HEALTH SERVICES AMENDMENT BILL 2021

Second Reading

Resumed from 15 November.

HON MARTIN ALDRIDGE (Agricultural) [2.00 pm]: I rise as the opposition's lead speaker on the Health Services Amendment Bill 2021. I indicate at the outset that not only do we support the bill, but also the bill has been a long time in the making. If I recall correctly, I recently received my third briefing on the bill. Given the time that has elapsed, if I did not support the bill, I would be inclined to do so just so that I did not have to be briefed on it one more time! It is quite an extensive bill. For those who have turned their mind to the bill, they will know it has some 89 pages and 99 clauses. It will do a range of things, but before I get to that—Hon Dan Caddy's favourite word—I want to put on the record that this bill was first introduced in the Legislative Council in September 2020, after first proceeding through the Legislative Assembly, where it was first introduced in October 2019. It obviously lapsed with the prorogation of the last Parliament and was reintroduced in the Legislative Assembly on 24 June 2021, and we received it on 15 November this year. It is fair to say that this bill is the lowest priority of the government, and the only reason we are considering it today on the last sitting day of the year is that it is the only bill that can be considered today, 1 December 2022. For those members who have access to today's notice paper, I can tell them that it is the only bill that can be considered today under our standing orders, after we earlier dealt with the Medicines and Poisons (Validation) Bill 2022, which was declared urgent. This is the only government bill that can be dealt with in the time remaining today.

Hon Martin Pritchard: If you finish it, we could go home!

Hon MARTIN ALDRIDGE: So the member wants to knock off early! This is quite an extensive bill, honourable member, and even though it is the last sitting day of the year, we still have quite a bit of work to do.

One of the things that I probably have not fully turned my mind to between the 2019 vintage and the 2021 vintage of this bill is whether any material changes have been made between the bill that was introduced in the last Parliament and the bill introduced in this Parliament. If I recall correctly—I really am going on my recollection—there was a supplementary notice paper and, indeed, I think amendments were made by the Legislative Assembly to the bill that was passed in the last Parliament. Because of the passage of time in dealing with the bill, I think they related to the passage of other bills at the time. The Procurement Act comes to mind and maybe even the Western Australian Jobs Act might have had an impact on the 2019 bill. It would be good to know when we get to the second reading reply whether any other substantive changes have occurred in the course of the reintroduction of the bill that is before the Legislative Council today.

As I said, I have been the beneficiary of a number of briefings on this bill. I think about an hour was allocated to the briefing. To get across the range of different measures and policy intents in the bill, it takes a good 45 to 50 minutes, and that would probably not cover it in any great detail, which does not leave a lot of time in the briefing to ask many questions, so a few will have to be dealt with during the committee stage as we work through the bill. Given the time that we have left this year, we will probably ultimately deal with this in February next year, if indeed this bill remains a priority of the government in February. I hope it will—so that we do not have to have another briefing in 12 months' time to progress the bill!

The bill will make a number of key changes. I will touch on the key ones and leave some of the more minor matters for the committee stage. As I was advised, when the 2016 act was operationalised, a number of implementation issues were experienced. One of those issues relates to land management. The current act sought to transition land and property held by various health organisations—primarily former hospital boards—to the ministerial health body. Following the proclamation of the act, it was determined that this was not achieved effectively. My notes say that some 49 sites did not transfer over and have remained the responsibility of the Department of Health and that these predominantly relate to staff accommodation. I might pause there, because this was one of the questions about land that I asked at the briefing. I was told that 49 sites did not transfer over to the health ministerial body but remain the responsibility of the Department of Health and that this land and property is predominantly staff accommodation. It could well be the case that it is predominantly in regional areas, where staff accommodation is often found alongside, or in the vicinity of, health facilities. That was in the supplementary information that I received on 22 November. About half an hour later, I received a clarification that 49 sites are held by the Crown or the state of Western Australia and these remain the responsibility of the Department of Health, and that the land and property that is held by the Crown or the state of Western Australia is predominantly staff accommodation. I received a further email on 30 November from the minister's office that provided further clarification. It states —

> Since the below advice was provided, Department of Health Infrastructure Unit has provided us with revised advice, and the correct number of sites held by the State/Crown is 41. Not 49 as previously advised.

Given that this was an issue with the implementation of the 2016 act, it would be good to get some certainty around the land issues, particularly as I have been given three slightly different responses in a very short period. I understand

that this bill will address the original oversight by allowing the minister to make orders for the transition of all freehold property and crown reserves used for the purpose of providing health care to either the ministerial health body or to a health service provider. As I understand it, there will be a mechanism to deal with land that is not captured following the passage of this bill via the minister being able to make an order, but it would be good to at least understand what we are talking about. I understand that at this point in time, 41 parcels of land, predominantly for staff accommodation, are the subject of these measures.

The other reform relates to capital works and the development of a new framework that will clarify the roles and responsibilities for the delivery of capital works and maintenance works, and provide greater flexibility in the delivery of those works. The main amendment will allow for the insertion of proposed section 20A, which is intended to improve the capital works and clinical commissioning of new public health service facilities by WA Health. The exercise of powers under this section will be subject to the Procurement Act 2020. Currently, only the department CEO provides this function. Proposed section 20A will establish the CEO as responsible for the overarching strategy for capital works and maintenance, and they may delegate works to be delivered by a health service provider. Generally, the CEO will retain responsibility for the commissioning and delivery of capital works of major or high-risk public hospital projects, such as the new women's and babies' hospital, while health service providers will be responsible and accountable for lower value projects.

As I indicated earlier, these amendments are all within the wider framework established by the Department of Finance under the Procurement Act 2020 and are subject to agency-specific directions under that act. Capital works and clinical commissioning are not expected to be the subject of a separate policy framework. If a health service provider is given any particular responsibility for the delivery of capital works or commissioning, the responsibilities will be a term of the service agreement between the director general and the health service provider and will be monitored and reported on within that context.

One other aspect of the bill in which I took some interest deals with the recovery of compensable fees and charges. To be honest, I do not quite fully understand it, so it will be interesting to explore it more fully in the committee stage. The bill will amend part 6 of the Health Services Act to establish a new and more comprehensive and effective scheme for the recovery of fees and charges from patients who sustain compensable injuries and receive treatment at a public hospital. The new scheme will allow health service providers to recover charges for the cost of health services from patients in situations in which the patient has either not disclosed their compensation or has received compensation after the treatment has been provided. It is intended that this will provide greater certainty to compensable patients regarding the fees that will be charged for the health services they receive.

At the briefing, I asked a number of questions about how this provision will work in practice. Initially, I thought it was a provision to enhance the public health system's capacity to recover funds from privately insured patients, but was advised that that is not the case. Rather, it relates to patients who sustain injuries, say in a motor vehicle accident or in the workplace, and are able to claim expenses through compulsory third party insurance or workers' compensation. I want to get a greater understanding of how these provisions will work practically, given the amount of time that may pass between a person sustaining an injury and making a claim and the claim being assessed and settled and some form of payment being made. It could be months, if not years, in the making. I want to understand how these provisions will help in practice, particularly for motor vehicle injuries and the role that compulsory third party insurance plays in providing everybody injured in a motor vehicle accident with cover for the injuries they sustain. I asked whether there were any information-sharing provisions with the Insurance Commission of Western Australia, for example, which is the body that would receive, assess and determine claims of this nature. It is not clear whether that will remain a voluntary process and this is just a way of recovering fees and charges when they become known to the health service provider.

The bill will also clarify who is the employing authority for employees of health service providers. Clause 45 confirms that for all employees, other than chief executive officers, the employing authority is the board for board-governed health service providers. To the best of my recollection, the only health service provider in Western Australia that is not board governed is the Quadriplegic Centre; all other health service providers are board governed. Clause 45 is the relevant part of the bill that sets out the employing authority; it is the board for board-governed HSPs and the chief executive for chief-executive governed HSPs. In board-governed health service providers, the board is the employing authority and has responsibility for the transfer and dismissal of employees.

I asked at the briefing whether this is a contemporary or modern governance structure for board-governed health service providers, which is effectively all of them, bar the Quadriplegic Centre. I asked whether it is normal for the ability to hire and fire to rest with the board rather than the chief executive. I was told that the Health Services Amendment Bill 2021 will give the board formal delegation powers, therefore allowing the board to delegate those powers as appropriate. We can imagine day-to-day employment matters. Some of our health services providers would be quite significant employers, and they would regularly deal with human resources and staffing issues. I do not imagine it would be practical or appropriate for boards to play a significant role in those processes. It is my belief

that boards are there to provide strategic direction and hold the executive accountable to that direction, rather than to be involved in the day-to-day machinations of delivering the service.

The other aspect of the bill that I found quite interesting was the powers to enter into arrangements. Proposed section 36D will allow health service providers to more effectively provide services to and receive services from one another, and to enter into contracts and act as agents on behalf of one another. I spent a little bit of time on that in my briefing. I was told that this provision is a proactive mechanism to make it clear that health service providers will have that power. I asked whether this bill sought to validate something that was already occurring amongst health service providers—that is, whether service sharing was occurring. I was told that was not the case and that there were no examples of services or arrangements requiring validation.

This bill has had a fairly long gestation period, and we now have available to us a document titled *Independent review of WA health system governance*, dated August 2022. The Department of Health website states —

> On 17 January 2022, the Minister for Health has appointed an expert panel to conduct an independent governance review of the Health Services Act 2016 …

That is the act this bill will amend. It continues —

> The purpose of the governance review was to examine the operational and practical effectiveness of governance structures set out in the Act and their impact on patient experience and outcomes.
>
> The efficiency and effectiveness of the WA health system has a direct impact on the health of Western Australians. It is critical to investigate and understand whether the current governance arrangements and operational instruments specified within the Act are operating in a way that is optimal and enables the best possible outcomes for patients and their families now and into the future.
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> …
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> The independent governance review of the Act has now been completed.
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> On 24 October 2022, the WA Government acknowledged the Independent Review of WA Health System Governance Report and approved the release of the report for further consultation.
>
> The Panel made 55 recommendations for improvement, shaped by extensive engagement with stakeholders throughout Western Australia.
>
> The successful implementation of recommendations made by the Panel will require collaboration with multiple government agencies. Therefore, the Government will further consult and seek feedback from relevant government and non-government agencies regarding the report.

As I understand it, that is the current status of the report within government. It appears that this report was made available to the government in August. It will probably be February 2023 at the earliest by the time we complete debate on this bill, so we may well be in an advanced position at that point to consider a government response to the 55 recommendations, noting that the governance review was made public on only 24 October; I recognise that is not long ago. It is a significant document and it will take time for relevant stakeholders and government to work through it. I asked at my briefing whether any provisions in the bill were inconsistent with the recommendations of the independent governance review. I received advice at the briefing, but the advice I received in writing states —

- Only one proposed amendment (new section 36D) has been identified as potentially not fully aligning with recommendations of the Independent Governance Review.
- The Government is currently working through the recommendations of the Independent Governance Review to understand and assess their implications for the WA health system.

So that members are aware, I indicate that obviously we are waiting for the government to formalise its response to the 55 recommendations, but at least one appears to be inconsistent with a provision on procurement in this bill. The *Independent review of WA health system governance* is a significant report, some 90 pages, and I do not profess to have read all 90. The relevant section for members to take some interest in occurs in the lead-up to recommendation 46 and is titled "A stronger mandate for HSS in procurement and digital enablement". I will quote from the section on procurement rather than digital enablement. Under the subheading "Procurement" it reads —

> Business support functions at an individual health service level are not optimising value and efficiency. In 2020–21WA's health system procured $4.8 billion through contracts. While a few contracts make up a significant proportion of this annual value (e.g. Fiona Stanley Hospital Serco contract, Joondalup Hospital, St John of God Midland Hospital, St John's Ambulance service), there are significant pharmaceutical, prosthetics, surgical and medical instruments, PPE and other clinical and non-clinical consumables amount to more than $500 million annually.
>
> At the time of this review, there are a total of 3,847 contracts across the WA health system —

I pause there to emphasise that that is a staggering number —

> with the Department of Health managing 675, HSPs managing 1,992 and HSS managing 1,180. It is important that the best value for money is achieved for every contract. The more that the WA health system can use its combined purchasing power to leverage better value by aggregating HSP volumes to reduce costs, the more funding there is available to direct towards clinical services.
>
> HSS is established to facilitate whole of system contracts and analyse where whole of system contracts can be established and used to deliver value for all HSPs and the System Manager. Consultations revealed mixed commitment to leveraging HSS' collective purchasing capability and inconsistent adherence to whole of government procurement policies designed to boost local manufacturing and support Aboriginal businesses.
>
> All parties should commit to the shared service model to leverage collective purchasing power, protect the security of supply chains and maximise opportunities for procurement from local and Aboriginal suppliers.
>
> HSS should be confirmed as the central hub for procurement activity and empowered to:
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> - leverage the collective purchasing power of the WA public health system
> - drive improvements in procurement processes by setting procurement policies that guide procurement activities retained by HSPs
> - take responsibility for commissioning statewide goods and services (with the exception of pathology services).

I will not quote the entire chapter, but that is the relevant section under the procurement subheading. It flows into recommendation 46, which states —

> That Health Support Services is formally recognised as the central point for goods and services tendering and contracting in the WA public health system drives value for money and customer experience by:
>
> a. progressively assuming responsibility for statewide contracts currently managed by other Health Service Providers (excluding pathology services)
>
> b. working with the System Manager and HSPs through the Strategic Leadership Forum to agree on the criteria for statewide and localised purchasing and conduct a rapid review of existing local contracts
>
> c. recommending to the Strategic Leadership Forum findings from this review on:
>
> i. contracts that would clearly benefit from statewide purchasing
>
> ii. contracts where there are possible benefits from statewide purchasing
>
> iii. contracts that clearly benefit from localised purchasing
>
> d. assume responsibility for renegotiating local contracts that would clearly benefit from a statewide approach
>
> e. undertaking a more comprehensive assessment of local contracts which may benefit from statewide purchasing to agree with the Strategic Leadership Group whether any of these should be migrated to statewide contracts.

That is a lengthy recommendation and if we are not in a position in February to understand the government's position on all 55 recommendations, it would at least be good to have some detailed consideration of this part of the governance review. I get a little nervous when we start talking about shared services, as I am sure the government is. I am not convinced that a one-size-fits-all approach to procurement and having Big Brother, the Department of Health, procuring all services for everyone is the best outcome for our health system. What I could glean from the briefing—I might get a stronger position from the minister in her reply or in Committee of the Whole—was the government's confirmation to proceed with the bill, particularly this section in the form it is, notwithstanding the recommendations contained in that August 2022 report. There are a number of examples. In my experience as a government member in the delivery of health services regionally, disadvantage certainly occurred in services that were caught up in whole-of-government or whole-of-state health contracts. An example is the Silver Chain remote area nursing posts. I am not sure whether it has been fixed, but for many years it was tied up with the whole-of-state Silver Chain aged-care contract. When the WA Country Health Service wanted to deliver a better outcome or change or improve the contract, it was always difficult because, first, it did not have control of the contract; and, second, the primary contract was involved with the delivery of Silver Chain aged-care services, predominantly a metropolitan service. For many communities, the important issue of where the remote area nursing posts were placed was not easy to deal with.

That is just one example, from my experience, of when I think we should tread carefully with recommendation 46 of the governance review. The briefing confirmed that there were no further examples, other than recommendation 46, in which there was potentially an inconsistency with the recommendations of the governance review, but it would

be good to get confirmation of whether other aspects of the report go to any of the provisions that we are considering in the bill.

Hon Sue Ellery: I am not sure how we are going to go, but we might get into committee on this bill today. I might have to give my second reading reply. There are some matters that you are raising about that report that we might be better off dealing with when we come back in February, so I might not be able to refer to them in my reply today.

Hon MARTIN ALDRIDGE: That is fine. Another section that I took an interest in but was not able to spend a lot of time on is the clause that will amend section 66. Clause 35 of the bill will effectively delete and replace section 66 of the act with proposed sections 66, 66A and 66B, which relate to the notice of financial difficulty of health service providers. I took an interest in this clause because I understand there has been some practical experience. I will just look at the EM for a second. The explanatory memorandum is quite long on this clause, so I will not quote it, but effectively it will alter the way in which a health service provider provides a notice of financial difficulty or, more importantly, what we then do with it. As I understand from the briefing, there was some experience in this regard, so I asked about it and I received this response —

- Since the Act commenced there have been two instances in which a notice of financial difficulty has been raised by a HSP under section 66.
- In each instance, the notice was triggered mainly due to a forecasted budget deficit position at the end of the financial year, rather than an imminent cash shortfall and was effectively managed within the WA health system.

It would be good to understand a little more about those two instances that were identified, in particular when they occurred, which two health service providers raised a notice and what action was taken within the WA health system to manage their financial difficulty. As I understand it, under the current section 66, there is an obligation for the department CEO to notify the minister, whereas clause 35 of the bill sets out some steps that will lead to the department CEO advising the minister and then the minister responding. They are set out in proposed section 66A, which says —

> (2) The Department CEO may —
>
> (a) require further financial information from the health service provider under section 67; or
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> (b) require the health service provider to take action; or
>
> (c) if the Department CEO is satisfied that the health service provider is not in financial difficulty — take no action.
>
> (3) If the Department CEO is satisfied that the health service provider is in financial difficulty, the Department CEO —
>
> (a) may take action to ensure that the health service provider is no longer in financial difficulty; and
>
> (b) must —
>
> (i) forward to the Minister the notice of financial difficulty; and
>
> (ii) advise the Minister about any action taken, or to be taken.

I got the impression that the minister would be notified of the notice provided by the health service provider in any event, but having read this proposed section, I am not convinced that that will be the case. The minister will be advised of a health service provider notice only if the department CEO forms the view that it is the case. I would like to explore that in the Committee of the Whole stage to gauge whether there is some merit in having the minister notified in any event. If I were the Minister for Health—notwithstanding the view of the department CEO—and a health service provider CEO formed a view that it was in financial difficulty, I would not want to know about it after the fact. I think I would want to be notified, perhaps with the advice of the departmental CEO on whether it is the case and what action has or has not been taken to rectify it. I want to try to explore that more fully when we get to clause 35 of the bill.

As I said earlier, the bill is quite significant. It has not been an easy bill to work through because of its wideranging nature. It does many things and some of them are quite significant. But they are probably the provisions that I wanted to touch on because I took an interest in them. I want to at least signal to the government that I want to explore them further when we get to the committee stage of the bill. As I said, with a bill that contains some 99 clauses, it is probably going to take us a little while to work through each provisions. Having said that, the bill has the support of the opposition. If I can emphasise it again before I take my seat, it will be of value when we get to the nuts and bolts of the committee stage, hopefully, we will be in the position in February or thereabouts to fully understand the government's response to the governance review. I think it will be sufficient time, given this is something the government appeared to receive in August this year; by the time we get to February next year, we will be in a more

fulsome position. It begs the question whether we will deal with another Health Services Amendment Bill in 2023 once the government has more fully considered the 55 recommendations contained in the August report. This bill has had a long history and certainly I am supportive to see its passage when the government prioritises it.

HON NICK GOIRAN (South Metropolitan) [2.38 pm]: I rise as we consider this 99-clause bill, the Health Services Amendment Bill 2021. At the outset, I want to recognise and thank frontline health workers, support staff, administration, security—both frontline and backroom—who all deserve our thanks and appreciation for the work that they do at the best of times and certainly over the past couple of years when COVID-19 has presented, I think what we would all accept, unique challenges for WA hospitals in particular.

I note that for reasons known only to the current Minister for Health, she has decided to wage what appears to be some form of antagonistic war with the Australian Nursing Federation. In recent times, as recently as 4 November, it was reported that the Australian Nursing Federation proposed that its wage negotiations with the state government be live streamed. That seemed to me to be quite a radical suggestion. The ordinary principle is that negotiations are conducted on a without prejudice basis so that nothing said in those rooms can then be used against another person at a later stage. That provides the best environment for good-faith negotiations to be undertaken. The response from the Minister for Health, Hon Amber-Jade Sanderson, was to label the union "disingenuous" in its bargaining. We have seen the consequences of the war of words that resulted from the health minister's intemperate remarks, albeit to an unconventional proposal that had been put forward.

Instead of intervening to sort out the situation, it appears that the Premier stokes the fire further and does not call his health minister and pull her into line. He does not intervene to try to sort it out. As members will be aware, we now have the quite extraordinary situation in which the union is under threat. Understandably, many people hold the view that the unions are the makers of their own misfortune on the matters before the Industrial Relations Commission, but my point is simply that we can ill afford to have this war being waged over health services in Western Australia. It will not be helped by the intemperate remarks of the health minister, and it will not be helped if the Premier is unwilling to get in there to try to sort things out.

Whatever might have been said about Hon Roger Cook, the former health minister who was sacked by the Premier, most fair-minded people would at least describe him as a person with a fairly calm demeanour. One wonders whether we would be in this situation today if he were still the health minister instead of the replacement health minister who made intemperate remarks. Be that as it may, the Premier now has an opportunity to step in and do something about this. Time will tell whether that occurs.

In the meantime, there are daily reports about issues in our health system. I draw to members' attention an ABC article from as recently as 9 November this year, entitled "WA emergency department overcrowding costing lives every year, report finds". The article says —

> Patients are facing dangerously long waits of almost three hours above what is recommended before being admitted through WA hospital emergency departments (ED), a damning report has revealed.
>
> The report found only 20 per cent of hospitals accredited by the Australian College of Emergency Medicine (ACEM) met minimum senior staffing recommendations.

This is the state of play at the moment. The article goes on to say about the current health minister —

> She pointed to the considerable investment in bringing new emergency beds online.
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> …
>
> But AMA President Mark Duncan-Smith said this still failed to bring WA up to the national average of beds per head of population.

The article goes on to say —

> "It's time the doctors and nurses of this state didn't have to fight ramping and bed block with one arm tied behind their back," he said.

These remarks were not made a long time ago; they were made only in the last four weeks. This article was from 9 November this year. A week before that, a different media outlet, *The West Australian*, had this to say on 1 November in an article entitled, "WA health crisis: State already reached worst annual ambulance ramping figures on record in just 10 months". The article says —

> WA has reported its worst annual ambulance ramping figures on record, already attracting the dubious honour in just 10 months.
>
> Ambulances have spent more than 54,000 hours ramped outside State hospitals in 2022, with the latest October figures also record-breaking for the month.

The whole point of the Premier sacking Hon Roger Cook as health minister was to replace him with a person who would not —

Several members interjected.

Hon NICK GOIRAN: After the Premier sacked Hon Roger Cook as health minister, it would have been his aspiration that the replacement health minister would not then break the ambulance ramping records that had been set by Hon Roger Cook. Those records have been not only broken by the replacement health minister, but also smashed. One wonders what will happen over the Christmas period—to what extent will this new record be set? What exactly does the Premier intend to do about this? Is his solution to replace the health minister yet again, or does the government have another solution in mind? This same political party was adamant that it was totally unacceptable when ambulance ramping was less than one-quarter of what it is now, yet we now have one sacked health minister being replaced by another, and going on to new record-breaking heights.

Meanwhile, the ABC has also reported "Fears changes to WA's mental health funding could lead to services falling through the cracks". This ABC article from 26 October 2022 reports —

> Currently, there is no single part of WA's health system responsible for mental health, with the Mental Health Commission (MHC) given the bulk of the task and other areas responsible for smaller sections.
>
> It is an issue a recent independent review into the health system identified as leaving mental health services "fragmented [and] operating separately from one another".

In addition to the concerns about the mental health system, we have the heartbreaking situation of child suicide. In a piece by *The West Australian* from 24 June 2021, entitled "Child suicide crisis: Families to help fix 'broken' mental health system", the shadow Minister for Health was quoted —

> Ms Mettam said despite the eight reviews and inquiries into the mental health system in WA, the system was still "broken".

This time, much reference was made to Kate Savage and her mum, Meron Savage, who had this to say —

> Mrs Savage had been unable to gather her own child's medical records, until articles from *The West* pushed Premier Mark McGowan to speed-up the process.
>
> Mrs Savage has since received all the documents with a committent from authorities to handover parts of the original two documents which had been significantly redacted.

These are just four examples of what seems to be happening on a daily basis in our health system. It is fair to describe it as a real mess, and it is having a devastating impact on the lives of Western Australian families. Consider for a moment, if you will, the family of Aishwarya Aswath or the family of Kate Savage. The bill that is presently before us, as I understand it, seeks to address some of the governance issues in our Western Australian health system. This is no wonder, when we consider some of the fairly recent reports into the North Metropolitan Health Service. Indeed, there was a Corruption and Crime Commission report on corruption and bribery in connection with the North Metropolitan Health Service that had been exposed in the last term of government. Of course, this highlights the need for greater governance and oversight mechanisms.

The report, dated 16 August 2018, is entitled *Report into bribery and corruption in maintenance and service contracts within North Metropolitan Health Service.* It is a significant report of some 85 pages and time does not permit us to analyse it in full this afternoon. At paragraph 431 the following is said by the CCC —

> This report details more than a decade of corrupt conduct reaching into senior levels within WA Health. It exposes a culture of contractors freely giving gifts and benefits to public officers with the expectation of thereby winning work and recovering the costs of the gifts through fraud.
>
> Every dollar corruptly converted was a dollar less to be spent on healthcare.

The question of course is whether this bill will address those types of gaps and issues identified by the CCC in this report from 16 August 2018. Meanwhile, the following year the Corruption and Crime Commission tabled another report, entitled *Report on misconduct risks in health support services and North Metropolitan Health Service*.

This is another lengthy report. At paragraph 104 it states —

> This report highlights the serious misconduct of a public officer. The amounts of money involved are significant. Whether recovery action is considered is a matter for NMHS. More importantly though, the investigation uncovered systemic risks, partly due to dated technology and partly due to lack of appropriate managerial vigilance.

The report concludes —

> Misplaced trust and familiarity can be the enemy of effective oversight, without which most controls can be circumvented.

I understand and support the need for relevant policies, procedures and management practices around risk management, but when we get to consider the 99 clauses of this bill in the Committee of the Whole House, I will ask a series of questions to ensure that there are no unintended consequences.

That is just two of the CCC reports looking into misconduct into our health system in Western Australia, but the Public Sector Commission also had something to say about this. In 2018 a report was tabled, prepared and published entitled *Arrangements to manage confidential patient information within WA Health*. A number of improvements have been suggested in this report from 2018. They can be found at page 8, which reads as follows —

> The following improvements are suggested with the aim of assisting WA Health to strengthen its current arrangements to manage confidential patient information.
>
> It is suggested that WA Health:
>
> 1. ensure leaders' expectations in relation to confidential patient information are regularly communicated and reinforced to staff
> 2. regularly test perceptions of the commitment to patient confidentiality and misconduct reporting
> 3. where breaches of patient confidentiality occur, ensure sanctions are appropriate to the seriousness of misconduct
> 4. continue to improve awareness and understanding of the *Data stewardship and custodianship policy* and the responsibilities of data stewards and custodians
> 5. maintain awareness of accessible avenues for staff to report alleged breaches of patient confidentiality
> 6. ensure avenues for patients to make complaints about breaches of patient confidentiality are well-publicised
> 7. enhance risk management controls for positions of trust that access and manage confidential patient information (such as regular integrity checks or confidentiality agreements)
> 8. implement repeated training and education for all staff, such as an AEDM refresher course, that covers obligations for the protection of patient confidentiality
> 9. formally assess the risk of breaches in patient confidentiality
> 10. continue working to improve misconduct detection and monitoring capability in information systems like iCM
> 11. ensure detailed reporting of misconduct trends to relevant boards to enable a proactive response to emerging issues
> 12. implement regular audits of the framework and policies relating to patient confidentiality and related processes (e.g. data breach response) relevant to their respective roles within the system.

We have 12 suggested improvements from the Public Sector Commission. The question for the minister who is representing the bill presently before the house will be about whether this bill addresses any of these recommendations; and if so, which ones; and, if not, why not.

This bill also seeks to clarify what is referred to as ambiguity and also the disclosure of health information. One question that I would like to tease out is whether things will improve as a result of this so-called clarification. I draw to the attention of members as an example a response that was provided to me by the Standing Committee on Environment and Public Affairs. It had written to me in response to petition 33, dealing with the release of the Coroner's Court recommendation. Associated with that response was a response that had been provided by the Attorney General on 5 May 2022. It is understood from those correspondences that the Attorney General said that a recommendation from the coroner is subject to active law reform, yet despite the fact that this matter has been pursued for several years, the recommendation from the coroner remains a secret. One wonders whether this type of information and the coroner's recommendation in respect of the Health Act amongst others, will be improved as a result of any of these enhanced governance arrangements presently before us.

In addition to that, on 2 April 2020 I had asked a question of the parliamentary secretary representing the Minister for Health at the time about a number of what is referred to as "form 1s" related to section 335 of the Health (Miscellaneous Provisions) Act 1911. At the time I had asked for the form 1s to be provided to the house. I was told on 14 May 2019 that there were 172 066 of the forms. Upon the request for those forms to be tabled, the response was —

> The provision of this information would unreasonably divert resources from the core functions of the Department.

That was perhaps not in this particular instance an unreasonable response from the government given that we were talking about 172 066 forms. As a result of that, the following year on 2 April 2020, I asked for the forms for one calendar year rather than all the forms. I was told that for the calendar year of 2019 there had been 7 870 forms. The government provided the following response to whether those forms could be tabled —

> The provision of this information would unreasonably divert resources from the core functions of the department.

We know that the government is not willing to be transparent when it relates to a number of documents in the vicinity of 170-odd thousand and nor is it willing to do so if that number is lessened to 7 000. What is the threshold number of documents that the government is prepared to make available as part of its so-called commitment to gold-standard transparency? If it is fair and reasonable that 172 000 forms not be provided, can that defence still be applied in the event that the number of forms is 7 000; and, if so, what is the level at which that defence falls away?

I also draw to members' attention on these issues of governance and oversight of health services in Western Australia that in 2015, then Minister for Health, Hon Kim Hames, conceded that a new reporting mechanism was required and requested a report be prepared on an annual basis by the Executive Director of Public Health. What were they to report on an annual basis? They were to report on the gestation and reason for termination for all post-20 week terminations. This report was prepared for two financial years. The first was in 2014–15 and the second one was in 2015–16. On 17 November 2017, there had been a change in government by this stage, and then health minister, Hon Roger Cook, discontinued this report because he deemed it was no longer required. I draw to members' attention specifically the response that was provided in annual report hearings in 2018. I asked —

> I refer to supplementary information No A6 provided as an answer to questions taken on notice at the 2014/15 annual report hearing in which the Committee was informed that the Executive Director Public Health had given an undertaking to provide an annual report in August each year with the gestation and reason for termination of all post 20 week termination, and I ask:
>
> (a) was this done in the 2017/18 reporting period:
>
> (i) if not, why not; …

The response was —

> The annual report with the gestation and reason for termination of all post 20 week termination for the 2017/18 reporting period was not done. The Department of Health was instructed by the Minister for Health that the above report is no longer required.

I then asked a further question about this issue by way of questions on notice in 2019. In this multi-part question, I asked —

> … when did the Minister inform the department that an annual report was no longer required …

A tabled paper was provided in response to that. The tabled paper is a ministerial memorandum. It is dated 16 November 2017. Very interestingly, by way of background, this briefing note says as follows —

- In 2014 the then Minister for Health requested a confidential report on Induced Abortions of 20 weeks or more gestation using information collected on the regulated Form 1 —

Hon Alannah MacTiernan interjected.

Hon NICK GOIRAN: Are we quite finished, Minister for Regional Development? I believe you are going to be making a speech a little bit later this afternoon and probably would appreciate a bit of silence while we listen to what I imagine will be your genuine and authentic response to a very distinguished and long career. If you could just afford me that courtesy, for a few moments, while I tackle this particular issue, which is not a new one. The minister might have a strong view to the opposite, which she is entitled to hold. If she wants to respond, she will get her chance in 17 minutes.

This briefing note says as follows —

- In 2014 the then Minister for Health requested a confidential report on Induced Abortions of 20 weeks or more gestation using information collected on the regulated Form 1 Notification of Abortion.
- This confidential report has subsequently been provided for financial years of 2014/15 and 2015/16. The report includes "Reason for Abortion text" which describes the medical condition of the foetus or that of the mother.
- These conditions are often rare and potentially recognisable to individual circumstances. This information is sensitive and should the Report be made public, and in particular if details of specific cases are revealed or discussed, its content could be distressing to the families involved and their healthcare providers.

- Aggregated information is publically available in the form of a Triennial Report on Induced Abortions, and through answers to parliamentary questions.

I will pause there to note that in the background to this ministerial memorandum, there is already a recognition that there is publicly available information in two forms, one being a triennial report. The question that immediately arises is: why is it triennial? If there is already an acceptance there is public interest in this information being available, why is it only every three years and not every year? The second mechanism by which this briefing note indicates that there is information made publicly available is what the authors of this particular briefing describe as "through answers to parliamentary questions". Why does it require parliamentary questions to systemically reveal information that otherwise would be on the public record? It is for no doubt those reasons that the then Minister for Health had asked for the reports to be provided on a confidential basis every year. The briefing note goes on to report on what is referred to as the "Current Situation". I quote —

- Multiple requests to the Minister of Health have been made to make this confidential report public.

I pause there to say—my word, there were multiple requests! I suspect that most, if not all, of those multiple requests were made by me. It has to be said, it was not for the purposes of identifying any person in Western Australia at any time. With regard to the condition that was said to justify the procedure for a late-term termination, yes, that information was sought. As we know, and as I have previously mentioned in this place courtesy of an investigation I undertook some years ago, it certainly was the case and may still be the case that we have late-term terminations in Western Australia. People have strong views about them across the community. We had late-term terminations happening for conditions compatible with life. I make no apology for continuing to ask the questions that need to be asked with respect to those terminations that take place because a baby has been diagnosed with Down syndrome. I make no apology for that. If other people have a different view about that, they are quite entitled to have that, but I think a late-term termination for Down syndrome is a matter of public interest because I do not think that is consistent with what the legislation ever intended when it was first passed. If members read the *Hansard* of the debate by members all that time back, it was for rare conditions that were incompatible with life. Members who have had anything to do with a person with Down syndrome will know that it is most definitely a livable condition. It is for those reasons that we wanted to find out the reasons to justify the procedure of a late-term termination.

The briefing note, under "Current Situation", continues to say —

- The reports are considered confidential because they contain medical information, such as diagnosis of rare conditions, for individual patients.
- The disclosure of such specific information increases the risk of identification of individuals.

There is then a recommendation that reads —

> The Director General provides this Briefing Note to the Minister for Health so that the Minister can advise the Chief Health Officer of his preference in relation to the following options:

Three options were provided —

- Option 1: Continue the Confidential Report of Induced Abortions in exactly the same format as previously produced.

I pause again to underscore the point that that confidential report was never made public. If the concern was that it was going to identify anyone, how could it identify anyone if it is never made public? The first option was to continue the status quo, if you like. Why would the status quo at least be worth maintaining? It is because at the very least, the minister of the day, whether their name was Hames, Cook or Sanderson—it really did not matter—would be able to provide some oversight of this regime. It would be a sensitive matter, but at least there would be some kind of oversight. At least the minister would then have this confidential report in their possession. Whether they want to make it public or not is another thing. I still maintain that if it does not contain the information of the individual patient, there ought to be no concerns—certainly nothing that could not be otherwise addressed by way of a redacted report. Nevertheless, that was option 1.

The briefing note goes on —

- Option 2: Continue the Confidential Report of Induced Abortions excluding the "Reason for Abortion text".

That is quite remarkable when considering that that was the most important part. If there is a view within the house that a termination is acceptable at, let us say, 30 weeks' gestation for any reason, then members are entitled to have that view. But I assume that there will also be a cohort who think: "No at 30 weeks and not for any condition—no." I assume that there will be a cohort of Western Australians who will feel likewise. The reason for the text is quite important, particularly for those families with children with Down syndrome.

Then —

- Option 3: Discontinue the Confidential Report of Induced Abortions.

What did Hon Roger Cook, the now sacked health minister, do as a result of all this? We have the document here, and in his handwriting it states —

> Please implement option 3.

He was given three options. Remember that the whole purpose of the Health Services Act and the amendment bill is to enshrine a strong governance arrangement with respect to health services in Western Australia. At the top of that strong governance for health services in WA is the minister of the day. In 2018, when this particular briefing note was provided to the minister of the day, it must be said that it was dated 16 November 2017—when it reached him is not necessarily apparent—and he signed it, from what I can see here, on 10 December 2017, and then at a later stage said, "Please implement option 3." One wonders whether it was just signed one month later. Was it read? Was it understood? Was it discussed? It is not necessarily apparent. There obviously needed to be a further discussion because at a later stage it states, "Please implement option 3."

Of all the options, it is quite remarkable that the option chosen was the one to remove an oversight mechanism. There is limited oversight as it already is. The decision was: we will have none; with respect to these things, we prefer to have none as we would prefer to think that this does not go on. It is almost as though Hon Roger Cook was saying, "I don't want to know if there is a late-term termination for a livable condition." Who could blame him, as it would be most troubling, particularly for any parent who has had a prematurely born child. These parents know the tremendous work and care that is taken at King Edward Memorial Hospital for Women for any premature-born baby. The care that they have is incredible. Any member who is a parent, or indeed a grandparent, and has had a premature-born baby in their family will understand just how significant that care is, and how babies can be born after 20 weeks' gestation, and certainly after 22 weeks' gestation and onwards, and be well cared for and live a long and fruitful life.

I would have thought that one would want to know what these conditions were that would justify such a late termination. However, the decision made was to remove the reports. Those reports no longer exist. One wonders if that is the standard that is being applied by the current government—that is, to remove oversight and lessen the oversight that exists. There will need to be some questions asked on these 99 clauses to ensure that there is an enhanced oversight regime, not a reduction.

By way of segue to the questions that will be asked in Committee of the Whole House, it will be important for the government to be prepared to answer the extent to which any of the clauses will reduce the oversight that is presently in place, in contrast to those clauses that will enhance the oversight. This government has form—not just in the examples that I have given, but even most recently even in the handling of bills before the house. I draw to members' attention that recently, as they will recall, we had the Human Tissue and Transplant Amendment Bill 2022 pass through both chambers. That bill, which received approval from both chambers, subsequently resulted in the Minister for Health on 17 November 2022 standing in the other place and making a personal explanation about a number of matters that had been stated that needed to be corrected. There is little point in correcting the record after the bill has already passed through both chambers.

We expect the information provided to us in the passage of these health bills, whether it is the Health Services Amendment Bill 2021 or any other health bill, to be accurate. From time to time, mistakes will be made. The mistake needs to be corrected at the earliest opportunity. In this instance, the correction that was supposedly made by way of a pointless personal explanation on 17 November this year, was as a result of questions that had been asked on 27 October. Questions had been asked on 27 October and, in the meantime, the bill had received approval from both houses, and then the health minister decided to get up on 17 November 2022 and make a personal explanation about a series of mistakes—a series of errors. Admittedly, she ended the statement by saying —

> I regret any inconvenience and apologise to members for this inconvenience.

It is more than an inconvenience if the house has been told things inaccurately and falsely, relies on that information and then passes a law accordingly. There is little point in making a personal explanation and trivialising it as an inconvenience to members. It is very significant. I make those remarks as a segue to the Committee of the Whole House phase to make sure that we do not run into this same problem when we consider the 99 clauses of this bill.

Deputy President, you will be aware that earlier today, the house considered the Medicines and Poisons (Validation) Bill 2022. As was remarked by the opposition at that time, we were grateful for the way in which the Leader of the House handled the bill. Nevertheless, that is another example of a matter that was foisted on Parliament at late notice. Why? It was because significant errors were made within the Department of Health in 2019. Significant errors that were made in 2019 resulted in a bill needing to be rammed through Parliament. In fact, there was so little time that even the time on the clock expired. Then we had the Human Tissue and Transplant Amendment Bill 2022, which was not subject to any bulldozing or special provisions, but, in the end, it resulted in the health minister needing to make a personal explanation for multiple false statements.

I just hope that when we get to the Committee of the Whole House stage of this bill, that type of form will not be carried over to this particular matter, least of all in circumstances in which we are dealing with governance and oversight. In the examples that I gave earlier, the former health minister, who subsequently was sacked, was given three options and chose to implement the option that would lead him to the least oversight and absolutely no transparency. There can be no transparency if there is no accountability. Transparency can follow only after accountability.

Although the opposition supports this bill, given the government's track record of hiding information from Parliament and making errors when providing information to Parliament, and the litany of reports on governance failures, a large number of questions indeed will need to be asked on this 99-clause bill.

HON SUE ELLERY (South Metropolitan — Leader of the House) [3.22 pm] — in reply: I thank Hon Martin Aldridge for his support of the Health Services Amendment Bill 2021 on behalf of the opposition, and I also thank Hon Nick Goiran for his contribution. I will touch on some of the issues. Perhaps I can exploit the fact that I am on my feet by telling the house what I intend to do. We will go into committee when I finish my reply and we will come out of committee at about 10 minutes to four, as we have a message from the other place that I would like to read in before we go to question time at four o'clock.

The first matter raised by Hon Martin Aldridge was whether there is any difference between the 2019 and 2021 bills. I am advised that the bills are very similar. There are minor technical and drafting differences, including moving some definitions from various parts of the act into section 6 where the main definitions sit, some changes in drafting style, and some minor amendments to ensure greater clarity. I am also advised that we can, if it is required—members can indicate this to me when we go into committee, although I am not sure I will have it then—provide a list and I can table the changes if that would be helpful.

Hon Martin Aldridge also raised the matter of new section 36D and the independent governance review. New section 36D will provide the ability for health service providers to act as agents for each other. The bill does not seek to validate any arrangements made. The honourable member asked a question about that. At present, the intention is to continue with the amendment, but, as I indicated by way of interjection when the honourable member was on his feet, we may have a slightly different position when we come back to complete the bill in 2023.

The independent governance review made a recommendation to amend the act to formalise Health Support Services as the central point for procurement in the WA health system. The government is considering this recommendation and we will respond to all the recommendations. Nevertheless, what is in the bill before us reflects our policy now—that there is benefit to the WA health system for health service providers to be able to act as agents for each other and that the ability to act on behalf of each other should not be limited to the type of procurement that Health Support Services is responsible for. The specific example provided of when it might be beneficial for one health service provider to contract on behalf of another or each other is the Child and Adolescent Health Service's expertise in child-related matters and services that other health service providers may wish to leverage off.

The member referred to clause 28, which deals with the definition of compensable, and raised two concerns. The first was about how it will work in practice, considering there may be a long time between the injury and the claim and payment of the claim. I am advised that once it is determined that a person is compensable, they will be classed as such and have a compensable charge raised for health services received. It will be monitored for payment from either the person who has received compensation or directly from the compensation payer—for example, the insurance company. In respect of information sharing, there will not be information sharing of a patient's health information with insurers. Instead, the department will seek information from patients about any claims made for compensation.

The honourable member also raised the issue of health service providers that are having financial difficulty. The amendments will provide a more workable system for those in financial difficulty and improve on the processes that are currently set out in the act. There will be no formal requirement for the department's CEO to notify the minister if a health services provider believes it is in financial difficulty. However, the department CEO meets regularly with the minister, and health service providers also meet regularly with the minister, so the issue would be able to be raised in any of those meetings.

In respect of boards and employment matters, I note the honourable member's comments about boards being perhaps too busy to be involved in employment matters. The policy position on boards, as the governing bodies, is that they should be the employing authority. They can delegate their functions to lower levels within the health service provider. Currently, this is achieved by authorisations. However, the amendments to the act will make it clear that boards are, and should be, the ultimate employing authority.

In relation to information about land transfers provided to the member following the briefing, I can confirm that land and property that did not transfer under the act was predominantly property held within the health portfolio. That includes the 41 sites in the name of the Crown or state but for which Health is allocated responsibility.

I note and appreciate Hon Nick Goiran's appreciation of health workers in the system, particularly with the challenges faced during the pandemic. He made some references to the act and to the bill before us and then he canvassed a range of other matters. I think it is appropriate to note for the record that the point that the honourable member was making—I do not think I am verballing him—around, for example, terminations and information about terminations and the link to the bill before us was about oversight. I think that is the connection that the honourable member is making, so that is the approach I will take when the member asks questions about this when we go into committee. There might be a point at which my judgement is that the member's line of questioning is more than oversight and is about a matter that is not within the bill before us. That is the approach I intend to take.

Hon Nick Goiran raised questions about the Corruption and Crime Commission and the Public Sector Commission. In response to the integrity risks raised in the CCC reports of the last few years, the director general has established policies under a binding integrity policy framework. That framework includes, but is not limited to, the integrity governance policy that requires health service providers to establish and document the integrity governance arrangements that are endorsed by the governing body, such as the health service provider board, and ensure they are evaluated and amended as required. These integrity governance arrangements include structures, systems and processes to ensure that integrity risks are identified and managed appropriately.

The fraud and corruption control policy requires health service providers to establish and implement a fraud and corruption control panel endorsed by their local governing body to ensure that risks of fraud and corruption are regularly assessed and identified risks are addressed and managed appropriately by the health service providers. The Department of Health and health service providers have local risk management functions in place to support risk management activities. The governing body of a health service provider—whether the board in the case of board-governed health service providers or the chief executive in the case of chief executive–governed health service providers—has responsibility for ensuring that risk management mechanisms are implemented in their organisation. As part of good management, health service providers address risks identified by various oversight bodies, such as the CCC or the Auditor General. The department CEO sets policy frameworks and has the power to issue directions to health service providers through mandatory policies, and the Minister for Health may also issue directions regarding health service provider performance.

Hon Nick Goiran referred a couple of times to the Deputy Premier as the "sacked Minister for Health". I want to make this perfectly clear. It was on the record at the time from both the Premier and the Deputy Premier themselves: Deputy Premier Roger Cook requested a change of portfolio, and he got it. There is a fundamental difference between that and a sacking, which the honourable member might remember happened to Rob Johnson, who got a letter from the Premier telling him he was sacked: "Don't come Monday; see you later." That is a sacking. What Roger Cook did was different. After 10 years in the portfolio—he had it in opposition as well; it may have been more than 10 years—he requested a change in portfolio, and he got it. That is the difference.

With those comments, I thank members again for their support of the bill and their contributions, and I commend the bill for the house.

Question put and passed.

Bill read a second time.

Committee

The Deputy Chair of Committees (Hon Jackie Jarvis) in the chair; Hon Sue Ellery (Minister for Education and Training) in charge of the bill.

Clause 1: Short title —

Hon NICK GOIRAN: The explanatory memorandum indicates that the Health Services Amendment Bill seeks to improve the functioning of the WA health system and to overcome what are referred to as operational burdens. What are these operational burdens that have necessitated the amendments being proposed in the bill?

Hon SUE ELLERY: By way of example, the restrictive delegation power in section 15 of the Health Services Act, whereby the minister is only able to delegate to the department CEO, means that it is only the minister or the director general who can approve property transaction. Although the health ministerial body has the power to enter into joint arrangements, joint arrangements do not allow health service providers to lease or licence the property or deal with it as though they were the interest holder or management body. That means that the health ministerial body—that is, the minister or the DG—must approve all dealings with land and property owned or vested in the health ministerial body but actually controlled and managed, for all practical purposes, by the health service provider.

Section 37 of the act requires all disposals of land to be approved by the minister or the director general. Disposals include entering into subleases, terminating leases of private property, assigning leases, lease variations et cetera. Responsibility for clinical and wider commissioning only is assigned to the director general. The reality is that the director general only retains formal responsibility for the most significant, higher risk capital works. A series of delegations are required to assign to health service providers responsibility for other capital works and commissioning.

With respect to some provisions that were not able to be effectively operationalised because there was ambiguous interpretation, the redraft of provisions will ensure that health service providers can effectively recover fees and charges from patients who receive treatment as public patients but subsequently receive compensation for the injury or illness that was treated by the health services provider.

Hon NICK GOIRAN: What is the volume of the property transactions and property dealings, referred to as operational burdens, that have been encountered and necessitate the amendments proposed in the bill?

Hon SUE ELLERY: I am not sure that I can give the member a measured number, with a portfolio the size of the Department of Health. It is the single biggest agency in Western Australia and it delivers services everywhere in Western Australia, so it is a sizeable asset portfolio. I am not sure that I have anything more specific. I will see whether the advisers can find anything, but I do not think that I can give the member a measurable number. No, I cannot.

Hon NICK GOIRAN: I note that we only have 12 minutes left. There is no chance of us moving off clause 1 in that time. Given that, can the minister take it on notice to ascertain the number of property transactions and property dealings? The basis for the question is this: the explanatory memorandum indicates that these are burdens and the implication is that the burdens are so large that they then justify them going to somebody other than the minister or the director general. In principle, that is sound, and I do not quibble with that, but I would like to understand what the size of this burden is. On the one hand, if it was one or two transactions over the course of the year, I would probably make the case that it is fine for the minister and the DG to keep doing it. If on the other hand we are talking about thousands of transactions, understandably the minister and the director general have a heap of other matters that they need to deal with. If that could be taken on notice over the break, that would be great. I say that by way of a comment and foreshadow it as something that will be pursued when we return. That is the operational burdens, but the explanatory memorandum refers also to administrative burdens. What is the distinction between operational burdens and administrative burdens?

Hon SUE ELLERY: I will take a step backwards first: I am happy to give an undertaking that we will explore what information we are able to provide about the size of the burden of managing properties and changes of lease. I will give the honourable member the example of the WA Country Health Service, which I am told manages around 500 properties, mainly for staff accommodation. They are leased and subleased and changes might occur during the course of the year that relate to the different leases. That gives a sense of the size of it. I give the member an undertaking that I will come back with a better description of the size than I am able to provide now, but it might not be a precise number. It may be that in 2019 it was X changes and in 2020 it was Y changes. What was the second question?

Hon Nick Goiran: It was the distinction between what is referred to as operational burdens and administrative burdens.

Hon SUE ELLERY: I am not sure this is a precise definition. Administratively, we are talking about when a number of changes need to be made; for example, lease arrangements. An administrative process must be gone through. Operationally, it is how that is put into effect: what is the practical way the measure can be implemented? That is not a precise definition and we cannot say, "This applies to this number of amendments, and that applies to that number of amendments", but it gives the member a broad sense of it.

Hon NICK GOIRAN: Is the package of those things that we talk about as operational burdens and administrative burdens all related to the property transactions and property dealings issue?

Hon SUE ELLERY: I think we can say at the outset of this discussion that they go across the relevant parts of the policy changes in the bill. We have discussed those around land, but there would be some with capital works and commissioning as well, as there would with the employing authorities. Arguably, when it comes to the recovery of compensables, there may be administrative changes as well. There might be some where it is both administrative and operational, and there might be some where it is just one or the other.

Hon NICK GOIRAN: The explanatory memorandum refers also to the rectification of drafting errors. Is there a convenient list of those drafting errors that can be tabled?

Hon SUE ELLERY: We do not have a list here, but given that we will be talking about this again, we will undertake to provide that. However, if it is useful now, before we break, to table the difference between the 2019 legislation and the bill before us now that I referred to in my second reading reply, I am happy to do that now.

Hon Nick Goiran: That would be one less question to ask.

Hon SUE ELLERY: Yes. I will table this document, headed "Health Services Amendment Bill 2021 —table of drafting changes from Health Services Amendment Bill 2019 to Health Services Amendment Bill 2021". I am advised that some things in this table are indeed grammatical and typographical changes.

[See paper 1933.]

Hon NICK GOIRAN: Reference was made also to certain parts of the act that have not been operationalised effectively. Is there also a list of those?

Hon SUE ELLERY: I am advised that it is mainly in the area that relates to the compensable arrangements. I am advised that what was in there referred to regulations but no head of power to recover the money.

Hon NICK GOIRAN: I note that I now have in my possession the table of drafting changes from the Health Services Amendment Bill 2019 to the Health Services Amendment Bill 2021. Was a governance review commenced of the Health Services Act 2016?

Hon SUE ELLERY: Yes, that featured in the second reading stage speeches and I referred to the independent governance review in my reply to the second reading debate. For completeness, that report was provided to the minister in August this year and tabled on 25 October 2022. The panel made 55 recommendations. They do not involve any change to the structure of the system manager and health service provider board governance, but the government is working through and developing its response that it will give in due course, and consulting stakeholders before undertaking any further reform based on the recommendations in that review.

Hon NICK GOIRAN: Is it possible at this early stage to indicate whether any of those 55 recommendations have an implication on any aspects of the bill presently before the house?

Hon SUE ELLERY: One was referred to during the second reading stage speeches—that is, the capacity of health service providers to act for each other in certain circumstances. I cannot tell the member what the government's position will be on that as government has not finalised its position on that matter.

Hon NICK GOIRAN: With respect to the consultation that was undertaken on the bill presently before the house, the Leader of the House has indicated that the government was starting some consultation as a result of the report that was tabled on 25 October 2022 before it finalises its position on the governance review. Has the same group of stakeholders been consulted on that matter as have been consulted about the Health Services Amendment Bill?

Hon SUE ELLERY: The independent governance review was open more generally, including for public comment, so it was indeed much broader than for the bill before us now.

Hon NICK GOIRAN: Which stakeholders were consulted on this bill?

Hon SUE ELLERY: In respect of this bill, it was Treasury, the Public Sector Commission, the State Solicitor's Office, the Department of Planning, Lands and Heritage, Landgate, the Mental Health Commission, the Department of Finance, health service providers and the Queen Elizabeth II Medical Centre Trust.

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