

HEALTH SERVICES AMENDMENT BILL 2021

Committee

Resumed from an earlier stage of the sitting. The Deputy Chair of Committees (Hon Steve Martin) in the chair; Hon Sue Ellery (Leader of the House) in charge of the bill.

Clause 11: Section 19 amended —

Committee was interrupted after the clause had been partly considered.

Hon MARTIN ALDRIDGE: I think just before we were interrupted by the taking of questions, I had just asked a question. If it helps the minister, I can refresh the question.

Hon Sue Ellery: Can the member just repeat it. Thank you.

Hon MARTIN ALDRIDGE: Clause 11 of this bill seeks to amend section 19. The explanatory memorandum states that this clause will clarify the department CEO's role within the WA health system. It continues —

The new subsection (2) gives the Department CEO responsibility for carrying out the 'system manager role'. The 'system manager role' is defined in the newly inserted subsection (1A) as the role of managing the WA health system for the purpose of providing stewardship, strategic leadership and direction and allocating resources for the provision of public health services in the State.

This section uses a new term "stewardship". In this context "stewardship" is intended to capture the System Manager's over-arching responsibility for the long term future of the WA health system.

I made some reflections on the *Independent review of WA health system governance*, which appears to commend the devolved governance structure of health service providers in Western Australia. I guess my concern in light of that is whether we are changing the relationship at all—and, if so, to what extent—between the system manager role of the departmental CEO and, with the exception of one health service provider, the board-governed, chief executive-run health service providers. I want some understanding or perhaps even some reassurance on how the relationship between the department and health service providers might change as a result of the passage of this provision.

Hon SUE ELLERY: I am advised that we are not changing the relationship. The specific words "overall management" have been removed. It is about stewardship, not managing the HSPs, so there is no difference in the relationship; it is just about making explicitly clear to everyone the role of the director general in the relationship with those HSPs. It is not looking to interfere, if you like, in the operating arrangements; rather, it is overall stewardship.

Hon MARTIN ALDRIDGE: I am asking these questions at this point, but this issue flows throughout the bill. Later on we will get to a clause that refers to establishing policy frameworks that will apply to health service providers. I am struggling with the concept that, on the one hand, we celebrate the devolved government structure—we have the independent boards—which the independent governance review said is working well for Western Australia, and, on the other hand, we have this tension almost with the departmental CEO providing a level of oversight and with the implementation of these policy frameworks. To what extent will that diminish the role of chief executives and boards with that devolved governance, which seems to be, according to the independent governance review, operating quite effectively? Perhaps that is something we might explore later rather than at this clause, but this is where it first starts to come in, because "system manager role" is defined in proposed section 19 for the first time.

Hon SUE ELLERY: We may have this discussion later on. I do not mind making my point now. It is completely consistent with the proposition of devolved management that we have a high-level strategic role exercised by the director general but the operational management rests with the HSPs and their boards. In fact, it is completely consistent with that. It is not about diminution in any way of the operational management roles carried out by HSP leadership and boards. In fact, if anything, we could argue that it will do the opposite. It makes it abundantly clear that the function of the director general is a broad strategic vision-setting role, as opposed to interfering in the day-to-day running of HSPs.

Hon MARTIN ALDRIDGE: Were HSP boards consulted as part of the development of this bill; and, if so, were any concerns expressed about the relationship between board-governed entities and the role of the system manager?

Hon SUE ELLERY: Yes, they were consulted. I am advised that a number of the amendments in the bill before us now are a consequence of that consultation with HSPs.

Clause put and passed.

Clause 12: Section 20 amended —

Hon NICK GOIRAN: Clause 12 seeks to amend section 20, "Functions of the Department CEO". I understand it is the case at the moment that the director general can classify and determine the remuneration of health executives

and their officers and can also vary the classification of or remuneration for the roles. This will change by virtue of substituted section 20(1)(g). Will this substitution restrict the existing function of the director general?

Hon SUE ELLERY: It is a bit convoluted in its expression. The exercise of the power will remain the same. If the bill before us proceeds, the director general will exercise that power in accordance with a set of regulations.

Hon NICK GOIRAN: I agree. Has that provision been put in place with the intention of restraining or restricting the function that is currently exercised by the department CEO? It appears at first glance that there is effectively an unrestricted function and that the government is saying, “No, you can only do it in accordance with the prescribed regulations.” What brought about the necessity for this?

Hon SUE ELLERY: A couple of points need to be made. It is not anticipated that regulations will be required. It may not automatically happen that regulations will be drafted. To the point of the member’s question about whether it will restrict, if regulations are made, yes. Regulations may be made under this subsection to set limitations on or control the exercise of the function by the department CEO in the interests of further transparency and fairness. However, the caveat is that there is no plan now to make such regulations. This provision will give the power to make them if it is deemed necessary.

Hon NICK GOIRAN: Is it the intention of the government that the director general will continue to have this function if regulations are not prescribed?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: I acknowledge that that is the intention. I am not sure that that is the effect of the words in front of us because to give effect to that intention, I would have thought that it would have been drafted to say “classifying and determining the remuneration of an office of health executive and varying an office of health executive’s classification or remuneration, subject to any regulations”. This is saying that the power, the function of the CEO, will be granted in accordance with regulations prescribed by this paragraph.

Hon Sue Ellery: Except the bit you just missed, which is in brackets—“if any”.

Hon NICK GOIRAN: That is right. If no regulations are prescribed for this paragraph, the function does not apply. I acknowledge the intention. At the very least, it is helpful that the intention is recorded. I am concerned about whether it will give effect to that. I make that observation; the government will do what it will. It may want to seek ancillary advice from parliamentary counsel about proposed section 20(1)(g). I simply make the observation at this time.

Hon Sue Ellery: It is a drafting difference between the two of us. If you were drafting it, you would draft it differently. This is the way that parliamentary counsel has drafted it, but the intention is that the function can continue—there may or may not be regulations to prescribe how that will be done.

Hon NICK GOIRAN: Just so long as that has been communicated to and understood by the drafter and that no crossed wires are operating here.

Proposed section 20(1)(na) refers to performance data. What type of data is being referred to?

Hon SUE ELLERY: This provision will make explicit in the legislation what currently happens in practice. That section will be inserted to make it explicitly clear that the department CEO has the function of collecting performance data and any other information from health service providers. That happens now but no expressed power gives the DG the authority to do that.

Hon NICK GOIRAN: This is not the collection of new performance data. Is it just a continuation of the collection of existing performance data and other information?

Hon SUE ELLERY: I am advised yes, but the member can imagine that in the management of large organisations that will change from time to time. It will reflect current practice at a point in time, but over time it may evolve that other forms of data are required.

Hon NICK GOIRAN: Is it intended that the performance data that will be collected by the department CEO will be publicly available?

Hon SUE ELLERY: Not necessarily. It will depend entirely upon what it is. There might be some performance measures that are made public in annual reports, for example, or in other ways. It will depend upon the nature of the data.

Hon NICK GOIRAN: Is it intended that the data will pertain to the performance of the health service provider or will it go beyond that to include the performance of persons employed by the health service provider?

Hon SUE ELLERY: It is about the performance of the health service provider, their throughput or whatever. It is not a human resources mechanism.

Hon NICK GOIRAN: Section 20 refers to the functions of a health service provider and states that it may include commissioning and delivering capital works and maintenance works. What mechanisms will be put in place to ensure that health service providers are able to source any necessary information from subcontractors?

Hon Sue Ellery: I am at a bit of a loss. Can the member tell me where he is.

Hon NICK GOIRAN: I am looking at section 20 in the blue bill and the deletion of paragraph (g).

Hon SUE ELLERY: I have got it—commissioning and delivering capital works and maintenance works for public health service facilities. I thank the member. I will be a pain and ask the member to repeat the question.

Hon NICK GOIRAN: It is proposed to delete the words “commissioning and delivering capital works and maintenance works for public health service facilities”. That is not replicated elsewhere in the bill. There is a proposed substituted paragraph (g) that, effectively, deals with what is currently section 20(1)(h). What is happening with the deletion of paragraph (g)?

Hon SUE ELLERY: If we stick with the blue bill and look down the page at proposed section 20A, that is where that is captured.

Hon NICK GOIRAN: In reading both of those in conjunction, what mechanism will be put in place to ensure that health service providers will be able to source any necessary information that they might need from subcontractors?

Hon SUE ELLERY: We need to be clear about what we are talking about. Section 20 goes to the functions of the department CEO. We have taken out that part that states, at the former paragraph (g), that the department CEO has responsibility for commissioning and delivering capital works et cetera. We are now proposing to insert proposed section 20A, which states that that same person—the department CEO—can do all those things that are listed. This is about the powers of the CEO, not HSPs. When it comes to HSPs, we need to look at the provisions in clause 20, proposed sections 36A to 36E. I will find that for the member. It is in part 4 of the blue bill, so we have jumped ahead a bit, at page 31, the functions and powers of HSPs. Section 36 sets out the general powers, such as that they can “acquire”. There will be no change to how they perform their functions.

Hon NICK GOIRAN: If the CEO wanted to collect performance data and any other information from health service providers as per this new provision in proposed section 20(1)(na), and the health service provider needed to access information from a subcontractor in order to provide that information, what would enable that health service provider to source that necessary information?

Hon SUE ELLERY: It would depend entirely upon the circumstances. They will have the power to enter into a contract, and they will be able to set out in the terms of that contract what they will need in order to be able to access information. That might even be set out in the tendering process, for example. There will be any number of levels at which, in the process of entering into a commercial arrangement, the HSP will be able to seek information.

Hon NICK GOIRAN: In other words, the HSP will rely on a contractual arrangement in order to obtain that information. I do not dispute that. That is fine. My question is that as part of this bill, we will enable the department CEO to enter into arrangements with HSPs, in which case as part of those contracts the CEO would also be able to obtain this information, yet this bill will specifically give him or her the capacity to collect performance data and any other information from health service providers. This legislation will explicitly give them this function, despite the fact that they have the capacity to enter into a contract arrangement, yet we will not be doing the same for health service providers.

Hon SUE ELLERY: The reference to the CEO being able to collect performance data is around the functioning of the health service provider to do all the things that it needs to do in providing clinical care. The provisions set out in the general powers and the provisions set out for joint arrangements are about them agreeing to enter into an arrangement to achieve, build or sell a piece of land and take responsibility for function X, or shared responsibility. I think the member is suggesting that we will be restricting the capacity of health service providers to do the things they need to do. That is not how I see it, but maybe I have misunderstood the point the member is trying to get at.

Hon NICK GOIRAN: I accept that the minister has said that HSPs at the moment can collect data and information from subcontractors by relying on their contractual powers to do so; however, we then do not do the same with the director general. Instead, we explicitly put into the statute that one of the functions of the director general is to collect performance data and any other information from health service providers. There is an arguable inconsistency in the way we treat the two. I acknowledge that the director general can say to the health service provider, “I want this information from you.” The health service provider can say to the subcontractor, “I want this information from you.” For one we rely on the contract and for the other we rely on the statute, and I wonder why.

Hon SUE ELLERY: It is about the different functions. The HSP can collect whatever information it needs from whomever it needs to collect it from to carry out its functions. Sitting above the HSP is the CEO. This provision makes explicit that the CEO as part of the stewardship, the system leadership, can say to the HSPs that in order to

make a judgement that they are delivering the government's policy around the number of beds, for example, the CEO needs to be able to collect the information. They are about different functions, because the HSP is managing its own business and it can seek information from whomever it wants. In order to make explicit the CEO's ability to provide oversight and overall strategic management, it needs to be clear that the CEO can say to the HSPs, "I need to see this, this and this."

Hon NICK GOIRAN: I note that despite that, that is not the case at the moment. This provision is being inserted for the first time. The CEO has already been collecting this information. That is why we are now saying that we will explicitly put it in place. If the HSPs are doing the same thing, it would follow that we would also explicitly put it in place for them. That is simply the point I make. Nevertheless, is the data that is collected by the director general subject to a framework or policy on the retention of that data?

Hon SUE ELLERY: I am advised that the department operates within a framework around the collection, use, retention and disposal of data. That will continue to operate and that is how data will be dealt with. There will be some that will be kept; there will be some that will not be relevant.

Hon NICK GOIRAN: Is the policy that guides the retention of data a system-wide policy or is it a policy specifically between the director general and the HSPs?

Hon SUE ELLERY: If we start at the top of how data and records are managed, state records legislation requires every agency to have in place certain policies and plans and to follow certain procedures. The department has a range of policies—subsets, if you like—about different kinds of data and the HSPs are required to follow the State Records Act 2000. If the State Records Act—I am sorry; I do not have it here—requires agencies, however it defines them, to control and manage the information flow and data in a certain way, that is what the HSPs have to follow.

Hon NICK GOIRAN: Noting that there are seven of them and that the CEO will receive seven lots of information, is it intended that the same policy applies to all seven HSPs and that the retention policy for the director general is the same, irrespective of which of the seven HSPs provides the information?

Hon SUE ELLERY: Yes.

Hon MARTIN ALDRIDGE: Proposed amended section 20(1)(g) refers to health executives. How many health executives does the current provision apply to?

Hon SUE ELLERY: It is 78, excluding chief executives—so add seven to that.

Hon MARTIN ALDRIDGE: This provision excludes chief executives. How is their classification remuneration determined? Are they an SES officer and, therefore, determined by the Public Sector Commissioner or the Salaries and Allowances Tribunal?

Hon SUE ELLERY: The remuneration of chief executive officers of HSPs is by the director general on the recommendation of the Public Sector Commissioner.

Hon MARTIN ALDRIDGE: These 78 health executives are subject to a classification that determines their remuneration and variation of that classification of their remuneration by the system manager—that is, the department's CEO. Does the system manager determine how many health executives each health service provider requires or is their role simply to determine the classification of remuneration as opposed to how many health executives are required to deliver the WA Country Health Service, for example?

Hon SUE ELLERY: There is no set number of health executives, and I am not advised that is planned. The proposition gives the director general, the CEO, the centralised capacity to determine whether it is right that there are, for example, 27 level 9s over there and two over there. There may be, because it might be entirely appropriate to what the HSPs are delivering, but that is the purpose of it.

Clause put and passed.

Clause 13: Section 20A inserted —

Hon NICK GOIRAN: To assist members, and perhaps also the minister, I indicate that the next round of questions will be on clauses 13, 15, 18, 19 and 20—not that we are stopping at 20. I think there might have been a little confusion earlier when I said —

Hon Sue Ellery: There was, yes. It doesn't matter.

Hon NICK GOIRAN: I apologise. I was just trying to get an early indication of the next few clauses. There are plenty more to go. With respect to clause 13, the minister will see here that what we are doing is lifting what is presently in section 20(g), which we spoke of earlier, and inserting the very elaborate proposed section 20A. What has necessitated the need to elaborate the existing function of the director general to the extent of what we see in proposed section 20A?

Hon SUE ELLERY: The clause inserts proposed section 20A, which is intended to more accurately provide for the capital works and clinical commissioning of the new public health service facilities by the WA health system. Section 20(1)(g) previously provided commissioning and delivery of capital works and maintenance. It is a function that only the department CEO performs. That did lead to some uncertainty as it did not reflect the actual performance of this function within the WA health system and it did not provide a framework for how clinical commissioning could be carried out. The absence of the function to undertake clinical commissioning created legal issues with the clinical commissioning of the Perth Children's Hospital. It meant that convoluted legal arrangements were required to be put in place to ensure that the department CEO could take responsibility for the clinical commissioning of the building.

Hon NICK GOIRAN: In the background of this is the corruption and bribery investigation into the North Metropolitan Health Service. What is happening here at proposed section 20A is to make sure that we are very clear as to the legal basis upon which the director general can, for example, commission and deliver capital works, carry out clinical commissioning of facilities and the like. That obviously has the support of members on this side of the chamber. Is it the case that special arrangements or provisions are being inserted into the Health Services Act—in light of the allegations that arose due to the commissioning and delivery of works—to ensure that there are, what I would describe as, enhanced checks and balances on health service providers, including the North Metropolitan Health Service, to make sure that they are transparent and properly accounted for?

Hon SUE ELLERY: There may well be other provisions in the bill before us that go to those issues. This bit is literally as a consequence of the legal difficulties that were faced commissioning the Perth Children's Hospital.

Hon NICK GOIRAN: I thank the minister for that reiteration. I understand that basis, that is why we are inserting 20A and are elaborating on that which was originally in section 20(1)(g) to make it clear. This all relates to works and clinical commissioning. At the moment, or is it intended, that there be another provision elsewhere in the bill that deals with that level of clarity as to what can and cannot be done, the checks and balances and so forth, so that there are no legal impediments and we do not have to have convoluted legal arrangements with respect to HSPs? This provision seems to do a good job with regard to the director general. Is there a like provision elsewhere for an HSP?

Hon SUE ELLERY: There are two areas that go to the issue that the member raises. One is within the bill before us and one is not. The one that is not is in respect of the Procurement Act 2020, which established a framework of oversight for the procurement of works. Under that act, the Minister for Finance issued an agency specific direction to the Department of Health. It provides—that was not me, that was previously—that the director general may undertake works up to the value of \$2 million without the involvement of the Department of Finance. For works above \$2 million, the director general may undertake works with the approval of the Department of Finance CEO. In the absence of that, the director general must engage the Department of Finance to undertake the procurement of works.

The director general may delegate his power to commission and deliver works under existing section 20(1)(g) to a health service provider when the value of those works is under \$2 million and for works over \$2 million when he has received approval to undertake the works. In respect of this particular bit of legislation, we deal with the power of HSPs further on in part 5. In sections 34 and 46 there are provisions relating to the service agreement between the department CEO and health service providers they can set out the capital works projects that the health service provider is responsible for managing and the budget constraints that they must meet.

Clause put and passed.

Clause 14 put and passed.

Clause 15: Section 26 amended —

Hon NICK GOIRAN: The minister will see at the amendment to section 26 that we are inserting a number of financial management and business activity provisions, specifically at section 26(2)(e). Immediately below that is section 26(2)(e)(v), which deals with the fixing of fees and charges that health service providers may charge. In other words, the director general can issue one of these policy frameworks with respect of the fixing of fees and charges that the HSPs might provide. What recourse, if any, does the HSP have in the event that they consider the view of the CEO on fees and charges to be unfair or unreasonable?

Hon SUE ELLERY: The technical answer is “too bad”. That is the advice I have been provided.

Hon Nick Goiran: You say that is the technical answer?

Hon SUE ELLERY: Yes. There is no right of appeal, if that is the question the member is asking.

Sitting suspended from 6.00 to 7.00 pm

Hon NICK GOIRAN: Prior to the interruption for the dinner interval, the minister was dealing with the scenario in which a health service provider might find that the CEO's determination for fees and charges was unfair and

unreasonable, and we had established that, at the end of the day, there is very little that the health service provider can do about that. They might make subsequent representations to the CEO to change their mind or whatnot, but that effectively concludes that matter.

Before we move on to, from my perspective, clause 18, I want to unpack the reverse scenario. If the CEO considered that fees and charges were excessive, would the CEO then have a unilateral capacity to be able to inject him or herself into that and have the fees and charges changed?

Hon SUE ELLERY: Further on in the bill, clause 29, which seeks to replace section 55, refers to the fees and charges for the provision of health services. It states that proposed section 55 will give health service providers the power to determine and impose fees and charges in accordance with the following regime.

There will be no charge in certain circumstances. A health service provider cannot determine and impose a fee or charge in a situation in which it has been agreed that a person is not to be charged for that health service under the National Health Reform Agreement between the commonwealth and the states, or in which the minister has determined that no fee or charge is to be imposed under an order made pursuant to section 56(2)(b) of the act. An example given for that is in the case of asylum seekers.

There are then tiers. Charges that are fixed by the minister are tier 1, and HSPs are not permitted to determine and impose fees for health services that are inconsistent with an order made by the minister. Charges that are fixed by the department CEO are tier 2. HSPs are not permitted to determine and impose fees for health services that are inconsistent with any policy framework. The clause in front of us now is about the CEO's power to set a policy framework. The third tier is charges that are fixed by the health service provider, which may otherwise determine its own fee or charge for a health service. For example, for tier 1, if the minister determines that a new charge is politically sensitive, such as a charge for accommodation for private patients, the minister may fix the same in an order under section 56. For tier 2, if the minister determines that a new charge is not politically sensitive but requires consistency across all the health service providers, the department CEO can fix the same in a policy framework. If the HSP were to do something contrary at that point, technically the CEO could intervene. It is not anticipated that that kind of dispute would arise, because HSPs are focused on delivering what they need to deliver; they are not driving for the dollar, if you like. It is not anticipated that that would happen, but, in any event, if the HSP were to exercise its power under tier 3 in a way that was inconsistent, for example, across all health services, the DG could technically override that.

Hon NICK GOIRAN: Would the overriding by the director general be in the form of a revised specific policy within the framework? Is that how that would be achieved? Because it is a policy framework, would it then restrict in some way the capacity of the director general to drill down to that level of specificity; and, if that were the case, would it be open for the director general to go to the minister to issue an order?

Hon SUE ELLERY: The anticipation is that the DG would just change the policy framework so that it says that HSPs need to comply with the following. It is not anticipated that it would ever need to be elevated to the minister, because the DG has that capacity.

Clause put and passed.

Clauses 16 and 17 put and passed.

Clause 18: Section 35 amended —

Hon NICK GOIRAN: Clause 18 deals with section 35 of the Health Services Act 2016. It will insert the phrase "Subject to any relevant policy framework". Is this one and the same policy framework that we were speaking of earlier—that is, the policy framework that is authorised or published by the department CEO?

Hon SUE ELLERY: Yes.

Hon NICK GOIRAN: Are those policy frameworks subject to any specific ministerial oversight? Is the CEO obliged to ensure that the minister is aware that these policy frameworks exist?

Hon SUE ELLERY: Nothing obliges the DG to do that. My understanding of the way the system works now is that a good DG does that if the matter is of significant public interest, as opposed to changing the fee for setting a broken arm from \$2.00 to \$2.50. If it is a significant matter, the DG would bring it to the attention of the minister in any event, I imagine.

Hon NICK GOIRAN: Noting that the DG is not obliged to do so and that there is nothing that makes it mandatory for him to bring such policy frameworks to the attention of the minister, if the minister becomes aware of a policy framework and has an issue with it, what is the mechanism by which the minister can ensure that the policy framework is changed?

Hon SUE ELLERY: There is no provision in the act that states how that would happen, but the minister would have a discussion with the DG. That happens all the time.

Hon NICK GOIRAN: If the minister has access to the blue bill, she will see at page 31 that an amendment will be made to section 35(4) by deleting the words “WA health system” and replacing them with “State”. What has brought that about?

Hon SUE ELLERY: It is recognition that commercial activity might be of benefit to the whole state, not just the Department of Health. It is recognition of the function that HSPs have. It might be something that is beneficial to beyond just the Department of Health.

Clause put and passed.

Clause 19: Section 36 amended —

Hon NICK GOIRAN: Amendments to section 36(5) will amend the capacity for a health service provider to make a gift or act-of-grace payment. Why has it been deemed necessary for the health service provider to make a gift or act-of-grace payment rather than, for example, leaving such act-of-grace payments or gifts to be made by the minister?

Hon SUE ELLERY: Health service providers already have the power to make gifts and payments under section 36 of the act. Gifts can be physical in nature—therefore, goods such as medical equipment; I recall Hon Helen Morton making arrangements for some medical equipment—whereas act-of-grace payments are monetary in nature; for example, cash reimbursements for lost medical aids. Examples of act-of-grace payments include payment made to the family of someone who might have died in a public hospital or reimbursement to a patient for medical aids that were lost in a public hospital.

Hon NICK GOIRAN: Is it common for these gifts or act-of-grace payments to be made by the health service provider? I acknowledge the example the minister gave earlier about Hon Helen Morton, who I think at the time might have been the Minister for Mental Health. But as distinguished from an act-of-grace or ex gratia payment made by the minister, which does happen from time to time, is it common for it to be done by health service providers?

Hon SUE ELLERY: I am advised that it is common at quite a low level, so perhaps providing a taxi fare for a patient who otherwise finds themselves in a position in which they are not able to pay for their taxi or if their glasses are lost between them going into surgery and coming out of surgery. It is common at that low level—yes. I am not aware of any significant or high level examples.

Hon NICK GOIRAN: Is there some form of a cap or restriction on the extent to which these gifts or acts of grace can be made?

Hon SUE ELLERY: The amendments to section 38 will require health service providers to seek the approval of both the Minister for Health and the Treasurer prior to making gifts or act-of-grace payments above a prescribed threshold. There is no prescribed threshold in place now. The threshold will be prescribed in regulations and the amount will be set based on a recommendation from the Treasurer. A threshold amount has not been recommended at this time, but it is anticipated that this will be aligned to the threshold for act-of-grace payments made under the Financial Management Act.

Clause put and passed.

Clause 20: Sections 36A to 36E inserted —

Hon MARTIN ALDRIDGE: This clause inserts sections 36A to 36E. We have previously engaged about section 36D, which is the authorisation for health service providers to act as agents on behalf of one another. I understand that that is not currently occurring, because I was told that this was not a matter of validating existing practices that might be in place but will allow for that to occur. I am wondering whether the minister could help me with the procurement issue. Health is obviously a significant agency in terms of procurement, and I read out a quote from the *Independent review of WA health system governance* in my contribution to the second reading debate. It states —

In 2020–21 WA’s health system procured \$4.8 billion through contracts.

...

At the time of this review, there are a total of 3 847 contracts across the WA Health system ...

How will it be determined whether the provision of a rural health service should be done across the whole system by the department, or should be left to health service providers to do independently, or perhaps collaboratively, as is provided for in proposed section 36D?

Hon SUE ELLERY: I did touch on this, if not in my second reading reply then perhaps in answer to earlier questions. It will depend entirely upon the particular circumstances. The example that I have given so far is that the Child and Adolescent Health Service may be able to enter into joint arrangements with other health service providers because of its particular clinical expertise, which is centralised, as opposed to HSPs, which might have very limited or

narrow scope to access that kind of clinical support. Unless I am advised otherwise, I cannot say to the member that it is only in respect of this; it is not in respect of that.

Hon MARTIN ALDRIDGE: I guess to challenge the assumption that I just made, do health service providers currently act on behalf of one another?

Hon SUE ELLERY: I am just checking whether there is another element that might be of use to the member. Currently, only two arrangements are in place that go to the provision of joint or shared arrangements. The first is Health Support Services, which provides backroom support across the system. The second is PathWest, which provides specific clinical expertise across the system. I am checking whether any informal arrangements are entered into from time to time between health service providers. I do not know whether that is the case or not. I cannot provide the member with any other information, but those are two examples of what I am talking about.

Hon MARTIN ALDRIDGE: I think the answer that I got back from the specific question in the briefing was that this is a proactive mechanism to make it clear that HSPs will have this power. There is obviously a lot of common procurement ground in the health sector. Personal protective equipment is one example. Is PPE procured at an HSP level, or does Health Support Services procure PPE through a single contract and make that accessible to HSPs as they require it?

Hon SUE ELLERY: I am advised that PPE, for example, is centrally managed through Health Support Services, and other things like stationery.

Clause put and passed.

Clause 21: Section 37 amended —

Hon NICK GOIRAN: The change in this clause is proposed section 37(3)(b). What is an example of some of the high volume, low value land options that might be captured by this particular provision?

Hon SUE ELLERY: An example might be short-term accommodation that the WA Country Health Service might need to provide. That could be in a range of settings from a house, a unit or motel rooms, for example.

Clause put and passed.

Clause 22: Section 38 amended —

Hon NICK GOIRAN: We touched earlier on gifts and act-of-grace payments, which is also addressed in this clause. This is where there is a prescribed amount. As the minister indicated earlier, they will be subject to some advice from Treasury. It has not yet been set but it is anticipated to be the same as other regimes. Will all of these acts of grace and gifts that will be made by the health service providers be reported in their annual reports?

Hon SUE ELLERY: I am advised that yes, under the *Treasurer's instructions*, they are required to report it in their annual report.

Clause put and passed.

Clause 23 put and passed.

Clause 24: Section 46 amended —

Hon NICK GOIRAN: How have the health service providers been commissioning and delivering capital works and maintenance work projects in the absence of this amendment to section 46?

Hon SUE ELLERY: Currently the act provides that the commissioning and delivery of capital works and maintenance works is a function that only the department's CEO performs. However, that does not reflect actual practice, and it certainly overlooks the accountabilities and responsibilities of existing health service providers in delivering capital works projects. In practice, the department's CEO takes responsibility for managing the commissioning and delivery of capital works for only high-risk health facility projects while more routine capital works projects are managed by the health service providers.

The amendments that we are talking about now sit across three sections—20A, 34 and 46. They ensure that the service agreement between the department's CEO and the HSPs can set out the capital works projects that the HSP is responsible for managing and the budget constraints within which they can do that.

Hon NICK GOIRAN: At the moment, the director general keeps for himself the commissioning and delivery of capital works and maintenance programs that are categorised as high risk. However, in practice, if it is not high risk, the health service providers have been doing it. The change to section 46 does not yet exist. Even though it has been happening in practice, what has been the basis upon which they have been doing this? The minister mentioned under an earlier clause that some complicated legal arrangements had been put in place for Perth Children's Hospital. Is that the type of mechanism that has had to be employed to get around the lack of amendment to section 46, or has some other mechanism been employed?

Hon SUE ELLERY: There is an absence of clear legal authority for what HSPs are doing. They have done it. It has been practised under consecutive governments. I am not sure that it is true that the issues associated with Perth Children's Hospital are about the distinction between what is a high-risk project and what is not. For the ordinary person ever reading this *Hansard*, we are not talking about risk in the sense that something could go badly wrong; we are just talking about the size of the project and the investment by the state. Real issues arose out of the commissioning of Perth Children's Hospital. I do not think that is an example of issues arising from an absence of clarity about what HSPs can manage and what the CEO can manage. They were as a function of the CEO not having the power, as I understand it, to resolve some of those issues, not because there was a distinction between what he could do and what the HSPs could do.

Hon NICK GOIRAN: A practice has been occurring, as the minister says, under successive governments whereby HSPs have been acting without a proper legal basis for the commissioning and delivery of capital works and other things. It is almost a bit trite to say it, but that is obviously not good and not to be seen as a proper way in which HSPs or any government agency or body should be acting. Nevertheless, this has occurred and it has been picked up and this bill will now rectify that legal basis. Has anything turned on that? For example, has an audit been undertaken to ensure that notwithstanding that in practice HSPs have been acting without the proper legal basis, in the end, nothing untoward has occurred as a result of that, and although it might not be desirable and is not to be applauded, there is no concern?

Hon SUE ELLERY: I will ask the advisers to see whether they can come up with some examples, but I want to clarify what I said earlier, because I do not want the practice to date being characterised as having been illegal; it is just that the legislation has not explicitly provided a power explicit to this. Delegations are being used by the department CEO to ensure that personnel within the HSPs can commission and deliver capital works and maintenance works. However, the delegations under the current framework do not allow the CEO to impose performance standards on HSPs for the delivery of those works, nor to ensure that HSPs are held accountable for the delivery of works within budget. I would not want anyone to think that it is illegal; delegations were put in place to protect taxpayers' money and to have various arrangements in place.

I will see whether there are any examples of anything turning, as the member described it, on the absence of that explicit head of power. We are not aware of any.

Clause put and passed.

Clauses 25 to 27 put and passed.

Clause 28: Sections 53A and 53B inserted —

Hon MARTIN ALDRIDGE: We now arrive at part 6 of the bill, which encompasses clauses 28 to 32. I understand that this is one of the parts of the 2016 act around which there were issues with regard to operationalising the intent, which was to be able to recover the cost of delivering services to a person when that person is subject to some form of compensation. I understand there was a lack of a head of power to provide for that recovery. We are dealing with clause 28 at the moment, which sets out the types of compensations that are envisaged, under proposed section 53B(1)(a)(i) to (v). With regard to fees and charges for health services under part 6, is this the provision that perhaps also applies to non-Australian citizens, in terms of the provision of healthcare services and the recovery of fees for such?

Hon SUE ELLERY: I think we are getting slightly ahead of where it appears. The provisions that might be used to apply to asylum seekers or other non-citizens are under clause 30, which sets out a power to make orders to define classes of patients and classes of service. The bit that is in front of us now—proposed sections 53A and 53B—relate to compensable charges, such as a workers' compensation injury et cetera. In respect of non-citizens, it is just a little ahead.

Hon MARTIN ALDRIDGE: I think clause 30 is about exempting a class of persons who may ordinarily be compensated and therefore a fee is raised against them. I guess my general question is: if someone is here on holiday from another country and they end up in an emergency department and they do not have a Medicare card, they are going to get a bill from the hospital. I assume it is not part 6 that provides the power for that hospital to charge that person?

Hon SUE ELLERY: I think we are back to where we started. Proposed section 56 could be applied to the member's example relating to non-citizens.

Hon MARTIN ALDRIDGE: Given that this act is a 2016 vintage—I understand it has not worked, so we are now fixing it—do we have a sense of the quantum of lost revenue that the state has forgone as a result of the deficiencies of this part of the act?

Hon SUE ELLERY: No, I do not, honourable member. It might be that way back then, someone did some work to demonstrate that to convince the government of the day to move down this path, but nobody here is aware of that.

Hon MARTIN ALDRIDGE: My last question is on proposed section 53B, which is effectively titled “What is compensation”. This turns on a person who has an injury and whether or not the payment is made to the person who suffered the injury and received the health service or former hospital service. It then goes into the types of compensation. Does it turn on the person being eligible to receive a payment, whether they have received that payment or not? Or if somebody made a claim to their insurance company and the insurance company approved the claim but the person may not have received the payment yet, is that person now captured by the definition of “compensation”?

Hon SUE ELLERY: I am advised that compensation includes compensation that is paid or payable after the day on which clause 31 comes into effect. Accordingly, it does not include compensation paid prior to the commencement of clause 31. I do not think that was the member’s question. As I understood the member’s question, he was asking at which point the compensation claim is triggered by the HSP or whoever. When the person has gained approval for compensation and it has been agreed upon, that is the point at which the claim can be made by the HSP. The payment may go directly to the HSP and skip the individual—that is, not go through them at all. That could happen.

Hon MARTIN ALDRIDGE: I guess the circumstances could be quite different in terms of the compensation source. Is there a risk that it could be counterproductive to make a claim if the person is simply going to get a bill from the hospital that may consume all the claim? Is there even a possible risk that the fee charged by the hospital may be greater than the claim itself?

Hon SUE ELLERY: As I understand it, this is the proposition: are we setting up a system that might have a perverse effect on a person deciding not to put in an application for compensation because all the money might be paid directly to the hospital? I am advised that the health service provider can charge no more than the compensation payment and the person will not end up with a bill that they cannot pay.

Secondly, the charges that the hospital could charge would be one of the head of components that the person might be claiming. If the patient gets paid for loss of amenity or some other element—excuse my inelegant description of it—that is not money that the hospital can take. The hospital can charge for and take money that is related to the service provided. If the compensation pays only 50 per cent of that cost, that is it. The hospital is not going to be able to charge the person for the remaining 50 per cent.

Hon MARTIN ALDRIDGE: Are those protections within the bill or is that simply a matter of principle in terms of how the department, or health service providers more likely, will pursue recovery? The first part is a payment of damages. The minister might knock me off my electric scooter, destroy my scooter and send me to hospital with broken bones. My lawyer then talks to the minister’s lawyer, we end up settling the matter, the minister gives me a bundle of cash and we all go on our merry way. We may settle for, say, \$10 000. I am not quite sure why I then tell the health service provider that I am in possession of a compensation payment, but let us say that I am an honest person and I do that. The health service provider then says that the services it provided to me in ICU for two weeks cost \$85 000, and gives me the bill. If that payment was for, as the minister said, things other than the medical costs—it might have been for loss of property, emotional distress, pain and suffering or a range of other things—how is that complex calculation going to be unscrambled so that the hospital gets a cheque?

Hon SUE ELLERY: I take the honourable member to proposed section 58(2)(b), which goes to the regulations about recovery and compensable charges. The intention, and the power here, is that it will enable —

... the chief executive of a health service provider to give notice to prescribed persons, or persons in a prescribed class —

That includes an insurance provider or whoever —

about compensable charges that may be recovered under this Part, including notice of —

- (i) a health service provider’s intention to recover the ... charges ... and the amount that the health service provider may recover; and
- (ii) the health services, or former hospital services, that the health service provider ... provided ... and
- (iii) the compensable charges ...

The intention is that the insurer will factor that into the settlement, so the costs of \$10 000 would be part of the settlement. The people engaged in the lawyer discussion that the honourable member and I talked about before would need to factor in other things to take into account the fact that the electric scooter was destroyed. That is not the business of the health service provider; that is another part to be determined. What this does is to say to the insurer that these are the elements and the rates of charges that we would be seeking for services provided by this hospital.

Hon MARTIN ALDRIDGE: I think I am rapidly getting out of a comfortable depth on this issue. The provision that the Leader of the House has taken me to in proposed section 58 is effectively a regulation-making power. As the Leader of the House said, proposed section 58(2)(b) may well provide limits, depending on the regulations. Proposed subparagraph (iii) in particular states —

the compensable charges for those services provided in relation to the treated injury in relation to which compensation is, or was, sought;

It will obviously be limited to the extent that compensation is received. Someone may have incurred an \$85 000 ICU bill, but if that person's compensation was \$8 000 for medical costs, one would assume that a sensible regulation would limit the HSP's ability to recover to the extent of compensation received.

Hon Sue Ellery: That is correct. That is what I said a few minutes ago.

Hon MARTIN ALDRIDGE: Yes, but these are regulations. I would prefer these to be statutory protections in the bill, because I think that is something we could all agree on. I am not sure why the government would want flexibility in a regulation that will allow a health service provider to recover above compensation that is payable. I think my point remains that necessarily having a compensation payment that is neatly itemised and contained in neat little parcels as to why someone is receiving a compensation settlement for certain things may not always be the case. People who find themselves in these circumstances may need to have regard for that when seeking compensation from whatever source compensation is sought.

Hon Sue Ellery: Noted.

Hon NICK GOIRAN: This is the start of part 6 and changes to part 6 of the Health Services Act 2016. If we consider part 6 as it stands prior to the amendments proposed, are all provisions of part 6 currently in operation?

Hon SUE ELLERY: I am advised that the bit that is not operational currently relates to compensable charges. That is for two reasons: the regulation-making power was deemed insufficient, and a lack of explicit head of power in respect to the recovery of the money.

Hon NICK GOIRAN: Specifically, in part 6, which ends at section 59, which sections are presently not in operation?

Hon SUE ELLERY: I am advised that existing section 58 is not in operation.

Hon NICK GOIRAN: The existing section 58 of the Health Services Act 2016, "Regulations about payment by compensable persons", has never been subject to proclamation and, therefore, is not presently in operation. When part 6 was originally passed by both houses, I understand it sought to do two things. One was to give health service providers the capacity to levy a fee or charge, and, in certain circumstances, to recover from people. Part 6 as it currently stands has been effective and useful for levying fees and charges but completely ineffective for recovery and, hence, it has not been proclaimed and it is not in operation. Because of the problem that has been identified, we have this substitute scheme, particularly for that latter part—that is, the recovery of fees and charges. It is understandable that the state will from time to time want to recover fees and charges from those in possession of compensation. Who will the onus be on to notify the health service provider that compensation is either pending or compensation has been paid? Will the onus lie on the patient—the person who has received the service—or will the onus lie on the compensation provider?

Hon SUE ELLERY: Specifically, it is intended that the regulations will give health service providers the power to request information from certain persons—for example, patients and compensation payers—to ascertain whether a compensation claim has been made, whether compensation has been received and the terms of any award or settlement in relation to the injury. When the patient is being admitted, there will be a part on the admission paperwork that they fill in asking whether it is related to something that is compensable. The persons or class of persons to be prescribed as being required to provide information is intended to include patients in the way that I just described, and insurers—that is, motor vehicle injury insurers, with the Insurance Commission of Western Australia as an example; workers' compensation insurers, with WorkCover as an example; private liability insurers; medical negligence insurers; and insurance intermediaries.

Hon NICK GOIRAN: I appreciate that when a patient arrives at a hospital they may not have capacity at that point. The person who completes the form might be a relative or a substitute decision-maker. All of the above might have no idea that compensation may flow from this. They may well be requested to give information but none is provided. Does an ongoing statutory onus exist on the patient as a result of changes to part 6 of the act to alert the health service provider that compensation may flow?

Hon SUE ELLERY: The regulations in proposed section 58(2)(a)(i) will have two triggers. The regulations may require a person to give information about whether they have made or intend to make a claim. At the time of admission, they may not have any clue or have the capacity, but these regulations will provide that if they intend to make a claim, the onus will be on them to tell the hospital. On the matter of how that will be enforced, if the health service provider became aware that a patient deliberately did not comply, that is different from someone who at the time of admission was not able to comply because they may not have had a relative with them and they did not have a clue that they subsequently needed to make a claim.

However, the regulations will allow for a penalty of up to \$10 000 to be introduced if patients deliberately do not comply with the requirements. The patients will be provided with an information pack at the time of presentation

to inform them of their obligations and any consequences of noncompliance. I am advised that that will be done in a variety of formats and languages.

Hon NICK GOIRAN: This is about requiring people to provide information. The minister is making it as clear as she can that it will be subject to regulations that we do not have the benefit of seeing at this time. I take it that in the usual way no work has been undertaken on those regulations at this point in time and there is no advanced draft.

Hon Sue Ellery: No, there is not, honourable member.

Hon NICK GOIRAN: We are operating blind on how this system will operate, other than the provisions that are in front of us in the amended part 6. What the minister has outlined is the regime for the requirement for a person to provide information to the health service provider. Will there be any obligation on a person to make any payment in the absence of receiving a notice from the health service provider?

Hon SUE ELLERY: I think the short answer, honourable member, is no. What is the expression that is used these days? It is not proactive, if I can use that expression. The obligation that will be set out in the regulations is to advise if someone has made a claim or they intend to make a claim. That is the obligation. In the absence of knowing whether someone has made a claim or whether they intend to make a claim, there is no provision in the proposed regulations, as I read it, unless I am advised otherwise, that proactively says someone should offer to pay before they are discharged.

Hon NICK GOIRAN: I want to establish, minister, whether it is a two-stage process. First of all, the health service provider will have to be alerted that a claim is underway and it can know that only if it is provided that information by somebody, whether that be the patient or some other person. I would describe that as stage 1 or the request for information phase. As I understand it, subsequently, there will be phase 2; the health service provider, after having assessed the information that it has received, will then issue some form of notice upon somebody, whether that be the patient or on the compensation provider. That will then trigger the liability of the patient or the compensation provider to pay the health service provider in accordance with that notice. I want to establish, firstly, whether that two-stage process is correct; and, if it is, whether there is any obligation to pay in the absence of one of those notices.

Hon SUE ELLERY: In the first instance, the honourable member's description of the two triggers is correct. I am advised the answer to his question is no. This regulatory regime will put in place provisions to allow the HSP to ask the question and if at some point of that two-step process the question is answered in the affirmative, it can proceed to prosecute with the insurer or whoever. In the absence of one of those two triggers, there is no obligation set out in the regulation-making power here that says in the absence of those triggers, there is an onus on a person to make an effort to pay. The onus on the person will be to answer the question accurately when asked it.

Hon NICK GOIRAN: Absolutely. We want to ensure there is not a situation in which somebody has never been asked and then they are surprised or ambushed at a later stage. That is very good. We are now clear that there will be no obligation on anyone to make any payment in the absence of the health service provider having provided a notice. That being the case, will there be any limitation period upon which the health service provider can provide the notice?

Hon SUE ELLERY: There is no regulation-making power or head of power in here that will set a time limit on it.

Hon NICK GOIRAN: Will it be possible for a health service provider to provide a notice after a person has received compensation?

Hon SUE ELLERY: It is not intended to be retrospective in the sense of applying to somebody who has received compensation today. It is not intended to apply until this legislation comes into operation. The patient will be asked whether they have made or intend to make a claim, and the obligation will be on them to tell the truth. There can be a fine of up to \$10 000 if they do not. If the HSP were to subsequently find out that the patient had not told the truth and did have a compensation claim, yes, it would be able to seek payment from the patient as the individual for the services that were provided.

Hon Nick Goiran: As well as prosecute; there is potentially a fine of \$10 000?

Hon SUE ELLERY: Correct.

Hon NICK GOIRAN: I understand the scenario of an act of deliberate deceit, and I think the minister has adequately covered it off. But in the absence of deceit, can the health service provider issue a notice after compensation has been provided? The health service provider has asked the patient whether they have been involved in a motor vehicle crash and whether they have put in a claim with the Insurance Commission of Western Australia. The patient has said "yes". That is the last the patient has heard from the health service provider. They then proceed with the claim. The Insurance Commission provides the patient with their compensation, and the patient is comfortably at home enjoying their compensation, albeit under duress because of the injuries that they have suffered. Then the health service provider decides, not at what we have described as the eleventh hour, but let us call it the 13th hour—

too late, in my view—to say, “Actually, here’s your notice.” Would that be too late, or would that be allowable under the scheme?

Hon SUE ELLERY: The answer is yes. Irrespective of the person never having heard anything from the HSP —

Hon Nick Goiran: They can still send a notice.

Hon SUE ELLERY: — the HSP can still send a notice to the person. The question arises: how would they know? I mean, the hospital is not going to employ 20 000 detectives to go out and spy on people. But the answer is yes, the regulation-making power will create a head of power to say that it can seek that money from the individual.

Hon NICK GOIRAN: That is outrageous. We cannot have a situation whereby we say to a Western Australian, “Under the new law of Western Australia, because of this bill that is presently before us, you are obligated to tell us the truth, and if you don’t tell us the truth, we can prosecute you with a fine up to \$10 000.” The Western Australian then tells the truth to the health service provider, which is a subset of this massive WA Health scheme that we have—one of the seven health service providers. The person tells the health service provider that they are putting in a claim. The health service provider, for whatever reason—maybe it is busy with some other scheme that it is involved in or maybe it is sheer incompetence—does nothing and says nothing to this Western Australian. The Western Australian continues with their claim and receives their settled compensation. That is a final amount; they are not able to go and receive any further compensation from the compensation provider. The compensation provider says, “Forget about it; the chequebook is closed”, but the health service provider comes along after the whole event and says, “Guess what? Here’s your notice. You now owe us \$10 000.” That is not taken into account by any particular person. That is grossly unfair. I cannot imagine that that is the intent of this legislation. If it is allowed for in the bill at the moment, it ought to be amended. We should not be relying on some kind of policy document or guideline. We have not even drafted the regulations at this point. This is wholly inadequate.

I had hoped that we might finish the entire bill this evening, but, frankly, right now, I hope we do not, because if there is an opportunity during the recess overnight for part 6 to be looked at in light of this information, I think it would do everyone a good service. I appreciate that those are my observations and the minister is, as we recognised earlier, here in a representative capacity and there are limitations on what she can do in this circumstance. Equally, she will appreciate that we have a responsibility and duty to make the points that we think are important and need to be made.

Hon Sue Ellery: The description that you just gave is when the HSP in the first place inadequately followed its own procedures.

Hon NICK GOIRAN: Inadequately?

Hon Sue Ellery: Yes. That is the description you have just made.

Hon NICK GOIRAN: Yes, I agree, but then it would still be allowed to seek compensation.

Hon Sue Ellery: Whether it chooses to exercise that power when it is the one that has not followed up in the first place —

Hon NICK GOIRAN: I will give the minister another example, because that is the extreme scenario in which there has been gross incompetence by the health service provider. Another situation might arise. Let us say that information has been sought from the injured person. They have quite faithfully reported to the health service provider that they have a claim with the Insurance Commission of Western Australia. A settlement conference then takes place. Remember, we are talking about the government insurer. If anyone were in the advantageous position of being able to speak to one another, it would be the Insurance Commission of Western Australia and, for example, the North Metropolitan Health Service, but let us park that to one side. A settlement conference takes place in the morning and a settlement is achieved. The North Metropolitan Health Service has said nothing to the injured motorist; nor has it said anything to the Insurance Commission of Western Australia, but it sends a notice in the afternoon on the same day. In the scenario I painted earlier, it was quite some time later, when the person was back at home enjoying the fruits of their compensation. But this happens on the same day. It seems to me that in the scenario that the minister painted earlier, the North Metropolitan Health Service would be quite within its statutory rights to issue that notice on the same day, notwithstanding the fact that the settlement occurred earlier in the day.

The minister can see, in a very timely fashion, the unfairness that could get created in all of this. I think I have adequately made the point that I am not at all satisfied with the capacity for the health service provider to provide what I would describe as late notice, but should it do so, will the responsibility to pay lie with the injured person or will it lie with the compensation provider?

Hon SUE ELLERY: The policy setting is this: I am advised that some patients seek a claim and reach a settlement that includes payment for medical costs even though they did not pay for those medical costs. That is money they keep. What the head of power in this regulation-making bit is trying to achieve is to say that if part of a person’s

settlement was payment for services received at an HSP, the HSP reserves the right to seek to recover that money. If a person's compensation payment does not include a head of payment that goes to services provided by an HSP, the HSP will not pursue the individual. But if their head of payment includes a component for medical services that was provided by an HSP—and that person has spent the money on other stuff after receiving services and knowing that part of the claim included payment for those medical services—the regulations will provide that the HSP can pursue them for that component of the payment they received for services received at an HSP, but not for anything else.

Hon NICK GOIRAN: I absolutely get the policy intent and what is trying to be provided here, which, of course, was sought unsuccessfully in 2016. We are trying to remedy that situation. Whilst I am supportive of the remedy and the fix, I do not want to see an injustice occurring as an unintended consequence. I make the observation that I do not know of any situation in which an insurer will pay for a past medical expense in the absence of it having been expended by the person. Insurers are not interested in paying, full stop, let alone paying in the absence of proof that person X had to pay for service Y. Putting that to one side, the minister mentioned that there needs to be a component. Is that intended to mean that there needs to be an express component for past medical expenses? The health service provider will not try to recover future medical purposes, only those that have happened in the past. I think the minister said a head of damage —

Hon Sue Ellery: A head of payment.

Hon NICK GOIRAN: Yes, a head of payment—an express line for past medical expenses. If that happens, under the regulations that will trigger the capacity for the health service provider to issue a notice. In the absence of that, there is no capacity to recover.

Hon SUE ELLERY: I might get the member to repeat the first part of his question. Essentially, what I am advised is this: yes, the insurance payment may well include a component—what I refer to as a head of payment—for services received from a health service provider. The way this will be implemented is that it is intended that when the person says that they have lodged or intend to lodge a claim for compensation, they will be provided with a notice that includes the cost of the services provided and further advice of what to include in their application—what they should bring to the attention of their insurer. Therefore, the proposal is that the insurer will have that information and include it in any final settlement. At the beginning of his question the member asked something about notice?

Hon Nick Goiran: Does the compensation provided have to have that head of damage past medical expenses?

Hon SUE ELLERY: Is that specified?

Hon Nick Goiran: Yes, specified.

Hon SUE ELLERY: To make sure that I understand the question that the member asked, does the payment that the insurer makes have to include a specified amount for medical services received at the HSP. Is that the question the member asked?

Hon Nick Goiran: That's right.

Hon SUE ELLERY: The example that I am being given is: in a normal set of circumstances in which the two triggers, which the member described earlier, have applied and a notice has been issued saying, "The cost will be \$10 000, take this to your insurer and make sure it includes this in the settlement," the person may receive a global amount. However, the notice will not necessarily say, "Of this \$100 000, \$10 000 is for this." But in the proper course of events, that was fed into the process and because the HSP followed the process, it will get that money.

The advice I am given is that if something had gone wrong, such as the triggers had not been properly followed and the notice had not been properly given, it is likely that the HSP would be able to pursue the money only if the settlement that the person received included a specified amount. In that case, it could be clearly demonstrated that they specifically got the money for the service they received, and they sat on it or spent it, or whatever, and did not provide it to the HSP. It is not accurate—if I described it this way previously, I am correcting the record now—to say that every compensation payment will include compartmentalised specified components.

Hon NICK GOIRAN: If the HSP had issued a notice, even a late notice, and it was satisfied that it should pursue its right to recover, the intention is that it would do that only if it was satisfied in its own mind that it would be able to demonstrate that there was a head of damage for past medical expenses. It is particularly complicated in the scenario to which the minister referred earlier, such as when global payments are made. It is further complicated when factors such as contributory negligence are involved and percentages are applied and the like. In all those circumstances, would they chase the patient or the compensation provider?

Hon SUE ELLERY: If compensation had not been paid, it would be the insurer. If compensation had been paid, it would be the patient. However, bear in mind the conversation we have just had about whether they will expend the money to pursue that if they have no idea that a specified component of that payment was for services provided.

Hon NICK GOIRAN: Where are the two provisions in the proposed amendment to part 6 that will enable the HSP to pursue the compensation provider, and, in the second scenario, the compensation receiver?

Hon SUE ELLERY: Does the member have the blue bill? Proposed section 57A(3) on page 52 states that the HSP may recover the compensable charge payable from either a compensation payer, the patient or the patient's estate, or another person who receives compensation on behalf of the patient. Proposed section 57D on page 54 of the blue bill, "Recovering amounts from compensation payer in relation to compensable charges", states that this section applies if a compensation payer has not paid, or has partially paid, compensation.

Hon NICK GOIRAN: Is the replacement recovery scheme in part 6 modelled on something else? The Department of Health has worked out that the 2016 version does not work. Has the Department of Health gone elsewhere to see what does work, such as in New South Wales or at the commonwealth level?

Hon SUE ELLERY: I am advised that it is based on commonwealth legislation. We will try to get the name of the act, but I think it is called something like the Health and Other Services (Compensation) Act.

Hon NICK GOIRAN: Is it the case that Medicare was consulted on the recovery regime that it implements?

Hon SUE ELLERY: No.

Hon NICK GOIRAN: Before the regulations are drafted, might I suggest that that might be an excellent place to start because those guys have been doing it for a very long time and it does not have all the problems that we have been discussing tonight.

If a notice is issued, will that then freeze the levy at that point in time or can subsequent notices be issued?

Hon SUE ELLERY: I might get the member to ask that question again.

Hon NICK GOIRAN: We have discussed the scenario of the health service provider requesting the information. The health service provider will then issue the notice. The minister referred us to proposed section 57D, which indicates that the intention is that the health service provider will provide this notice to the compensation payer. Proposed section 57D(2) states—

The compensation payer must pay the compensable charge to the health service provider before paying the compensation to the patient or patient's estate.

My question is: is that it? The health service provider will get one chance. Will it issue a notice or will it have the capacity to issue a revised notice or multiple notices, including a notice after the compensation has been provided?

Hon SUE ELLERY: It is not the intention for the HSP to go back again and again, but a regulation-making power in proposed section 58(2)(f) says that a person in receipt may seek review. So it might be envisaged that the HSP could revise down, for example.

Hon Nick Goiran: I am not worried about going down.

Hon SUE ELLERY: But whether it goes up—there is no intention to do that.

Hon NICK GOIRAN: In a dream scenario in which we do not finish this bill tonight and there is a capacity overnight to enshrine that intention, I think that would be a good thing. It seems to me quite improper that the health service provider could issue a notice, the compensation provider would comply with that and provide the balance of the compensation to the individual and then an extra notice would be issued.

Hon Sue Ellery: In what circumstances do you envisage that the extra notice is issued?

Hon NICK GOIRAN: I would hope never, but let us say for example that a settlement has been achieved and the next day the person is booked in for some form of surgery at Royal Perth Hospital. The notice has been issued, as far as I am concerned, and that is the end of the matter. The health service provider should not be seeking to try to recover anything further at that point in time. This is why I have suggested that there ought to be some consultation with Medicare, because when Medicare issues a charge, the charge is frozen for a period of time. I cannot recall how long; it might be three months or six months, but there is a period of time in which, if there happens to be anything else added to the tab after that, too bad—the commonwealth government will wear it, and —

Hon Sue Ellery: Further treatment related to the original —

Hon NICK GOIRAN: That is right, because otherwise, next there will be a time when the notice comes to an end. Is that something that can be at least considered, since the intention is not to do that, and it can be enshrined in the legislation?

Hon SUE ELLERY: I understand what the honourable member is trying to get at and so do the advisers. I give the member my undertaking that I will raise this with the minister. We think it could be captured under proposed section 58(2)(f)(i) —

how the health service provider may recover the amount;

That is where there could be included a limitation or a cap on how the recovery might apply. That is where it could be covered. I am not going to give the member a commitment to seek permission to amend or anything like that. The point he makes is understood and agreed. It is not the intention to have ongoing, endless bites of the cherry. It is about recovery for costs already expended; it is not looking to the future, but we think that is probably the regulation head of power that could capture that.

Hon NICK GOIRAN: I thank the minister for that further advice. We already discussed earlier whether there has been any consultation with Medicare and there was an indication that there has not been. Has there, however, been consultation with regard to this recovery scheme with compensation providers—for example, the Insurance Commission of Western Australia or, even though it is not a compensation provider, perhaps another government statutory body like WorkCover?

Hon SUE ELLERY: I am advised that the Insurance Commission of Western Australia has been consulted. I do not have any detail here on the extent of that consultation, when it occurred, or the issues raised within.

Hon NICK GOIRAN: I know that once upon a time—I do not know whether it still does it or not—the insurance commission used to make some form of payment to the state for these unrecovered medical expenses that the minister referred to. It was a lump sum to the state to try to globally cover this type of scenario. I do not know whether that arrangement exists at the moment.

Hon SUE ELLERY: No. The advisers here are aware that there is dialogue about that, but I cannot tell the member whether there is any specific arrangement in place.

Hon NICK GOIRAN: I think the minister has indicated that the intention is that the scheme is going to apply not only for motor vehicle accidents, but also for workers' compensation matters. Remembering that the minister said earlier that the policy here is only intending to try to recover past medical expenses, if a notice has been issued and the worker has exhausted their initial cap of medical expenses and the only way in which they can get any further money for medical expenses is to make an application to WorkCover WA for an extension, what will happen in that scenario? Will the health service provider assist the injured worker to make the application to WorkCover? Remember, in this situation there is nothing in it for the worker. The health service provider wants to recover \$10 000, but the worker could not care less because they have not paid it. They have received their final wages and so forth. Their claim is extinguished. Technically, there is this capacity to apply for this further \$10 000. Someone would need to make an application to WorkCover. Will the health service provider be intending to assist the worker to make that claim? Will they be providing the legal costs for the application to be made? How would that work in a workers' compensation claim where a specific application would have to be made in order to access the funds?

Hon SUE ELLERY: I am advised that it will be voluntary. The worker will not be compelled to make the claim. If there is no claim made and no consideration by the insurer to provide funds, that will be it; the HSP is not going to pursue it. The HSP will advise the worker that they could make a claim, but it will be entirely voluntary. There is not going to be any bureaucracy put in place to assist or insist that the worker do that.

Hon NICK GOIRAN: Let us imagine a scenario in which the worker has a significant back injury. In addition to that, they have some form of psychological injury. All of their psychological treatment has already been paid for and has exhausted that cap of money, but through the public health system, the health service provider has provided some kind of back operation, and would like to recover those fees. The person has been compensated for the past expenses for psychological treatment, but they cannot get any more money without making an application. In that scenario, are we saying that the health service provider would effectively concede that it no longer has a statutory right to pursue this person, and that it will not?

Hon SUE ELLERY: I go back to what I said before: it will be voluntary. The HSP is not going to be in a position to demand that the individual worker make that claim. The language the honourable member used to describe it was: will the state cede that? Yes, the state will cede that.

Hon NICK GOIRAN: I am glad that we are getting all this on the record, because I think that quite a few lawyers and insurers in Western Australia will be poring over *Hansard* in due course. This proposed provision, which will come under part 6, has what I would describe as a carve-out provision at proposed section 53B(2) that specifies that "compensation does not include a payment of a kind, or in circumstances, prescribed by the regulations". What types of payments of compensation are intended to be excluded from this scheme?

Hon SUE ELLERY: Payments under a scheme of insurance, such as life insurance or health insurance, to which the recipient has themselves contributed are excluded from the definition of "compensation" under proposed section 53B(1)(a)(ii).

Hon NICK GOIRAN: Proposed section 53B(1) states that —

... *compensation* is a payment —

- (a) made in relation to an injury to a person (whether or not the payment is made to the person who suffered the injury and received the health service or former hospital service) that is —
...
- (ii) a payment under a scheme of insurance or compensation under a written law or a law of the Commonwealth, a State or a Territory, but not including a payment under such a scheme to which the recipient has contributed; ...

In other words, that carve-out already exists in proposed section 53B(1)(a)(ii). My question is: what is intended to be covered by proposed section 53B(2), which states —

However, *compensation* does not include a payment of a kind, or in circumstances, prescribed by the regulations.

Hon SUE ELLERY: Hon Nick Goiran, I am advised that regulations made under proposed section 53B(2) will prescribe payments that are excluded. At this time, it is not intended that any types of payments will be excluded. The provision has been included to allow for circumstances that might arise in the future. Don't shoot the messenger.

Hon NICK GOIRAN: At this present time, it is not intended to exclude any kind of payment or circumstances. That is fine; that is the intention at the moment. Thank goodness proposed section 53B(2) exists, because then there will, hopefully, be circumstances whereby ministers might be inclined to use this regulation-making power. One example I want to give the Leader of the House is national redress payments. Once this bill comes into effect—as I understand it, it will be fully operational in three months' time—is it intended that health service providers will seek to recover from victims of child sexual abuse? In four months' time, if somebody gets a national redress payment, are health service providers going to chase them?

Hon SUE ELLERY: That is a good point that has not been contemplated, but the member is quite right. The provision we have just discussed in proposed section 53B(2) would allow regulations to specifically exclude that, but it has not been contemplated.

Hon NICK GOIRAN: A similar case could be made for victims of crime in Western Australia who might make an application under the Criminal Injuries Compensation Act. There, the compensation provider is the state of Western Australia. Might I suggest to the government, respectfully, that it would be pointless for one arm of the government, a health service provider, to try to chase down money from a consolidated fund. If I might make the general observation, I think one of the Treasurers of the Liberal government used to say that Health had an insatiable appetite. I am sure most Treasurers would probably say that. I can see that a health service provider might well want to try to extract more money from the consolidated fund. Whilst the two government entities or the two arms of government might play this game—I do not use that in a derogatory way—about which silo this money will ultimately sit in, my concern is that we will create yet another circumstance whereby a victim of crime becomes ineligible for compensation.

I go to the scenario that Hon Martin Aldridge was touching on earlier. Could this scheme create a situation in which it becomes off-putting and a barrier for person to make an application in the first place? What will happen if a victim of crime has been so badly assaulted over an extended time that they have, let us say, had medical expenses exceeding the statutory limit of \$75 000 and the criminal injuries compensation assessor says, "Yes, I acknowledge that you have been assaulted; I acknowledge there has been a conviction, but you will receive nothing because in actual fact all the money is going to go to the health service provider"? I cannot imagine that any person in government wants to see that scenario happen. I acknowledge that the Leader of the House has said that the National Redress Scheme has not been considered at this point in time, but hopefully will, for exclusion under proposed section 53B(2). Has criminal injuries compensation been considered or is it intended that it will be applying for that scheme?

Hon SUE ELLERY: Honourable member, there is no intention to be seeking payment out of the criminal compensation injuries scheme, but again I make the same point I made in respect to redress. Proposed section 53B(2) is the section if government wanted to make explicit its intention in the regulations. That is where we would do it; that is the head of power that would make a list of exclusions that could include redress and the criminal injuries compensation scheme.

Hon NICK GOIRAN: I think all those matters give the government a reason to pause and think about part 6. Is there any appetite to defer consideration of the proposed sections to be inserted at part 6 and we progress with the amendments to part 7?

Hon SUE ELLERY: No, honourable member. I do not say that lightly and I understand the member's motivation and that he probably brings some personal experience in dealing with compensation matters before he entered Parliament. I will say nothing about the member's motivation or whatever. I have noted the issues that the member has raised and I have given responses that I think are reasonable. I do not intend to put this clause aside to ask the

minister to consider changing the policy settings. The member may disagree, but I think there is provision in the regulation-making power to address the issues that he has raised.

Hon MARTIN ALDRIDGE: We have been ranging over the entirety of part 6 in this discussion rather than necessarily confining it to clause 28. My intention is that once we have exhausted our questions, we will move on from part 6, but I have a couple of questions about part 6; one seeks some confirmation. On clause 29, the explanatory memorandum says —

... the new section 55 gives HSPs the power to determine and impose fees and charges for the provision of health services.

That gave me cause for concern. On clause 31, paragraph (b) of the explanatory memorandum says —

the fees charged by a HSP under section 55 will be consistent with fees set by the Health Services (Fees and Charges) Order 2016 made by the Minister or, if no fee has been set, will be determined by the HSP in accordance with the fees and charges fixed by the Department CEO (in a policy framework).

I want to put this beyond doubt. On the one hand, the EM says that HSPs will have the power to determine fees, but will they really be able to if we consider that, on the other hand, the EM on clause 31 suggests that uniform pricing will be applied to the services provided by HSPs?

Hon SUE ELLERY: I do not know whether the honourable member recalls the conversation I had earlier with Hon Nick Goiran, I think, about tiered decision-making. That is where that is captured. Ultimately, there will be the power for the CEO to step in when the HSP legitimately exercises its powers under tier 2 of that hierarchy and say, “No. For the purposes of consistency, you need to revisit that.” If it helps the honourable member, I will repeat what I said.

The purpose of proposed section 55 is to give HSPs the power to determine and impose fees and charges in accordance with the following regime. No charge: an HSP cannot determine and impose a fee or a charge when it has been agreed under a national health reform agreement that they cannot do that or when the minister has determined that no fee or charge is to be imposed—for example, for asylum seekers. Charges can be fixed by the minister. That is tier 1. HSPs are not to be permitted to determine and impose fees that are inconsistent with that. Tier 2 is charges fixed by the department CEO. HSPs are not to be permitted to determine and impose fees for health services that are inconsistent with any policy framework issued by the department’s CEO. Tier 3 is charges fixed by the HSP. The HSP may otherwise determine its own fee or charge for a health service. I went through the examples of when that is possible. That is the kind of hierarchy of fee setting.

Hon MARTIN ALDRIDGE: In one sense, it would be a strange circumstance if Western Australians were charged different fees by a public health service for the same service. I appreciate that some HSPs may have different costs. I think the costs associated with the WA Country Health Service delivering a service in a remote location are probably not the same as for North Metropolitan Health Service, so there will be variability. I would think it would be difficult from a public policy perspective to then defend setting a fee and charging a patient at a different rate for the same service as a public patient. Is tier 3, whereby there is scope for HSPs to set their pricing, when an HSP may perhaps provide a specialised service that is unique to its service, such as —

Hon Sue Ellery: Child health services is a good example.

Hon MARTIN ALDRIDGE: Yes, that is a good example, as opposed something that would be delivered by every HSP in Western Australia such as dealing with a fractured arm or something like that.

Hon SUE ELLERY: That is my understanding of it, honourable member.

Hon MARTIN ALDRIDGE: Another issue I want to take up here is found at clause 31(e) and (f) of the explanatory memorandum. I would like to get an appreciation of the government’s policy underpinning pursuing somebody who has died to recover the costs of providing medical services.

Hon Sue Ellery: Awkward.

Hon MARTIN ALDRIDGE: Yes. Paragraph (e) anticipates that an HSP may pursue to recover the compensable charge from the patient or the patient’s estate, and paragraph (f) anticipates recovery —

if the compensation payer has not paid, or has partially paid, the compensation to the patient or the patient’s estate, the compensation payer is to pay the compensable charge to the HSP before paying the compensation to the patient or the patient’s estate ...

Obviously, the policy that we are pursuing specifically targets the patient, whether they are dead or alive, effectively. I am wondering what worth there is in pursuing these matters after someone has died.

Hon SUE ELLERY: It is important to go back to the purpose of this provision, which is about the recovery of fees for services provided. If an estate has received payment for those services provided, it is not unreasonable for the state to pursue that.

The DEPUTY CHAIR (Hon Dr Brian Walker): Honourable member, before you proceed with more questions, you have thoroughly confused the chair. I need to ask: are we still on clause 28, because we seem to be ranging far and wide?

Hon MARTIN ALDRIDGE: I think the term is that we are seeking the indulgence of the chair to have a broad-ranging discussion on part 6, which is clauses 28 through to 32, because they all intersect. But, strictly seeking, no.

Hon Sue Ellery: We did not seek your permission, chair.

The DEPUTY CHAIR: With members' indulgence, I will put the question later to include clauses 28 to 32.

Hon MARTIN ALDRIDGE: I can anticipate a circumstance in which someone seeks medical treatment and perhaps their death is not related to either the injury or the medical treatment they received. Their death could have occurred months, if not years, afterwards. Their death could be completely unrelated to the health care they received. In my mind, I was probably thinking about someone who had died as a result of an injury. I would have thought that making a claim for compensation or damages in those circumstances may well be quite different from someone who was living, and that the damages that may be provided may be claimed through the form of a life insurance payment. I guess damages could be paid if the claim was made for a workers' compensation injury. I am just wondering whether this is a matter that needs to be pursued. I accept the government's position, which in principle is that it is about recovering the costs of service provision where it is payable to that person, whether they are alive or not.

Hon Sue Ellery: Correct, honourable member.

Hon MARTIN ALDRIDGE: I was listening intently to the conversation between the minister and Hon Nick Goiran around potential other sources of compensation. There is probably not an exhaustive list. There are probably many when we consider paragraph (ii) of proposed section 53B(1)(a) —

a payment under a scheme of insurance or compensation under a written law or a law of the Commonwealth,
a State or a Territory ...

An endless number of schemes probably exist. I was contemplating that while the minister and the member were having that exchange about some of the redress schemes for police officers. I am not an expert in this area but we have had a redress scheme and now we have a medical retirement scheme for police officers. That may well be something that ought to be contemplated, although one would think if an injury occurred in the course of a police officer serving—although it is not workers' compensation in the strictest sense because police officers are protected differently from other workers—those costs would be met by that scheme separately from some sort of redress or medical retirement, or even the criminal injuries compensation scheme that Hon Nick Goiran talked about. The point I am making is the more we think about this, the wider the net grows in potential. My initial thought was that it is going to be a workers' compensation and motor vehicle personal injury arrangement. They may well still be the bulk of the things we are talking about but I think there are probably some more discrete schemes that perhaps fewer people access, but would still potentially fall within the scope of this bill. It is not technically a question. It is more of a comment.

Hon Sue Ellery: Noted. By interjection, a whole range of those discrete programs may well end up being captured by the exclusion provision. That is not a commitment on my part to do that, but that is how those things might be captured. The member's assessment is right; the intention is primarily around motor vehicle insurance, workers' compensation and the like.

Hon MARTIN ALDRIDGE: With the regulation-making power, as those things become known, probably through experience, that list can grow over time. The other observation I would make is, as I understand it, hospital public health service funding is based on activity through a national agreement between the commonwealth and the state. I think Health needs to be mindful of pursuing compensation where that compensation is payable by a state entity or a state fund and it may well be counterproductive because it could be letting the commonwealth off the hook in its activity-based funding contribution.

Hon Sue Ellery: Correct. The member would recall an earlier discussion in which I mentioned that there may be fees and charges that are unable to be set because they are covered by a national health reform agreement, for example.

Hon NICK GOIRAN: I know that the deputy chair is keen for us to move off clause 28 but, before we do that, I want to draw to his attention and the minister's attention and those members following that clause 28 ends at page 26 at lines 29 through to 31 with a proposed subsection that reads —

- (2) However, **compensation** does not include a payment of a kind, or in circumstances, prescribed by the regulations.

In the exchange I had with the minister earlier, it was made clear that at that time, and prior to the introduction of this bill and the debate today, the government had no explicit intention to prescribe anything in the regulations under that provision. I make no criticism of that. That is simply a statement of fact. But it is the case that we have exhaustively considered clause 28 and a range of scenarios in which it would be plainly unjust for a health service provider to seek to recover compensation from certain persons. Two such scenarios were explicitly canvassed. The first is under the National Redress Scheme. Let us stop and think for a moment here that these people make an application under a commonwealth-supported scheme for abuse that they have suffered at the hands of an institution—historical sexual abuse—and it is now clear that it is not the government’s intention that health service providers should be able to recover in those circumstances. It is also now clear that it is not the government’s intention that health service providers be able to recover from victims of crime, specifically under the Criminal Injuries Compensation Act 2003. I asked earlier whether it was possible for this part to be deferred to a later stage and I respect the decision that has been made, albeit I hold a different view. I move an amendment to clause 28, specifically —

Page 26, line 31 — To delete the line and insert —

regulations, or under the National Redress Scheme for *Institutional Child Sexual Abuse Act 2018* or the *Criminal Injuries Compensation Act 2003*

The DEPUTY CHAIR: I am advised that you can speak to your amendment, but we are waiting for that to be tabled.

Hon NICK GOIRAN: I am happy to do so. I think that it is fair to say that, for those who have been following the debate, it has been extensively canvassed. I think that in fairness there is not a disagreement between me and the government with respect to the intent of this. It is just a question of how it might be best captured. My considered view is that there is no good reason why we cannot do this now. I quite genuinely put to the Leader of the House that another alternative is that we could defer consideration on this bill so that, in fairness, the minister, who has had no notice of this—along with the representative minister—might be able to consider this overnight. We have literally 20 minutes left before members’ statements are taken. I see no reason that we cannot start the next bill. I am sure that those with the carriage of that bill might be in a position to do that. We would then be in a position to come back to this matter tomorrow and settle a position on it.

If I can indicate to the minister, for what it is worth, although I have some other questions on this bill, it was always my view that part 6 of the bill was probably going to create the most trouble and I think that the rest of the bill can be passed relatively efficiently if we can get past this matter. I offer by way of suggestion that the honourable Minister for Health might have an opportunity to consider this amendment overnight. It is even quite possible that the government may come back with an improvement, if I know it and the drafters. I make that suggestion. Otherwise, I ask members for their support for the amendment.

Hon SUE ELLERY: I indicate that we will not be supporting the amendment. I understand the member’s motivation, and I would agree with him that if we were going to use the regulation head of power to exclude certain schemes from being compensable, it would be important that these two be on that list. But there is a regulation-making power so that we can consider the appropriate things to be excluded, and we have the capacity to do that. I am advised by those at the table that there has been no intention stated by government that we intend to pursue compensation through either of these two schemes.

As I said, I understand the honourable member’s motivation, but we will not be accepting the amendment. We think that the regulation-making power gives the government the capacity to exclude schemes that clearly should not be contemplated to have compensation sought from.

The DEPUTY CHAIR (Hon Dr Brian Walker): Might I confirm with the Leader of the House, is it your intention that I put this question to the chamber, deal with it and move on?

Hon Sue Ellery: Yes.

Hon NICK GOIRAN: In response, what the minister has said is not unreasonable. I simply make this point. The minister seeks for us to rely on the fact that a regulation-making power is available. That is not in dispute. Clause 28 before us seeks to insert section 53B(2), which will plainly insert the capacity for this government or a future government to regulate which schemes of compensation would be carved out. That point is conceded. The point of the amendment is to ensure that whether it is the McGowan government or any other government, it is to be enshrined in statute now that whatever that government might do in respect of the regulations, it is absolutely the case that there will be no recovery against those who have had a national redress payment, and there will be no recovery against those who have been victims of crime. I understand that the government accepts that that will not happen; therefore, there should be no problem putting it into the legislation so that there will be no errors here.

The minister knows that when a regulation is made, there is capacity for members to move a disallowance. The minister also knows that we cannot disallow parts of a regulation; we have to disallow the whole regulation. The minister also knows that when disallowance motions come on, with all due respect, we are given about five minutes, maybe 15 minutes, at best half an hour, to have a debate about a serious matter, whereas we have the opportunity now to indicate to victims of crime and those who are survivors of institutional abuse that under no circumstances will a Western Australian health service provider seek to recover money from them. It is worth us supporting this amendment. I acknowledge that the government is not going to, but I call on other members to do so.

Division

Amendment put and a division taken, the Deputy Chair (Hon Dr Brian Walker) casting his vote with the noes, with the following result —

Ayes (6)

Hon Martin Aldridge
Hon Donna Faragher

Hon Nick Goiran
Hon Tjorn Sibma

Hon Neil Thomson
Hon Colin de Grussa (*Teller*)

Noes (18)

Hon Klara Andric
Hon Dan Caddy
Hon Sandra Carr
Hon Stephen Dawson
Hon Kate Doust

Hon Sue Ellery
Hon Lorna Harper
Hon Jackie Jarvis
Hon Kyle McGinn
Hon Shelley Payne

Hon Stephen Pratt
Hon Martin Pritchard
Hon Rosie Sahanna
Hon Matthew Swinbourn
Hon Dr Brian Walker

Hon Darren West
Hon Pierre Yang
Hon Peter Foster (*Teller*)

Pairs

Hon Dr Steve Thomas
Hon Peter Collier
Hon Steve Martin

Hon Dr Sally Talbot
Hon Samantha Rowe
Hon Ayor Makur Chuot

Amendment thus negated.

Clause put and passed.

Clauses 29 to 34 put and passed.

Clause 35: Section 66 replaced —

Hon MARTIN ALDRIDGE: Clause 35 will replace section 66. One of the matters that I canvassed in my contribution to the second reading debate was about notices of financial difficulty by health service providers. The first observation I will make—perhaps it is an unreasonable one, and the minister might be able to correct me—is that I thought that our health system was always in financial difficulty. I thought that the health department almost had free rein to overspend its service allocations in the state budget. There were some examples. Forgive me, but I cannot recall whether the minister provided some further detail in her reply. I understand that there were two instances in which a notice of financial difficulty had been raised by a health service provider under the current section 66. I am not sure whether we got into the detail of which providers they were and the circumstances and whether they were substantiated. I think this is where we are going in the main with the reform. It anticipates a circumstance in which the department CEO may form a different view from the health service provider about its declaration of financial difficulty. Perhaps we could start by understanding the two instances that are known. What information do we have on those?

Hon SUE ELLERY: I can advise that following the commencement of the act in July 2016, there have been two instances in which a notice of financial difficulty has been raised by an HSP under section 66. In each instance, the notice was triggered mainly due to a forecasted budget deficit position at the end of financial year rather than an imminent cash shortfall. It was, effectively, managed within the WA health system. Neither HSP was in financial difficulty. As the system manager, the department CEO determined that the best action to take at the time was to provide system support by monitoring the HSPs' cash position during the financial year. At the end of the financial year, the HSPs were not in financial difficulty and they were able to satisfy the financial obligations that were due from available financial resources. The amendments will allow policy frameworks to provide more detailed guidance to HSPs about when it is appropriate to issue a notice of financial difficulty.

Hon MARTIN ALDRIDGE: A couple of questions flow from that. Does the minister know the years in which the two instances occurred and which health service providers were involved?

Hon SUE ELLERY: I am advised that the government does not want to disclose the names of the HSPs on the basis that it was not actually financial difficulty. Yes, they lodged a section 66 notification, but it was not about cash flow; it was about whether or not they anticipated that they would be within budget. I am the representative minister; I cannot do more than that. The member has other avenues by which he can seek to have that information provided.

Hon MARTIN ALDRIDGE: It is interesting that the minister advised that the government's position is that it does not want to disclose that information. I remind the government advisers that there is an obligation under section 82 of the Financial Management Act to advise the Auditor General as to why that non-disclosure is required. I do not think it is material to advancing this point, although I would not have thought that it is not one of the state's biggest secrets. Nevertheless, I can appreciate that it might cause embarrassment to the health service providers involved, depending on how recently the instances occurred.

One of the things that is changing with the redesign of section 66 is effectively the chief executive officer or department CEO capability. Currently, section 66 empowers the board to effectively fly a red flag and say, "We've got a problem." What is the policy reason behind removing the board—the governing body of a health service provider—and its right to perhaps have a different view from the CEO of a health service provider and declaring or giving a notice of financial difficulty?

Hon SUE ELLERY: I am advised that it is still the board; it is a bit convoluted to get there, honourable member. Proposed section 66 refers to the accountable authority. The accountable authority—the member would then need to go and look at the definitions—refers to the Financial Management Act. The Financial Management Act refers to the person or body having the general direction and control of, and overall responsibility for, the operations et cetera.

Hon MARTIN ALDRIDGE: Thanks, minister, for clarifying that point. Therefore, it will continue to be an instrument available to the board. Will it be available to the board exclusively or will we be empowering the chief executive officer to make the notification? It is currently a board power, but will it remain a board power once this provision is proclaimed?

Hon SUE ELLERY: The advice I have is that it is the board. The chief financial officer of the HSP might be the person with the responsibility for collating the information, but ultimately they will provide that to the board, and it is the board that will determine whether it intends to raise an issue under proposed section 66.

Hon MARTIN ALDRIDGE: Okay, so that issue is not changing. The other concern that I have with clause 35 is that we are effectively removing the notification to the minister. I understand that we are now putting another step in the process, which is that the board will fly the red flag, say it thinks it has a problem, the department CEO forms a different view, and the minister will be none the wiser. I expect the government response will be that the minister meets regularly with these CEOs, and the government is sure that the CEOs will let the minister know what is going on. Some of these health service providers are large financial entities; they are bigger in their own right than many government agencies. A board-governed entity could form a view that it was in financial difficulty, and one person, the department CEO, could form a different view, and the minister would be none the wiser. That worries me a little. I would have preferred the government to retain the requirement that the minister be notified. That might not prevent the department CEO from undertaking further investigation or remedial action.

Progress reported and leave granted to sit again, on motion by Hon Sue Ellery (Leader of the House).