislation, so it really depends on when we pass it and when the Queensland legislation passes. I can go through each of those clauses if the member likes, but it is pretty long. I am very happy to perhaps provide a more comprehensive briefing offline if that is required.

Mr W.R. MARMION: Rather than deal with the different clauses, I just want an explanation for the majority of part 2. If the Queensland legislation is already in operation, why would we wait one day for the majority of part 2 to come into operation? If it has not come into operation, it will come into operation only when the Queensland bill comes in. It is just that simple, first part of the question.

Mr R.H. COOK: The vast majority of the clauses in part 2 will come in straightaway, but there is a range that refer to national regulations so they cannot come into effect until the national regulations themselves are struck. There is a range of clauses about that, but that is essentially the interaction.

Mr W.R. MARMION: That is a good answer. Paragraph (c) states —

> section 38—on the 28th day after the day on which section 3 (of this Act) comes into operation;

Is there any reason that period of 28 days was chosen for clause 38?

Mr R.H. COOK: Clause 38 relates to restricted practice, particularly in relation to doulas and other birth companions. The idea of the 28 days is essentially to provide us with that month—the 28 days—to get the word out to make sure that people who are doing things stop doing it.

Mr W.R. MARMION: Just to conclude on clause 2, paragraph (d) states —

> The rest of the Act—

Presumably that is the rest of part 2 that has not been approved. It continues that it will come into operation on a day fixed by proclamation. That is not dependent on other jurisdictions. I would not mind an explanation of, firstly, why that can come in later, and, secondly, whether there is a rough idea of how long after proclamation it might come into effect.

Mr R.H. COOK: Paragraph (d) relates more to the operations of the Paramedicine Board of Australia. The idea of the board is that it will come into operation in December 2018, so there is a range of instruments that we expect to come into play in the lead-up to that process.

Clause put and passed.

Clauses 3 to 23 put and passed.

Clause 24: Section 71 replaced —

Mr W.R. MARMION: Clause 24 seeks to replace section 71 of the act. Can the minister give a practical example of when a "limited registration not to be held for more than one purpose" might take place? Firstly, can the minister give me an example of a limited registration? Secondly, under what circumstance would we want to make sure it could not be held for more than one purpose?

Mr R.H. COOK: There is a good example in the explanatory memorandum, so I will read it. It states —

> … for professions that have divisions, new sections 71(3) and (4) provide that health practitioners may not hold limited registration in the same division of the register for their profession for more than one purpose … For example … a person may hold general or limited registration as a dental therapist or hygienist and require limited registration as a dentist to undertake post-graduate training or supervised practice to qualify for general registration as a dentist.

It essentially provides a qualification relating to restricted practice but provides the capacity to transfer it across. I think that is the best way to describe it.

Mr W.R. MARMION: I think I get it. I wondered when that would apply, but I can see that it will give someone limited capacity during their training program to do some part of the practice. It limits that and only in that particular division. Is that right?

Mr R.H. COOK: That is my understanding, yes.

Clause put and passed.

Clauses 25 to 37 put and passed.

Clause 38: Section 123A inserted —

Mr W.R. MARMION: Clause 38 is the important one that is specific to Western Australia. Could the minister elaborate a little bit on how he sees this clause working in practice? Obviously, it restricts birthing practices to midwives or medical practitioners under certain practices. Could the minister outline to the house, if he can, what sorts of restrictions might be imposed in the guidelines for a homebirth, for instance? How would the guidelines be developed?

Mr R.H. COOK: The Nursing and Midwifery Board of Australia would obviously undertake the crafting of the guidelines and regulations for the way the practice is carried out. Proposed section 123A deals with the way that we would expect a restricted birthing practice to be carried out. As the member said, it may be a homebirth and we would expect that to be undertaken by a midwife or a medical practitioner. The proposed section allows for a person who is training in the role of a midwife or other medical profession to undertake the practice under clinical training supervision by an appropriate health professional. The proposed section will ensure that appropriate regulations are in place for the planned delivery of babies in non-hospital environments. In particular, it also provides a catch clause. A person will not be subject to penalty simply because they are assisting someone who is having an unplanned birth if the baby comes out quickly. It really provides the meat to the bones for restricted birthing practices.

Mr W.R. MARMION: I have a follow-up question on this clause. We are putting this proposed section into Western Australian legislation and I understand that South Australia also will adopt it through regulation, I presume. Does the minister know whether other jurisdictions or the COAG Health Council are perhaps considering this proposed section as a national measure that might apply right across Australia?

Mr R.H. COOK: This aspect of the legislation was identified in Kim Snowball's independent review. It is one of the recommendations that was not immediately accepted, but it is understood that it will come back for further consideration by the COAG Health Council. I think it is a pretty sensible approach, so I cannot understand why there would be objections from other states. I have not been involved for that long to have that historical knowledge yet, but my understanding is that it will be considered with further issues around the law.

Clause put and passed.

Clauses 39 to 96 put and passed.

Clause 97: Various penalties amended —

Mr R.H. COOK: I move —

Page 55, line 5, the table — To delete the table and substitute —

Table

Sch. 5 cl. 2(1) and (2)	Sch. 5 cl. 10(1) and (2)
Sch. 5 cl. 21(1)	Sch. 5 cl. 22(1)
Sch. 6 cl. 2(1) and (2)	Sch. 6 cl. 10(1) and (2)
Sch. 6 cl. 21(1)	Sch. 6 cl. 22(1)

Mr W.R. MARMION: I would like an explanation for why this amendment has been brought on.

Mr R.H. COOK: My understanding is that this table has essentially been adjusted for drafting purposes. The change is in the second line of the table. The original legislation referred to schedule 5, clause 20; it now refers to schedule 5, clause 21(1). The table will now refer to penalties under subclauses when it used to refer to penalties under clauses. It is simply a drafting adjustment.

Mr W.R. MARMION: I have lost the proposed amendment, but I have the original. I think the amendment had one or two fewer tables. I would like an explanation about the difference between the two. The table to be deleted

has six rows and the new table has four rows. It is either a different way to present it, so it needs only four rows, or some schedules have been deleted.

Mr R.H. COOK: The old version of the bill has four references to clauses whereas the penalties relate to subclauses. They have been removed for that purpose; that is, to relate specifically to the subclauses.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 98 and 99 put and passed.

Clause 100: *Civil Liability Act 2002* amended —

Mr R.H. COOK: I move —

Page 57, after line 4 — To insert —

(3) In section 5AB in the definition of ***medical qualifications***:

(a) in paragraph (a) delete "the medical" and insert —

a health

(b) in paragraph (c) delete "officer or other paramedic;" and insert —

officer;

Mr W.R. MARMION: I seek an explanation of why this amendment is necessary. Was it something that was left out in the original drafting; or, if not a change, why has it been added?

Mr R.H. COOK: This amendment arose further to the decision to present the bill. It is the subject of further advice we received around drafting. The first part is to delete "the medical" because what we are trying to do, obviously, in this particular part is to define the definition under "medical qualifications" as all health professions; so all 15 professions are now recognised under the national law. In the second instance, because paramedics are now recognised as one of the health professions, it is appropriate, under paragraph (c), to acknowledge the qualification as ambulance officer, not paramedic, because paramedics are part of that first group. It is simply a tightening up of the wording to clarify the health professional and obviously the ambulance officer.

In terms of all other arrangements, they are protected under the good Samaritan clause under section 5AD of the Civil Liability Act, which covers them in relation to civil liabilities on that issue.

Amendment put and passed.

Clause, as amended, put and passed.

Clauses 101 to 117 put and passed.

Title put and passed.