EDUCATION AND HEALTH STANDING COMMITTEE

HEARING WITH CHIEF HEALTH OFFICER

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
WEDNESDAY, 14 FEBRUARY 2018

Members

Ms J.M. Freeman (Chair)
Mr W.R. Marmion (Deputy Chair)
Ms J. Farrer
Mr R.S. Love
Ms S.E. Winton

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Hearing commenced at 10.17 am

Dr TARUN WEERAMANTHRI
Chief Health Officer, examined:

Ms KELLY CROSSLEY
Principal Adviser Legislation, examined:

The CHAIR: Good morning and thank you for coming. On behalf of the committee I would like to thank you for agreeing to appear today to provide evidence in relation to the public health plans in local government. My name is Janine Freeman and I am the Chair of the Education and Health Standing Committee. I will introduce you to the other members of the committee: Mr Bill Marmion, deputy chair; Mr Shane Love and Ms Sabine Winton. Ms Josie Farrer is also a member and may come in at some stage.

It is important that you understand that any deliberate misleading of this committee may be regarded as a contempt of Parliament. Your evidence is protected by parliamentary privilege; however, this privilege does not apply to anything you might say outside of today's proceedings. Do you have any questions about your attendance here today?

Dr WEERAMANTHRI: We really welcome the opportunity to discuss public health planning. It is a complex thing but it is exciting that people are talking about it and that you have got the level of interest, so thank you for inviting us along.

The CHAIR: Would you like to make an opening statement or provide an outline of where you think the current environment is in terms of public health and some context of what is going on in the sector at this point in time?

[10.20 am]

Dr WEERAMANTHRI: We would like to help the committee as much as possible. If you are keen to focus on a particular angle, that would be of interest to us.

Just to give a little bit of background, it is a couple of years now since the Public Health Act was passed. You would remember Ms Crossley from the committee stage of the bill. A good decade of work preceded the passage of the act and now we are in the five or six year phase of fully implementing the Public Health Act. There are five stages of implementation and we are very pleased to have really progressed successfully through stages 1 to 4. The last stage was always going to be the most time intensive in that it would take at least three years to progress stage 5. That is because that contains the majority of the environmental health changes. There are currently 47 sets of regulations existing which we have to transfer into the new framework. We will create a streamlined set of regulations that are much fewer in number. They will be umbrella and thematic regulations that bring together some of the individual-specific regulations of the past. Each of those regulatory changes will have to go through a process including consultation, which is mandated, and the involvement of the better regulation unit. There will be time taken to both develop them and get them through a process, so stage 5 will be a few years away. The public health planning part is in stage 5 and the requirement in terms of introducing the state public health plan from the Chief Health Officer is a year after stage 5 comes in and for local governments to produce their plans it is two years after stage 5 comes in. So there is quite a bit of time here.

Having said that, this was one of the most warmly welcomed parts of the Public Health Act and people are already getting on and doing this and we want to encourage that. There is a philosophical change here which is written largely in the whole act but which also applies to public health planning, which is that we want to move away from a tick-the-box compliance approach when old health inspectors go around and give people sets of things that they have to satisfy themselves they have done and they tick the box as they hand it back to us that they are compliant, "Yes" or "No". All we are encouraging is a risk-based approach; that is the whole act. People assess their own risks—what is reasonable, what is proportional—and manage those risks, and they tell us how they are going to do that. I absolutely assure you that there is a test of reasonableness underneath all of the act and there are lots of checks and balances and safeguards for people, so you cannot inadvertently contravene the act without knowing and then be penalised. It is not written like that at all.

Similarly with public health planning, it gives you a chance for local governments in particular to proactively plan. Many local governments—I would say all local governments—are already in the health and wellbeing space. They may not have recognised it as such and they may not have packaged it as such, but they clearly are doing it. What we said when the act went through was that we produced an interim state public health plan to get ourselves going, to test it, to give the sector some idea about what it might look like and then we iterate that a number of times and take feedback. Between 2016 and mid-2017 when we produced the interim state public health plan I made a statement to the sector that I was not going to consult on the first draft. We did not have the resources to be able to go out and extensively consult before the first draft. What I do is produce it in house within nine months and then use that as a basis for consultation. Given that we have so many years now to get feedback, and we got feedback that ended at the end of December—Kelly has produced a report for me about the feedback —

The CHAIR: That is not public, though.

Dr WEERAMANTHRI: It is not public yet, but I can share with you that although it has not been announced, we are currently planning to produce another state public health plan—I am not sure whether it will still be interim; I am not sure what we will call it—for people to look at in about 18 months' time. That will incorporate feedback. It will still give a couple of years for further feedback, but it is in the process of getting that discussion going.

I want to stop in a second. Ms Crossley is very much across the detail. She has been doing a lot of the face-to-face with a whole range of stakeholders in other government departments as well as with local government. I think you would benefit from hearing from her more than me just talking generally.

The CHAIR: The big feedback I heard is that although there is a great welcoming of the issues around Aboriginal health, the issues around newly arrived Australians and multicultural communities, the core community health issues, have not been included in that. I understand that you have got feedback on that. I assume that has come in. Are you able to give us an idea of other areas where there has been feedback that will instruct how you look at this document in 18 months?

Dr WEERAMANTHRI: I might just make two quick comments and then hand to Kelly for the other details. There is one around Aboriginal health. First of all, all the plans, whether they are the state plans or the local government plans, will have to be based on data that is actually written into the act. It is probably based on some analysis of what the local population needs are. We have clearly indicated in the state public health plan, based on the data we have got, that Aboriginal health is one of the major priorities. We would expect that to be considered when each local government looks at its priorities.

With respect to culturally and linguistically diverse communities we do have an issue that we do not have the data to provide that. Separately in the department, with my other hat on, we are going to produce the report, which is near finalisation, based on work we did last year around all of the data needs to get a better understanding of CALD communities. So that work was done last year. It is in final preparation to come out in the next couple of months. That is the kind of way we go around this. As we get better data we will be able to drive priorities and planning.

The CHAIR: Can you not rely on some of the data, such as that in Victoria, that shows, for example, the Somalian community has high diabetes risks that is also based on research that is done around San Francisco? Can you not rely on data outside that can indicate what risk factors are in play for culturally and linguistically diverse communities?

Dr WEERAMANTHRI: We definitely think it is a good idea. Just like we have immunisation data that is not all generated in Western Australia—we rely on stuff historically from other countries. Clearly, that is part of the picture of building our understanding that says that you are probably going to have a problem, so let us have a look at it. Ideally, for any public health issue, we want local data as well. We want to know specifically where the communities are living and the precise local government areas. From the point of accountability and interventions—I know you have a specific interest in this and I am sure that local members as well as local councils would welcome better data at the local level. One of the things we have also done inside the department in the past 18 months is recut all our routine datasets to local government level. If any local government writes to us now—we are encouraging them to do so as part of the planning process—within a few weeks we can deliver them a cut of all the state data but based on the local government boundaries, so then they can take that and they can start their plan.

Ms CROSSLEY: With regard to the first interim state public health plan, we received 61 submissions in total and we had quite a few comments. We received one very late submission. The CALD communities did put forward a submission. Other common themes that we got feedback on were mental health—they want to see mental health included in the state public health plan. There is a request for us to expand the harmful use of tobacco and alcohol to include other drugs; to include climate change; and also to look at the impact of lifestyle on cancer incidence in the communities.

Mr R.S. LOVE: I do not know who to address this to, so I will address it to both of you. I am just looking though the plan. Forgive me, I have only just seen it. It does touch on a number of diverse areas such as mental health and road safety. It is all very high-level stuff. How does that tie in to any actual meaningful change? What are the ramifications of something appearing in the plan? Is there any underlying structure that will drive better road safety or an improvement in mental health outcomes?

[10.30 am]

Dr WEERAMANTHRI: I welcome that question. If you look at the Public Health Act, it is the alignment of the state plan to the local plans that is critical. There are objectives and priorities laid out in the state plan at a high level, as you say—at a state level—because that is all you can do at that level. What is expected then is that each local government would get its own data. Again, it sets out the processing in the Public Health Act. It would make its own assessment of its objectives and priorities for all local government with regard to the state public health plan. There may be things in the state public health plan to which you go, "Yes, reasonable, but not an issue for us." There may be things that are not in the state public health plan that are an issue for local government. It is based on creating a narrative that says, "We have had good regard for this, but we have made a decision here and this is how we are going to approach it." As long as that is a sensible, reasonable narrative, we will be happy with that. Local governments are doing this all the time; they are totally engaged in

this. What it gives us is a chance. It would not actually happen, but it is an example: let us say that we have set Aboriginal health as a priority and the needs are this much greater and there was a local government that had 10 per cent Aboriginal population in its boundaries. If the data was there and there was nothing very specific written about how those needs of that population were addressed, we would have a way of going back to them and asking how they got to that point. Truth be told, we have had those discussions informally all the time and we would not expect to be using a stick there. What is really fantastic is that this process, because it is occurring across 130 local governments, is creating synergies, it is creating a bit of healthy competition, it is creating a bit of excitement and it is sharing innovation. I think we will find that people really move themselves to this point.

This afternoon I am going to the launch of the Cockburn Healthy Lifestyle Program. Many of these initiatives are already taking place. Many local governments already have health plans that they specifically call health plans. We have the ability for local governments to say, "No, let's integrate all this into our community plan. We won't have a separate plan." Or they might, if they have the resources and the inkling, have a separate health plan. However they chose to do it is fine with us as long as the objectives are met. We want flexibility for them and we want autonomy for them. I know you will probably get to the question in a minute. We do not want to give them a template. It is the most attractive seeming thing for them to say, "Give us a template and we will fill it out." The whole point is that that reverts back to this idea that somehow we have all the answers: here is the template and it is one size fits all. The reality of local government is that it is very different. There are 130-plus local governments and they need to own this and tell us how they are going to address it.

Mr R.S. LOVE: That sort of explains the local government side of the underlying structure. I get that. Although you might not put out a template, there would be some consultancies that will develop some sort of a template. You know very well that small local governments will just grab an off-the-shelf plan and chuck in their own information and that will be that.

I was also interested in how this marries into the agencies of state government. For instance, although local government has a role in the area of road safety, primarily state government has a leading role in that—in mental health, suicide prevention and all those types of things. To what level does this plan drive other agencies towards a common outcome?

Dr WEERAMANTHRI: I will also ask, if you do not mind, we have a series of planning guides and tools that we have published, which I would not mind the opportunity to show you at some point, which bridges that gap with local government in particular. We can actually help them by producing planning guides and frameworks for them, so we have already developed some of that material. To come to your question about other government departments, I think we need more thought in this area. I think we have done most work in the past 18 months with local government and we start to engage other government agencies. If I can return to what we said prior to the introduction of the Public Health Act, there is no sense in which this act somehow trumps all the other acts that are out there—the Road Safety Council Act, the Liquor Control Act, this act, that act. If there is already legislation on the books that deals with that area, we are not seeking through this act to reinvent that legislation. It would be reasonable to just focus on the other things that are not covered under a specific legislative framework.

Mr R.S. LOVE: Just to interrupt: in order to develop those, do you not have to have an overarching road map, if you like, or a map of where all the responsibilities lie, so local governments and others can actually know exactly where they can move, because if something is covered by statute, there

is probably no discretion for anyone to be involved in it anyway, but it could be very good to have an understanding of where all the other agencies fit into the health plan.

Dr WEERAMANTHRI: It would be good to have that. Whether it is possible to produce that kind of map of everything is a little debatable. It would take a lot of work. We need more discussion on this. What you are saying is reasonable. I am just not sure how much effort it would take to get there. What we are saying is that perhaps the local governments themselves from the bottom up are seeing their various responsibilities come together and already integrating it into, for example, their 10-year community plan and their four-year operational plan. In a sense, they have already done the "How does this all fit together for me?" The Public Health Act is not overly burdensome in creating new expectations on people. It is essentially codifying existing expectations. There is a promise of producing a risk framework that we have to do at a state level, so we have to help local governments—we have not done it as yet—with providing a framework to assess risks. That will be another piece of this. Whether we have to provide a framework for how all the different aspects of public health legislation come together, I would have to give that some thought. The problem is that everything in the end impacts on health and wellbeing. Where do you draw the line between all the different bits of legislation?

Mr R.S. LOVE: If I could just have one more follow up, then I will be quiet. In terms of local governments in regional areas which I represent especially, there are many different statutory obligations already, and you are well aware of all of those. How do these plans make sure that none of those responsibilities is forgotten in the drive to present some glossy document which might show healthy old people walking down footpaths or something? But we also need to make sure that there are websites for foot-and-mouth outbreaks or whatever. There are all those other things which local governments have always had responsibility for under their previous regimes, so how does that all fit into this?

Dr WEERAMANTHRI: We have done our best to do that under a planning guide, which is actually a kind of guide to the Public Health Act, which goes over the major bits of legislation—not just the Public Health Act, but the Food Act and the various bits of the Radiation Safety Act et cetera. Actually, local governments are already dealing with those major bits of public health legislation. They normally give it to their environmental health officer staff, who would know all of those. There are at least 10 different bits of primarily public health legislation under various act titles and they are very used to pulling that all together. But it gives me an opportunity to ask Kelly to talk about, initially, the "Public Health Act Handbook" and then the specific public health planning guide.

Ms CROSSLEY: When the Public Health Act became an act in 2016, we put together the "Public Health Act Handbook", which takes local government—it is aimed at local government—through a step by step: this is the Public Health Act; this is what it involves. We go through it part by part to provide explanatory information. In regard to public health planning, we have produced the public health planning guide, which, again, is a step-by-step guide to say to local government, "These are the steps that you should follow to make sure that you are producing a plan that complies with the requirements of the act."

If I can go back to your previous question about other agencies, we will be going out and speaking to other government agencies; that is on our list of things to do. The initial plan was in response to cries from local government: "We want a state public health plan. We have to align with it and so we would like a plan so that we can start our plans." Our instructions from Tarun were to take our current priorities and put them into the plan and put it out for consultation. Based on the consultation that we have got back, we have seen what the common themes are and we will be going out and talking to those state agencies.

[10.40 am]

Mr W.R. MARMION: The point I would make is to say that when I read this for the first time today, it is really good and I think you have got to be careful that you do not overplay things. As an engineer, this is an ideal document, and anything further than this, you would go, "Let's put it on the shelf." Either you are cautious, which I think is the point you are making, in going out to public consultation and every time someone says that, let us put that in and put that in. The massive thing is that no-one cares and you lose the power of these very strong objectives and a short list of key policy priorities. I was interested in your comment on climate change. I am trying to work out how climate change —

Ms S.E. WINTON: That was my question. I wanted some more information on what the thinking was on the submissions about climate change.

Mr W.R. MARMION: Yes, how the hell climate change—because someone said, "Let's put climate change in". It is a nice topic. How would it fit in your term "objective"?

Dr WEERAMANTHRI: Thank you, Mr Marmion. That is very much our consideration as we develop this—that we do not overload it. On the point already made about other legislation, if there is other legislation already there, we are not going to be putting our energy to reinvent road safety legislation or liquor control legislation et cetera. We already have a role in that that is already happening. The value-add here is in the other areas and then making sure they link appropriately, obviously. We would have to think very carefully about putting stuff in just because people want it in. You can imagine that we have lots of people writing to us saying that they would like this or that issue included. It is not that they are not legitimate issues; of course they are legitimate issues, but you might give them some mention somewhere without —

The CHAIR: My understanding is that the issue about the changing nature of climate is more to do with the different infectious diseases that can come as part of that, just taking into account the public health risks if we had extended periods of time of heat waves or extended periods of time of cold because of the uncertainty. What it is saying to local government is: "You should be aware of those things when you are doing your public health plans." Is that not the point? That is my understanding.

Dr WEERAMANTHRI: Yes. That would be a way of introducing something which is kind of a guidance or a tool. Just to be very clear, I think it is an extremely important health issue—both the mitigation and adaptation aspects of climate change. The idea, though, that it is going to be dealt with primarily through this kind of mechanism, I think, overloads this mechanism. There will be other mechanisms that we have to create and other processes which would address that. We have done extensive work—more than any other state government health department—on health heatwave, for example. You are quite right, Chair —

The CHAIR: Or the mosquito outbreak that we have currently got up in the north west. There are questions about whether there is linkage if we have further off-season wet seasons. My understanding is some of the issue is with off-season wet seasons.

Mr W.R. MARMION: My comment on that is it is covered—preventable, controlled diseases and stuff. That is obviously an implication. You have to be alert to a big dry period as well, but a wet season —

The CHAIR: Anyway, let us not get into the argument over it.

Mr W.R. MARMION: It is covered.

The CHAIR: There is often criticism by community organisations that want to hold a barbecue or want to hold a quick festival around the obligations that are placed on them by local government in terms of delivering a community service to their community because of the public health and food requirements. How does the public health plans for local government interplay with that to ensure that it does not become this punitive tick-a-box that says to communities, "No, you can't have your regular food market"? I can give a great example. The Burmese community loves having their food market outside of one of the particular temples. It is not in the electorate I represent. It was a monetary exchange. Now it has become a barter exchange so that they get around those sorts of things. They constantly get cracked down on by the local council to the point where they basically have to take themselves out of the council and do it in other places. But that is a cultural thing that they do. How do you interplay that for local government, or do you not? You do not go near it?

Dr WEERAMANTHRI: The precursor of the Public Health Act and its new approach was the Food Act, which came in six or seven years ago now, and that has the new risk-based approach. We had plenty of discussions about sausage sizzles in the lead-up to the new Food Act. Sausage sizzles still go ahead. It is not as though you cannot have sausage sizzles —

The CHAIR: Yes, but sausage sizzles are very much an Australian cultural thing. I am talking about other sorts of community functions that are beyond the sausage sizzle.

Dr WEERAMANTHRI: There is a risk framework here, and so you would expect that local governments, and they do, make these decisions all the time about what the level of risk is and appropriate activities. They are best placed to do it for a particular stall in a particular shopping centre or whatever it is. We accept that you would not want some person in a central office in Perth making decisions for the whole of this wonderful state; you actually want devolved responsibility, as long as we give them reasonable frameworks to make those decisions. Local governments are closer to the community than we are in state government; that is the whole point. They are more receptive to the feedback and therefore they will generally get to a reasonable outcome.

The CHAIR: How is that appealable?

Dr WEERAMANTHRI: I am not an expert on local government —

The CHAIR: Just in a practical sense of trying to serve your community, that capacity to be able to go from a state level, where you are saying we cannot determine what happens on a local level, but you get the complaints up, how do you then go actually —

Dr WEERAMANTHRI: We do not see most of the complaints; most of the complaints would come back to local government, I would have to say.

The CHAIR: Maybe I can take that offline with you.

Ms CROSSLEY: The public health planning and the legislative requirements sit alongside each other. I can also talk from working for a not-for-profit organisation. It can be difficult to set up events. But we have to manage the risk, and that is what the legislation is there for. You have to manage food risk; you have to manage crowd risk. It may actually be, though, that public health planning can help organisations such as that, because a lot of the public health plans have said that they want to increase community involvement. If one of the things that gets fed back to local government is, "Actually, we want to do this, but it's really difficult", they may then develop a policy of, "How can we help you to do that? How can we develop a template risk management plan that you can put the right information in? How can we provide you with a venue that is suitable for what you want to do that provides you with handwashing facilities that you need to serve food?", and things like that.

The CHAIR: How do people know, though, to input into the public health plan? Once the public health plan is done, then you just get the local government official who says, "Don't talk to me about it. It's what's written down here." That is what they say. You have got your inspectors, or whatever they are called, from local government, and they basically say, "That's the rules." They do not say, "Actually, it is an overarching risk management plan." They say, "They're the rules and that's what you should do!" How can you say to the community, "This is how you input"? How do you ensure that local government is doing that?

[10.50 am]

Dr WEERAMANTHRI: This conversation does need to change and this process does support such a change in the conversation. We do not want environmental health officers just saying, "Well, they're the rules and lump it or leave it", because that is not an explanation about why the rules are there and why that is an appropriate risk management strategy. But you want a discussion about what is a reasonable thing to be doing to increase community involvement or something with basic safeguards. People do not want to be carried away on stretchers, sick, following the event, and no-one wants that. Food illness is a major cause of illness in our community. If we can provide the environment that Kelly just said, with appropriate facilities for you, we can come to some kind of agreeable outcome where everyone's needs are met.

It has to be a more nuanced conversation, and the new legislation actually does give a real strong push to that. We have got a bit of a cultural change that we have also had with environmental health officers. We have not shied away from that at all in the last few years. I would go to the environmental health association every year and we have pretty tough conversations about the shift in mindset that is needed to be an authorised officer or environmental health officer under the new act. A couple of years ago I went to the environmental health association conference and said the talk was "a new Public Health Act requires new public health thinking and ways of being". That is a tough message for some people who were trained under oldschool. But it is changing and all you can do is encourage the shift in conversation. Some of the younger, and older, environmental health officers are successfully making this shift.

I agree with you, but no form of government should ever be engaged with the public—no public officer should ever be engaged with the public in that kind of matter. Seriously, that is not the world we want, is it? You go to a Centrelink officer, you go to your local post office, or you go anywhere. You do not want to be engaged in a kind of arbitrary manner.

The CHAIR: No, you do not, and what it does is that it means that people go off grid. They do it off grid and they put people at more risk, because that is what you see happen. I always joke that I have got my own form of Uber Eats going on in the seat of Mirrabooka, and it certainly is not being regulated by anyone, you know. That is what happens; things go off grid and people will do what they do because you start to place—it is not a risk minimisation. For me, coming from an occ health and safety background, it is that whole thing. You can write all the policies you like, but when the workers get to that workplace, if they think that they are stupid policies, they will do things that are unsafe.

Ms CROSSLEY: The beauty of public health planning and the strategic planning in the Local Government Act before it is that it actually requires them to go out and have that conversation and consult with the community. The Health Act 1911 that we are replacing essentially provides a set of rules for local government to go out and enforce. This says now: go out; consult with your community; see what they want; see what the data says.

The CHAIR: And the data is the important thing.

Mr W.R. MARMION: An area of interest is immunisation—the concern that it is more of a statewide policy rather than local. If it is supposed to flow down, I would be interested in how it does. But that is of concern too, I think, as general policy. If we try to get 100 per cent immunisation, that would be fantastic. I think it is important that politicians promote that. All you need is a couple of weak links and someone saying, "No, we don't think immunisation is any good", and you end up getting a crack. I am interested in how that policy, which I am sure you probably support—how we can make sure that is strengthened?

Dr WEERAMANTHRI: It is a really good question. It goes back to honourable member Mr Love's question before about how you link up these things. We have a statewide immunisation strategy. The issue, though, is that immunisation is delivered primarily in general practice—it can be in health centres, in Aboriginal health centres. No one group is providing immunisation, but we take accountability of it through this overall strategy. We also now have data, which is actually produced at a national level, that goes back to each local government about their performance against immunisation standards. That is in the papers every year when it comes out because there is always one area of western suburbs, plus —

Mr W.R. MARMION: Denmark.

Dr WEERAMANTHRI: Yes, but it is also the western suburbs too sometimes.

Mr W.R. MARMION: I know; I agree.

Dr WEERAMANTHRI: And the highest immunisation rates sometimes are in the Kimberley in Aboriginal communities

Mr W.R. MARMION: They have got a vineyard down in Denmark as well.

Dr WEERAMANTHRI: So it drives the conversation we need to have about what more could we do, because that is not a good look for local government. Are they going to run education campaigns? Some local councils actually provide community health clinics specifically for immunisation and they have a variety of responses, and some will not be very active at all and will just let their GPs and community health centres get on with it. It is varied, but the data then drives some accountability. It all does need to be linked up. We have got the immunisation advisory committee. We have a responsibility to the state government. We have to link up with the federal government and their important initiatives. Ultimately, though, what is the outcome for the people of Western Australia? We have driven immunisation rates up together over the last five years since we have had a concerted strategy, and we have still got a way to go.

The CHAIR: I am interested in why we do not just link it with the child universal health checks. I cannot understand why we do not link that. When we have nurses going and checking kids at 18 months, two years, why are we not getting those same nurses to just give them their immunisations then?

Dr WEERAMANTHRI: I think we have had this conversation in the past. I think we have had some progress around linking those two activities, but if you can find a way of asking the department that question —

The CHAIR: I have; I have asked the department that question.

Dr WEERAMANTHRI: I do not think I am the right person to answer it, I am sorry.

The CHAIR: That is all right. I have also asked the department that question. It just seems a no-brainer to me. If you have got, especially now that we have child health centres attached to schools, child health nurses attached to schools, you know, there seems to be a link that you could just click it into them and they could be doing the immunisations when they are doing the child health checks.

But if you cannot answer that question, then that is fine. We can maybe ask the department. I have asked them for information personally because it just seems a bit odd.

Ms S.E. WINTON: I was going to ask about local governments. You are saying that some local governments are well advanced. Can you provide a bit more detail in terms of the sector overall; is it just individual councils, or what is your sense of local government's engagement so far?

Dr WEERAMANTHRI: Thank you for the question. I will go to Kelly in a second, if that is okay. I have had recent discussions with WALGA and they are playing a terrific role. Obviously, on the one hand, they are collecting a lot of the feedback from local councils, some of which is, "We don't have enough resources to do this," et cetera, so we are hearing that. But also they are trying to be really constructive and generate sharing and work with us to support the sector to do this. There have been some really positive conversations. It is not to say that individual local governments are not having problems as well, and they are also feeding back into our process directly to the interim state public health plan. Kelly, do you want to add to that?

Ms CROSSLEY: Some of the local councils have produced public health plans, and produced them many years ago in anticipation of the bill in 2014 and 2013. My impression seems to be that the metro local governments are the ones that are most active in it, but certainly we know that Port Hedland has got a public health plan—City of Albany. I can leave some examples with you. We are currently working with WALGA and also with Curtin University to start developing resources so that we can get out to the ones that are not as confident in doing it so that we can provide support to them in terms of education and resources.

Ms S.E. WINTON: That was the follow-up. Is the department closely monitoring local governments to know specifically which ones might need support or is that being left to hopefully they will do it? Are you monitoring it?

[11.00 am]

Ms CROSSLEY: At this stage we are not monitoring them because there is not a legal requirement for them to produce a public health plan, but we are certainly engaging with them and we are producing resources to try to assist them. I am going to the Kimberley and the Pilbara in April to discuss public health planning with them and to get a feel for how they feel about it, what they are happy with, maybe how we can support them. We will be going across the state to try to speak to the local governments.

Ms S.E. WINTON: Further to the point you were making in terms of some of the feedback from local governments in regard to resourcing, can you be more specific on the extent to which the sector has perhaps pushed back or said that they are going to find this difficult from a resource perspective, rather than just a generalised comment about that? Do you think that might be a problem?

Dr WEERAMANTHRI: I might start if that is okay. This was a big issue in the lead-up to the act. We discussed this at length, and it was a good discussion. There was clear policy intent that this not be an extra financial burden, in particular, on local government and that this would be about helping local government to use their resources more efficiently and effectively and tailored to the public health needs of their population, not adding extra services on top of what they did. It was not like, "You've got to do all of this environmental health stuff and now you'll have to do all of this healthy lifestyle stuff—go for it." It was not that discussion. Part of the way that we sought to make that real was to give local governments the capacity to integrate their planning with their existing plans, as opposed to having a standalone plan, giving them the flexibility to either ask the environmental health officer to do it or they could ask someone else in local government to do it, or they could get a consultant to come in and help them write their plan. Essentially, whatever worked for them, they

would be free to do. They have also got the capacity to recoup costs, as you know. If the cost of their activities based on their statutory responsibilities they have an ability to recoup, and that would be a local government decision.

The CHAIR: Recoup from ratepayers?

Dr WEERAMANTHRI: Yes. That was part of the discussion we had in committee. But it should not be that you would need to do a lot extra; you just need to use your existing resources in a different way. The other thing is time. Given the nature of how long people have got to prepare for it, it is not like you have to do it next week; people have got years of preparation. The other thing is resources. We are providing as many resources as we can to assist people. I think the last thing, as Kelly mentioned, is training. For those local governments that are particularly struggling, we will try to develop targeted training for them to assist them. Just like there might be a local government officer who has to do mosquito control, and they are not that au fait with all of the ins and outs of mosquitoes but they still have to do it in their local government area, so we go in and we get our experts to train them so that they become confident to do it. If we can do the tie-in, the tools, the training and there is a capacity to integrate with what you are already doing, and also name some of your existing activities as contributing, we think that the extra resourcing requirements are pretty minimal.

Ms S.E. WINTON: Do we have any specific numbers about how many local governments have actually commenced the work? Can we get that level? The department does not have that?

Ms CROSSLEY: We do not, because it is not a requirement for them to do it at this time and they are not required to notify us that they have done it. A lot of them have notified us, but we do not have specific numbers, no.

Dr WEERAMANTHRI: To answer that question, though, it is possible that WALGA may have done a survey. They were going out and surveying their members. They have not shared that. I do not think they have shared that bit of information with us, but they may have a better indication than we can give you.

Mr W.R. MARMION: Nedlands are not a member.

Dr WEERAMANTHRI: You are the only one.

Mr W.R. MARMION: I know.

Ms S.E. WINTON: Eventually then—apologies if I am asking a dumb question that I should know the answer to—the local governments will be required to write a report.

Dr WEERAMANTHRI: Write a plan.

Ms S.E. WINTON: But on their performance of how their plan is going? From my perspective, I am very interested in the actual accountability and auditing. Does this actually make a difference on the ground? I think it is one thing for local governments to be able to write a plan; how is it going to work to see whether their plan is making any key differences? How is that going to work?

Dr WEERAMANTHRI: I think it is a really good question. The act will say what it says.

Ms S.E. WINTON: But how does that look in terms of what local governments are required to do in terms of the department, in terms of producing their—I guess it is an annual report that they have to produce?

Dr WEERAMANTHRI: Part of the feedback is that we need a better evaluation framework for our state public health plan, so at a state level are we getting to where we said we would get to? Given that state and local public health plans have to align, how local public health plans are evaluated is

a really important question. I do not think we have a full set of answers in terms of how that is to be done yet.

Ms CROSSLEY: That is correct. We do not have the full set of answers just yet, but they are required to replace their plan every five years. In replacing the plan, they are required to look back at the previous plan to see if they have completed the tasks that they said they were going to and also to evaluate whether it has had the desired effect.

Ms S.E. WINTON: Does that evaluation—is there prescription in terms of how that evaluation is done? Is it just a generic evaluation or is it pushing back towards datasets to see if there are actually measurable improvements and outcomes?

Dr WEERAMANTHRI: We would, presumably—I am looking forward quite a few years here—produce guidance for local government around a kind of evaluation framework that they could use for their plans, so where that has not been written yet and will not be written for some years, I imagine. But it would almost certainly, given where we are going with our state public health plan, absolutely have that "Let's look at the data and performance indicators that you put in." So I totally agree.

The CHAIR: I have just two really quick questions; we have to wrap it up. Other states have done this some period of time ago, so they are all in front. Have there been any criticisms or any learnings—"learnings" is a terrible word—from the other states with respect to the path that we are heading down?

Ms CROSSLEY: South Australia and Victoria have legislated public health planning. Victoria is certainly much more advanced. South Australia introduced their act in 2011 and had their first plan in 2013. Victoria goes much further back than that; I think it is 2008. We have not received from them any feedback on things that did not work, but certainly because they are so much more advanced, they have a very mature system and we are looking at and learning from what they have done.

The CHAIR: Just finally, you have got all these planning documents and all this assistance for local government, but have you got a bit of a quick summary sheet that we could make available to our colleagues in the Parliament that would have some of the questions that local state members of Parliament should be asking their local governments about their state plans?

Ms CROSSLEY: For your state members, I am not sure. But certainly we have got frequently asked questions on our website about public health planning and, as we have said, we have got the documents.

The CHAIR: But that is more for planning. This is about how you are going with it, what data are you looking at and where are you heading. Can we ask you to put something together and write us back a letter so that we can then present it to our colleagues and say, "These are some of the questions you might be wanting to ask about what is happening in your local government", or are you not —

Dr WEERAMANTHRI: Before you write that down, with respect, I think we just have to be careful stepping into giving you advice about questions you ask your local council.

The CHAIR: I am just trying to help my colleagues be aware, because I have helped four colleagues be aware that there is a whole process going on in their communities around local health plans and I am not particularly sure that there will be lots of other colleagues who are quite so aware. There is a whole heap of work that is getting done in the local governments around the health of our communities and I am not sure that our colleagues are aware of that.

Dr WEERAMANTHRI: Let me put it this way: we are always seeking to help; that is our starting point. I always prefer a written request, which I can do something with. If you were to put something in writing to the Minister for Health, saying that you have talked to us, you are aware of public health planning and you feel that it would really help elected members to have some guidance or something—whatever you want—the minister can ask us to do it and we have authority to do that and we will do it as instructed. I just worry about a verbal interaction, because we do not quite know what you want us to do and we end up writing something that does not meet your needs and puts us in a slightly difficult position.

The CHAIR: I will have a discussion with my colleagues about it as well.

Mr W.R. MARMION: Perhaps something should come from the Minister for Health for his colleagues, saying, "You might want to get in touch with your electorate"—blah, blah, blah.

The CHAIR: I suppose the issue for you is that they are not required to do them at the moment, but they are getting on and doing them. So there is a whole bunch of activity about how that is happening. I am aware of it, so I am having conversations, but I do not think other people are having those same sorts of conversations.

Dr WEERAMANTHRI: It is pretty exciting. If you look at what we are trying to do and the conversations we are having, it is an exciting development. If people were absolutely quiet about this, we would be in trouble.

The CHAIR: Thank you.

Hearing concluded at 11.11 am

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