
Legal Issues in Business

Health

Volume 14, 2012

ISSN: 1442-911X

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Legal Issues in Business

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Objectives and Policy

Legal Issues in Business is a publication of the School of Business Law and Taxation at Curtin University, Perth, Australia. It fulfils a need amongst business law and taxation academics and professionals in business in Western Australia as it provides a vehicle to demonstrate how law is applied in business.

The journal aims to enhance knowledge transfer amongst academics, professionals, managers, educators, researchers and students in the area of business law and taxation. Businesses only survive by keeping abreast of current information that is pertinent to their area of commercial enterprise. Law and taxation are topics that regulate how business operates. This journal is designed to assist the transfer of knowledge from those who research and analyse the law to those who have to apply the law in their commercial undertakings.

The law that is applied in Western Australia is often based on legislation that emanates from the State parliament and thus tends to have either detailed or fundamental differences or similarities with the legislation found in other jurisdictions. An objective of this journal is to discuss these similarities and differences. Other law and taxation topics are based on legislation from the Commonwealth of Australia and, to that extent, discussion on these topics may be of interest to a wider audience throughout Australia. Other topics based on common law or 'judge made law' may have some general appeal throughout common law jurisdictions.

The initial editions of the journal have been designed to focus on particular businesses or industries. Earlier volumes of this journal can be obtained from the following webpage:

<http://www.cbs.curtin.edu.au/business/research/journals/legal-issues-in-business/table-of-contents>.

All Legal Issues in Business articles are subject to a double-blind peer review by specialists in the fields of law and taxation. Legal Issues in Business satisfies the requirements to be regarded as peer reviewed as contained in current Higher Education Research Data Collection (HERDC) Specifications (C1 Category). Legal Issues in Business also meets the description of a refereed journal as per current Department of Education, Employment and Workplace Relations (DEEWR) categories.

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Editorial

This volume of *Legal Issues in Business* examines some legal aspects that apply to health. The term 'health' as used in this edition of the journal encompasses a wide range of topics that apply to the general topic of health. The volume contains four articles that satisfied both the publishing criteria relating to references to the theme, and the double blind referee process. The contents of the papers apply to a variety of health topics. These include the statutory requirement for hospital boards to make financial reports, the absence of a global or regulatory structure to protect the right to health, the need to pay donors for egg donations during therapeutic cloning/somatic cell nuclear transfer (SCNT) research and the implications of workplace bullying in relation to occupational safety and health at the workplace.

The leading paper for this edition examines the need to pay egg donors for use in therapeutic cloning/somatic cell nuclear transfer research. It examines the *Prohibition of Human Cloning Act 2002* (Cth) and argues that egg donors should be paid for their significant contributions to this important research, and that in the formulation of an appropriate regulatory framework, there should be adequate safeguards to protect their interests. This is followed by an article that examines workplace bullying in the context of health and safety laws with particular reference to the application of key provisions of the new national model *Work Health and Safety Act*. It explains that businesses have an obligation to educate employees about their responsibilities in relation to workplace bullying.

The third and fourth papers have an international focus. One of them examines the challenge that globalisation poses to health and to health systems. It argues that health is a progressively realised right, and that the right to health lacks the protection of a global legal or regulatory structure. It examines the right to health in international instruments and some of the global challenges that are foreshadowed. The final paper examines the financial statement reporting by provincial hospital boards in Papua New Guinea in their attempts to comply with mandatory financial statement reporting requirements under the *Public Finances (Management) Act 1995* (PNG). The conclusion is reached in the paper that many of the hospital boards struggled to prepare the financial statements required by the legislation.

It is the aim of this journal's editorial board and its committees that the refereed articles in this volume will provide a useful resource for people working in the health sector. It is also hoped that some of the legal concepts dealt with in the articles will be of assistance to people exposed to the activities undertaken in this sector or for anyone who is working closely with the legal issues considered in these four papers.

Finally, we wish to thank the contributors and the anonymous referees who willingly and without any tangible recognition give such support to this journal. We should point out that for this edition a number of submissions did not proceed after the review process. Finally we wish to notify readers that due to strategic and policy changes at Curtin University the future production of this ranked journal is in doubt. All enquiries concerning future editions should be directed to the Dean of the newly created Curtin Law School.

Kevin G Brown and Pauline Sadler

Joint Editors

Legal Issues in Business

The Need to Pay Egg Donors for Use in Therapeutic Cloning/Somatic Cell Nuclear Transfer (SCNT) Research

Patrick Foong
New Zealand

Abstract

Therapeutic cloning/somatic cell nuclear transfer research was legalised in Australia when the *Research Involving Human Embryos Act 2002* (Cth) was amended in 2006. Human eggs are in demand as they are vital components for the research and one of the issues being debated is whether egg donors should be paid. Presently in Australia, the provision of monetary payment to these donors is prohibited. This article argues that egg donors should be paid for their significant contributions to this important research and in the formulation of an appropriate regulatory framework, there should be adequate safeguards to protect their interests.

Introduction

Since 2006 when the *Research Involving Human Embryos Act 2002* (Cth) ('RIHE Act 2002') was amended, therapeutic cloning/somatic cell nuclear transfer ('SCNT') research has been legalised in Australia. In this type of research, scientists hope to derive embryonic stem cells matched to a patient's DNA, by transferring the nucleus of the patient's cells into a human egg and developing it into a cloned embryo from which cells can be derived. As master cells, stem cells can give rise to a wide range of cells and tissues. They can become any type of cell to form skin, bones, organs and other body parts. Thus this research is important and scientists hope to discover medical treatments for patients who suffer from various types of serious diseases including diabetes and Parkinson's disease, and conditions such as spinal injuries.

Human eggs are vital elements for SCNT research. While scientists have created human embryonic stem cells ('HESC') from unwanted excess assisted reproductive technique ('ART') embryos, they prefer to

create stem cells from cloned embryos.¹ This is because excess ART eggs are usually from older women undergoing fertility treatments and as such, they are likely to be of lower quality. In addition, these leftover eggs are the ones that fail to fertilise and are usually ineffective for experiments.² Further, being frozen eggs, they need to be thawed and in the process, they tend to disintegrate.

Human eggs are in demand. SCNT is an inefficient process with an approximate success rate of one out of 200 attempts.³ Therefore, numerous eggs are needed to create stem cells from cloned human embryos and even scientists do not know how many eggs are required for the research.⁴ Without sufficient eggs, it is not possible

¹ Excess embryos are embryos that have been created in order to achieve a pregnancy and they have been created for an intended pregnancy, but after a period of frozen storage, are no longer needed for this purpose.

² Gretchen Vogel, 'Picking up the Pieces after Hwang' (2006) 312 (5773) *Science* 516.

³ *Ibid.* Dolly, the cloned sheep, was successfully cloned after 277 attempts.

⁴ Emily Singer, 'Lack of Human Eggs Could Hamper US Cloning Efforts' (15 June 2006) *MIT Technology Review*

to proceed with SCNT research.

As noted earlier, the legislation was amended in 2006 to permit SCNT research to be conducted in Australia. It is also noted that the provision of monetary payment to egg donors is currently prohibited by law under s 23 of the *Prohibition of Human Cloning Act 2002* (Cth) ('*PHC Act 2002*'). To ensure the availability of sufficient eggs for use in SCNT research, it is argued that egg donors should be paid for their donations, and to ensure ethical research, there should be adequate safeguards in place to protect the donors. This article explores the issues arising from the debate on paying egg donors and concludes with some recommendations to amend the existing Australian regulatory model on stem cell research.

The Prohibition of Payment to Egg Donors

As noted earlier, the provision of payment to egg donors in SCNT research is presently unlawful under s 23 of the *PHC Act 2002*. However, reimbursement of reasonable out-of-pocket expenses associated with the procedures is permitted, including travel expenses and loss of wages.⁵

The issue of monetary gain for egg donors in research raises concerns about the commodification of human tissue and the commercialisation of stem cell research. The expression 'commodification' can be explained as the attachment of financial value to something which is situated outside the economic domain. The value of some things cannot be conveyed in terms of money and the human body is one of them. Therefore, all donations of human bodily parts and tissues to research are expected to be altruistic, and in this context eggs cannot be sold or bought.

Another issue is the exploitation of women in research, namely lack of informed consent and duress as well as undue influence, all of which nullify genuine consent. It is crucial that women donate their eggs out of their own free will. There has been some negative publicity about research overseas which involved the unethical act of coercing research staff to donate their eggs. For instance, the 'Hwang debacle' concerns the South Korean experiment which required an average of 17 human eggs from donors for each successfully cloned human embryo. About 20 donors were paid 1.5 million won (approximately US\$1400) each.⁶ In addition, there were questions raised about the exploitation of the women who donated their eggs for the experiments and exposed themselves to serious health risks, including death, due to ovarian stimulation to obtain their eggs. Some of the egg donors were junior research assistants from Hwang's team.⁷ He drove one of them to a clinic where her eggs were removed, and accompanied her as she went through the egg extraction procedure.⁸ He even held her hand during the process.⁹

For a head researcher to physically accompany his research assistant for such a procedure is not compatible with the requirement that participation in research must be voluntary. It raised the question whether there had been genuine consent provided by the donors or whether these were cases of coercion or undue influence. A core commitment of research ethics is voluntariness and no research subject should be pressured to participate in research. Employees/research assistants of the research team should not be research subjects since they might feel compelled to participate. The same argument could be made about family members. During difficult economic times like the

<<http://www.technologyreview.com/news/405941/lack-of-human-eggs-could-hamper-us-cloning-efforts/>>.

⁵ Guideline 17.21.2 of the National Health and Medical Research Council's *Ethical Guidelines on the use of Assisted Reproductive Technology 2007* (Australian Government, 2007) ('*ART Guidelines 2007*').

⁶ Josephine Johnston, 'Paying Egg Donors: Exploring the Arguments' (2006) 36(1) *Hastings Centre Report* 28, 30.

⁷ *Ibid.*

⁸ Seoul National University Investigation Committee, 'The Final Report on Hwang's Research' (2006) *Seoul National University*

<http://www.useoul.edu/news0204_view.jsp?idx=63459&DI=EMP>.

⁹ Josephine Johnston, 'Paying Egg Donors: Exploring the Arguments' (2006) 36 *Hastings Centre Report* 28, 29.

global financial crisis, an economically disadvantaged woman might end up selling her eggs. She could be pressured or unduly influenced by her husband (or other family members) to donate her eggs to research.

On the issue of informed consent, there is a risk of money being used to induce women to donate their eggs without receiving sufficient information, such as the various health risks associated with egg extraction. As egg donors are exposed to an increased risk of morbidity or mortality by the stimulating hormone treatment required for egg retrieval, they must be informed about these serious risks prior to donation. Without this knowledge, there is significant doubt as to whether there is informed consent.

Arguments in Favour of Paying Egg Donors

As mentioned above, the provision of money to egg donors in SCNT research raises concerns about the commodification of human tissues, commercialisation of stem cell research and exploitation of women. However, it is argued that donors should be paid on condition there are adequate safeguards to protect their interests.

In sharp contrast to sperm and blood donation, egg donation is far more complex and risky. The egg retrieval process is invasive, painful and uncomfortable. The donor needs high doses of ovary stimulating drugs to force the ovaries to produce many eggs which may cause health risks to her.¹⁰ The risks include infections and moodiness and about 6% of egg donors experience ovarian hyperstimulation syndrome ('OHSS'), a condition which can lead to nausea, bloating, kidney failure and even death.¹¹ Despite the frequent use of ovarian stimulation and egg retrieval in IVF cycles, there is a dearth of studies on both short-term and long-term adverse consequences of ovarian stimulation and egg donation, which leads to uncertainties surrounding

the effects of the drugs and procedures.¹² There have been at least two deaths in UK following IVF treatment.¹³ The long-term risks of ovary stimulating drugs include the possibility of cancer. Use of fertility drugs could be linked to certain cancers, for instance reproductive cancer, which may not develop until donors reach their 50s or 60s.¹⁴ Thus, egg collection and ovarian stimulation are associated with more risks than the removal of other tissues for research.

In view of these risks, burdens and inconveniences, donors who provide their eggs for SCNT research should be sufficiently compensated provided there are adequate safeguards in the regulatory framework to prevent the exploitation of these women. Complete prohibition of payment to egg donors in order to protect their interests reflects paternalism or patriarchalism of the state. In contrast, there are other highly risky jobs like film stunts and construction work where payments are not prohibited but the state protects workers' safety.¹⁵ By the same token, it is argued that women who participate in risky activity such as egg donation for research should be paid and they are better protected with open procedures and proper regulation than by prohibiting payment.¹⁶

If the law permits the payment of donors for supplying eggs for SCNT research, it is crucial to provide appropriate safeguards in the regulatory framework. The next section of the article explores the importance of various safeguards.

¹² Heidi Mertes and Guido Pennings, 'Oocyte Donation for Stem Cell Research' (2007) 22(3) *Human Reproduction* 629, 630.

¹³ Katrina George, 'Women Overlooked in Biotech Debate' (2006) <<http://www.onlineopinion.com.au/view.asp?article=4887>>.

¹⁴ Ibid. See also Helen Pearson, 'Health Effects of Egg Donation May Take Decades to Emerge' (2006) 442 *Nature* 607.

¹⁵ Loane Skene, 'Why Not Pay Women to Donate their Eggs for Research?' *The Age* (online), 17 November 2009.

¹⁶ Ibid.

¹⁰ Helen Pearson, 'Health Effects of Egg Donation May Take Decades to Emerge' (2006) 442 *Nature* 607.

¹¹ Ibid.

The Importance of Safeguards

Safeguards are essential for protecting the interests of egg donors in SCNT research. As discussed earlier, there have been serious concerns raised about the exploitation of women in research if payment to egg donors is permitted by law. There are a number of safeguards proposed in this article and the importance of each of them is examined below.

All potential donors should be provided with comprehensive written information in the form of pamphlets, about egg production and the egg extraction process, as well as the attendant health risks. Information on the unknown and unstudied health risks should be included, as well as information on deaths, albeit only a few cases, associated with the development of OHSS. It is also crucial that the information be drafted in lay language that is comprehensible to donors from a variety of backgrounds, and that it also be available in different languages. Technicalities should be avoided and it is suggested that the language be appropriate to a person with at least high school education.

One-on-one counselling must also be provided to egg donors. Written information in itself is not completely effective as some donors may not even read the brochures provided. While it is necessary for a potential donor to receive extensive standard information on egg donation to research, it is possible that despite having received the relevant information, she does not fully understand all aspects of egg donation and may have some unanswered questions. She may feel overwhelmed and confused by the amount of complex information provided on egg donation. Therefore, it is recommended that personal one-on-one counselling be provided to a donor, either face-to-face or by telephone, so that she can freely ask questions and receive direct, specific answers and professional advice from a trained counsellor.

An egg donor should be allowed to change her mind about the donation up to the time her eggs are used in the research. It is important to recognise that some donors may reconsider and regret their decisions subsequent to providing consent to use their eggs in research. A donor may change her mind after reading, evaluating and reflecting upon the literature. She may receive additional information or advice later from another source and after considerable thought, decide to revoke her consent in light of the fresh information. She may also change her mind after having donated her eggs. In addition to being allowed to withdraw, the donor should be entitled to pro-rated payment for the portion of the research to which she has contributed, as well as her continuing medical and other care.

A woman who is at risk of developing OHSS should not be allowed to donate eggs. As previously discussed, OHSS is a serious medical condition that could lead to death, and this is a sound reason to refuse the donation.

A woman should not be allowed to donate if she has already undergone egg extraction six times in her life.¹⁷ The purpose of this safeguard is to limit the health risks of egg extraction for the donor. In addition, she can be allowed to donate her eggs only after she has had her own child(ren) and has decided not to have any more.¹⁸

The Stringent Regulatory Framework

Human embryo research is regulated by the *RIHE Act 2002*. This section analyses the *Act* in order to determine the extent of its strictness in the regulation of research involving embryos.

The *RIHE Act 2002* creates a national licensing scheme whereby researchers must be licensed for each research project that involves the use of a human embryo. It also creates a series of offences relating to the use of the

¹⁷ Pamela Foohey, 'Paying Women for their Eggs for Use in Stem Cell Research' (2010) 30 *Pace Law Review* 900, 924.

¹⁸ Loane Skene, 'Call to Pay Women for Stem Cell Research Eggs', *The Australian* (Sydney), 8 July 2009.

embryos without a licence. It is an offence to use an embryo that is not an excess ART embryo or SCNT embryo (s 11) and to breach a licence condition (s 12). The seriousness with which the legislature views these offences is reflected in the penalties with a maximum of five years' imprisonment.

The *RIHE Act 2002* establishes the Embryo Research Licensing Committee (s 13) whose principal task is to license the use of excess ART embryos and SCNT embryos in research (s 20). It is important to note that there are two stages to the issuing of a licence. First, s 21(3) of the *RIHE Act 2002* provides that the licensing committee must not issue the licence unless it is satisfied that the necessary conditions have been fulfilled, one of which is that the applicant must have obtained approval for the project from a human research ethics committee,¹⁹ in accordance with and acting in compliance with the *National Statement on Ethical Conduct in Human Research (2007)* ('*National Statement 2007*'). Secondly, s 21(4) of the *RIHE Act 2002* provides that in deciding where to issue the licence, the licensing committee is directed to have regard to various matters including 'any relevant guidelines ... issued by the CEO of the National Health and Medical Research Council (NHMRC) ...' and 'HREC's [human research ethics committee's] assessment of the application ...'.

It is noted that the *RIHE Act 2002* is accompanied by the NHMRC guidelines which set out the steps that researchers should follow. While these guidelines are not legally enforceable, failure to follow them is likely to result in non-issuance of a licence to conduct the research. As explained, the licensing committee will not issue a licence to a scientist who wishes to pursue SCNT research unless the research proposed in the application has been assessed and approved by a human research ethics committee. This committee will ensure

that the researcher has acted in accordance and in compliance with the *National Statement 2007*. Thus the research ethics committee's approval of the application is a condition for the issuing of a licence. There are important provisions that protect the interests of all research participants including egg donors in HESC research. The general guidance on consent is found in Part 2.2 of the *National Statement 2007*. Guideline 2.2.9 provides that a research participant's consent must be voluntary and no person should be coerced or pressured to participate in research. It stresses that in such circumstances, the consent must be voluntary, as always. Guideline 2.2.19 provides that people who decline to consent to participate in research need not give any reasons for their decisions. Moreover, the researcher should see that they will suffer no detriment as a consequence of their decision to decline. As for participants who initially agree to consent but later change their minds and wish to withdraw their consent, they are entitled to do so at any stage according to Guideline 2.2.20.

In deciding whether to issue a licence to the researcher, the licensing committee is also directed by s 21(4) of the *RIHE Act 2002* to have regard to the researcher's compliance with other NHMRC guidelines. Of significance is the *Ethical Guidelines on the use of Assisted Reproductive Technology (ART) in Clinical Practice and Research (2007)* ('*ART Guidelines 2007*'). Guideline 17.21.5 of the *ART Guidelines 2007* provides that donation of eggs must be voluntary and free from exploitation or coercion. According to Guideline 17.21.6, the potential donor should be given information in both oral and written form, including: a brief description of the project in lay language, a clear statement that the provision of her eggs is voluntary, a description of the intended use of her eggs, a description of the egg retrieval process including what will be done, where the procedure will be done and by whom, a statement of the potential risks associated with retrieving and donation of eggs, a description of how to

¹⁹ Research ethics committees are found in institutions and organisations. They are registered with Australia's National Health and Medical Research Council (NHMRC).

withdraw from egg donation, her right to refuse donation for a specific project but to agree to donation for another, and a statement about the availability of counselling resources.

Guideline 17.21.15 provides that donors should be offered counselling on the health risks as well as the psychological and ethical implications of donation. In addition, counsellors should be available at any time from before the commencement of the egg retrieval procedure till the time the eggs are used in research. An egg donor is entitled to change her mind and choose to withdraw her consent as provided in Guideline 17.21.8.

From the discussion above, it can be concluded that the current regulatory framework governing research involving human embryos is stringent. The author recommends that the law in Australia be amended to permit payment of those who donate eggs for SCNT research on condition that adequate safeguards in the regulatory framework are established. While the guidelines in both the *National Statement 2007* and *ART Guidelines 2007* provide various safeguards to egg donors for SCNT research, it is observed that they do not completely protect the interests of the donors. Accordingly, if the law is amended to allow payment of egg donors, it is crucial that the safeguards should be more comprehensive. For instance, detailed information must be clearly communicated in the brochures, including information on the unknown health risks and the known fatalities, as explored earlier. In addition, some women, such as those at risk of developing OHSS and females who have already undergone egg extraction six times, should not be allowed to donate.

Conclusion

As SCNT research is now permitted in Australia, human eggs as vital elements to the research are required. To recognise the risks of the medical procedure of egg extraction for research and to ensure a steady supply of human eggs so that meaningful

research can progress, it is recommended in this article that the current law in Australia should be amended to permit payment to be made to egg donors for their significant contribution to the research. In order to adequately protect donors' interests, the regulatory framework must incorporate additional robust safeguards that must be adhered to by the researcher.²⁰

²⁰ The following references were considered during the writing of this paper: David Cyranoski, 'Stem Cells: A National Project' (2008) 451 *Nature* 229; David Scadden and Anthony Komaroff, 'Will Stem Cells Finally Deliver?' (5 December 2008) *Newsweek* <<http://www.newsweek.com/2008/12/05/will-stem-cells-finally-deliver.html>>; Donald Kennedy, 'Editorial Retraction' (2006) 311 *Science* 335; Hub Zwart, 'Challenges of Macro-Ethics: Bioethics and the Transformation of Knowledge Production' (2008) 5 *Bioethical Inquiry* 283; Hwang W-Suk, et al, 'Evidence of a Pluripotent Human Embryonic Stem Cell Line Derived from a Cloned Blastocyst' (2004) 303 *Science* 1669; Hwang W-Suk, et al, 'Patient-Specific Embryonic Stem Cells derived from Human SCNT Blastocysts' (2005) 308 *Science* 1777; Katrina George, 'Women Overlooked in Biotech Debate' (13 September 2006) *On Line Debate* <www.onlineopinion.com.au/view.asp?article=4887>; Peter Aldhous, 'Forgotten Wrongs of Cloning "Pioneer"' (2006) 2537 *New Scientist* 22.

Workplace Health and Safety: Managing the Risk of Workplace Bullying

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Abstract

Workplace bullying is a threat to work health and safety. Bullying can create an unsafe, hostile, and threatening working environment. This article addresses workplace bullying in the context of health and safety laws with particular reference to the application of key provisions of the new model *Work Health and Safety Act*. To ensure a safe work environment, businesses have a duty and responsibility under work health and safety legislation to proactively manage risks, which includes a comprehensive and systematic approach to identifying, assessing, controlling and monitoring workplace bullying. Importantly, businesses have a duty to educate employees about their responsibilities in relation to workplace bullying.

Introduction: Why Focus on Workplace Bullying?

Workplace bullying is global, pervasive and a threat to work health and safety. Bullying left unchecked can create an unsafe, hostile, and threatening work environment that can have a very profound impact on employees affected by the bullying, whether it is the person targeted, the bully or the bystanders. Although there is no large-scale study on workplace bullying in Australia, research nonetheless highlights that bullying is a workplace health and safety issue that needs to be purposefully addressed. A national poll conducted by Essential Research in 2011 for Jobwatch reported that almost one in five Australians surveyed reported being bullied, intimidated or harassed at work. Of the 1037 people surveyed, 37% had experienced or were aware of workplace intimidation, bullying or harassment, with 19% having being affected directly.¹ Other research has

highlighted the financial cost of workplace bullying. For example, the Australian Human Rights Commission has estimated that when hidden and lost opportunity costs are considered the annual financial cost of workplace bullying in Australia is between AU\$6 billion and AU\$36 billion.² This estimate was calculated by including costs such as absenteeism, labour turnover, loss of productivity, and legal costs. The Victorian WorkCover Authority estimates that bullying costs businesses more than AU\$57 million a year in that jurisdiction alone.³

Although Australia does not have specific laws that deal with workplace bullying, various systems of protection

<http://www.jobwatch.org.au/images/stories/pdf/Media_release_Intimidation_Bullying_Rife_Vic.pdf>.

² Human Rights and Equal Opportunity Commission, *Factsheet: Workplace Bullying* (1 December 2004)

<http://www.hreoc.gov.au/info_for_employers/fact/workplace.html>.

³ WorkplaceInfo, *Bullying Issues* (2012)

<<http://www.workplaceinfo.com.au/nocookie/subjects/OHS/bullying.htm>>.

¹ JobWatch Employment Rights Legal Centre, 'Survey Shows Intimidation and Harassment Rife in Australian Workplaces' (Media Release, 11 July 2011)

are incorporated under different areas of the law including occupational health and safety, workers compensation, equal opportunity, contract law, and industrial relations.⁴ A failure to prevent bullying in the workplace is also actionable under common law. This article specially addresses workplace bullying in the context of health and safety laws and regulation with particular reference to the application of key provisions of the model *Work Health and Safety Act*.⁵ This article explains the meaning of workplace bullying, the consequences of workplace bullying and the obligations under the model *Work Health and Safety Act* that are relevant to managing and eliminating workplace bullying.

Defining Workplace Bullying

One of the problems associated with responding to and managing workplace bullying is the imprecise use of the term. However, while there is no single definition of bullying or workplace bullying, definitions in academic literature and workplace codes of conduct consistently characterise bullying as: repetitive, systematic behaviour; an abuse or misuse of power; and unwelcome and unreasonable behaviour that can have physical and psychological consequences for the victims of bullying. Namie and Namie describe bullying at work as 'repeated, health-harming mistreatment of a person by one or more workers that takes the form of verbal abuse; conduct or behaviours that are threatening, intimidating, or humiliating; sabotage that prevents work from being done; or some combination of the three'.⁶ The definition provided by WorkSafe Western Australia is typical of definitions found across all Australian jurisdictions: bullying is 'repeated unreasonable behaviour directed towards a worker or

group of workers that creates a risk to health and safety'.⁷ Similar definitions are to be found in WorkCover and WorkSafe guidelines in other jurisdictions.⁸

Common to most definitions is that workplace bullying is evidenced by at least three essential elements: (i) unreasonable behaviour; (ii) persistent behaviour repeated over a period of time; and (iii) harm or the threat of harm, whether physical or non-physical, to one or more persons. However, for bullying to be present there is no need for the behavior to be intentional.

Definitions and explanations of workplace bullying also refer to the imbalance of power. Field, for instance, notes that bullying at work 'occurs when one person, typically (but not necessarily) in a position of power, authority, trust, responsibility, management etc, feels threatened by another person, usually in a subordinate position who is displaying qualities of ability, popularity, knowledge, skill etc'.⁹ Rigby describes bullying as 'repeated oppression, psychological or physical, of a less powerful person by a more powerful person or group of persons'.¹⁰ This power imbalance is not confined to positional power but may also be based on expertise, experience, control of information and social position.¹¹

⁴ For a comprehensive discussion on bullying and the law see Joan Squelch and Robert Guthrie, 'The Australian Legal Framework for Workplace Bullying' (2010) 32(1) *Comparative Labor Law and Policy Journal* 15.

⁵ Safe Work Australia, *Model Work Health and Safety Act* <<http://www.safeworkaustralia.gov.au/sites/swa/legislation/pages/modelwhslegislation.aspx>>.

⁶ Gary Namie and Ruth Namie, *The Bully at Work* (Sourcebooks, 2009).

⁷ Commission for Occupational Safety and Health, *Dealing with Bullying at Work: A Guide for Workers* (November 2008) WorkSafe WA

<http://www.commerce.wa.gov.au/WorkSafe/PDF/Guidance_notes/Dealing_with%20bullying_english.pdf>.

⁸ See eg, WorkSafe Victoria, 'Your Guide to Workplace Bullying – Prevention and Response'

<http://www.worksafe.vic.gov.au/__data/assets/pdf_file/0008/42893/WS_Bullying_Guide_Web2.pdf>. WorkSafe ACT, *Bullying 3: Recognising and Responding to Bullying* (2010) ACT Government <http://cdn.justice.act.gov.au/resources/uploads/Worksafe/Publications/Handbooks/WSACT_HB_0016_-_Bullying_3_Recognising_and_Responding_to_Bullying_.pdf>.

⁹ Tim Field, *Bullying in Sight: How to Predict, Resist, Challenge and Combat Workplace Bullying* (Success Limited, 1996).

¹⁰ Ken Rigby, *Bullying in Schools and What to do About It* (Jessica Kingsley Publisher, 1996).

¹¹ Carlo Caponecchia and Anne Wyatt, 'Distinguishing Between Workplace Bullying, Harassment and Violence: A

Bullying is characterised by behaviour that is repetitive rather than a one-off incident. Nonetheless, depending on the circumstances a one-off episode signals a warning of bullying tendencies, and the incident may well escalate into a pattern of repeated bullying behaviour. The Tasmanian guidance note on bullying explains that if 'behaviour goes beyond a one-off disagreement, if it increases in intensity and becomes offensive or harmful to someone it becomes bullying' and that this is a workplace health and safety risk.¹² Similarly, the Queensland Practice Note on preventing workplace harassment states that a 'single incident of harassing type behaviour is not considered to be workplace harassment'. Nevertheless, 'single incidents of harassing type behaviour should not be ignored or allowed' and may be actionable as forms of harassment and/or assault depending on the circumstances.¹³

The concept of bullying is often used interchangeably with harassment and/or discrimination, which may lead to confusion. Bullying, harassment and discrimination are not mutually exclusive terms. They are distinguishable and should not be confused. Unlike bullying, harassment and discrimination do not have to be repeated and have to be based on some characteristic of the target. Harassment that becomes persistent and repetitive over a period of time may escalate into bullying. Notably however, the Queensland *Code of Practice* uses the term 'workplace harassment' rather than bullying, which is described as 'repeated behaviour, other than behaviour amounting to sexual harassment, by a person, including the person's employer or a coworker or group of coworkers of the

person that is unwelcome and unsolicited, the person considers to be offensive, intimidating, humiliating or threatening, or a reasonable person would consider to be offensive, humiliating, intimidating or threatening'.¹⁴

In Australia harassment is covered by various Commonwealth and state anti-discrimination legislation. Harassment is generally described as unwanted and unwelcome behaviour that causes humiliation and creates a hostile working environment. Harassment based on a particular characteristic such as gender, race, sexual orientation, age and religion is prohibited under anti-discrimination legislation. Harassment includes sexual and racial harassment that is repetitive, unwanted, demeaning, and threatening. Examples include name-calling, offensive comments and jokes based on race or gender, displaying of offensive material that is sexist and racist, and isolating a person because of their gender or race. For example, s 17(1) of the *Anti-Discrimination Act 1998* (Tas) states that a person must not offend, humiliate, intimidate, insult or ridicule another person on the basis of sex/gender, marital status, pregnancy, breastfeeding, parental status or family responsibilities where a reasonable person, having regard to all the circumstances, would anticipate the other person would be offended, humiliated, intimidated, insulted or ridiculed. Some bullying behaviour may fall within this provision and be unlawful. Harassment, however, may be distinguished from 'discrimination' in that discrimination is concerned with the 'unfair treatment' of a person as opposed to behaviour generally that causes humiliation and an unsafe environment.¹⁵

Risk Management Approach' (2009) 25(6) *Journal of Occupational Health Safety Australia and New Zealand* 439.

¹² Workplace Standards Tasmania, *Bullying: A Guide for Employers and Workers* (June 2010) Tasmanian Government <http://www.wst.tas.gov.au/__data/assets/pdf_file/0006/146256/GB253.pdf>.

¹³ Workplace Health and Safety Queensland, *Prevention of Workplace Harassment: Code of Practice 2004* (2011) Queensland Government <<http://www.deir.qld.gov.au/workplace/resources/pdfs/prevention-workplace-harassment-cop-2004.pdf>>.

¹⁴ Ibid.

¹⁵ Caponecchia and Wyatt, above n 11, 442. For a useful explanation on harassment and discrimination, see the New South Wales Anti-Discrimination Board, *Harassment and Sexual Harassment* (20 March 2012) NSW Government <http://www.lawlink.nsw.gov.au/lawlink/adb/ll_adb.nsf/pages/adb_harassment#What>.

Bullying: A Risk to Work Health and Safety

Rigby notes that it 'is not uncommon to find people who believe that bullying does no real harm'.¹⁶ However, substantial research-based commentary¹⁷ as well as examples from case law indicate otherwise. Research has shown that respondents who have reported being bullied¹⁸ at work were more likely to report psychosomatic symptoms, and that mobbing has severe health consequences.¹⁹ Bullying does cause harm. Bullying has been associated with absence from work,²⁰ burn-out,²¹ and stress.²² Whether bullying is verbal or non-verbal, physical or non-physical, intentional or unintentional, direct or indirect, the effect is the same: it is designed to control, hurt, intimidate and humiliate, with potentially serious consequences for the health and safety of those concerned. Besides the physical injuries that might be sustained from physical bullying, it can give rise to various psychological symptoms that have severe consequences for the victims including anxiety, fear, depression, low self-esteem and, in some extreme cases of bullying, suicide. Often these symptoms of serious psychological harm render a person unfit for work leading to absenteeism, reduced productivity and incapacity to work.

¹⁶ Ken Rigby, 'Bullying in Schools and the Workplace' in Paul McCarthy et al (eds), *Bullying. From Backyard to Boardroom* (Federation Press, 2001) 5.

¹⁷ See, eg, Namie and Namie, above n 6; Tim Field, above n 9; Margaret Kohut, *The Complete Guide to Understanding, Controlling and Stopping Bullies and Bullying at Work* (Atlantic Publishing Group, 2008).

¹⁸ Mobbing is a term sometimes used to describe bullying behaviour where the perpetrator is a group of people rather than an individual.

¹⁹ Dieter Zapf, Carmen Knorz and Matthias Kulla, 'On the Relationship Between Mobbing Factors, and Job Content, Social Work Environment, and Health Outcomes' (1996) 5(2) *European Journal of Work and Organizational Psychology* 215.

²⁰ Adrian Ortega et al, 'One-Year Prospective Study on the Effect of Workplace Bullying on Long-Term Sickness Absence' (2011) 19 *Journal of Nursing Management* 752.

²¹ S Einarsen, S Matthiesen and A Skogstad, 'Bullying Burnout and Well-Being Among Assistant Nurses' (1998) 14(6) *Journal of Occupational Health and Safety – Australia/New Zealand* 563.

²² Heinz Leymann and Annelie Gustafsson, 'Mobbing at Work and the Development of Post-Traumatic Stress Disorders' (1996) 5 *European Journal of Work and Organizational Psychology* 251.

The harm caused by bullying is starkly demonstrated in a recent case in which a Melbourne café owner was fined AU\$220 000 under Victoria's *Health and Safety Act 2004* for failing to provide a safe work environment after an employee waitress committed suicide because of workplace bullying.²³ The bullying was described as 'persistent and vicious' and included the employee being spat on and regularly called hurtful names. The magistrate reportedly described the atmosphere in the café as poisonous. The coworkers who carried out the bullying were individually fined between AU\$10 000 and AU\$45 000.²⁴ The case of *Naidu v Group 4 Securitas Pty Limited*²⁵ is a further example of the harmful consequences of bullying. In this case the employee was subjected to ongoing harassment, racial and sexual abuse, humiliation, unreasonable workloads and pressure, and threats of violence and financial harm by his supervisor,²⁶ and as result suffered post-traumatic stress disorder and major depression. Adams J noted that 'so extreme was [the supervisor's] behaviour that he well knew, or would have known had he reflected as a reasonable man should have, that prolonged misconduct of the kind he exhibited towards the plaintiff could reasonably be expected to expose him to the real risk of such psychological injury'.²⁷ Adams J further concluded that 'the conduct as a whole indeed

²³ 'Company, Workers Fined \$335k for Waitress's Bullying' *ABC News* (online), 8 February 2010 <<http://www.abc.net.au/news/stories/2010/02/08/2812998.htm?site=Melbourne>>. The Victorian *Crimes Amendment (Bullying) Act 2011* [Assented to 7 June 2011] amends s 21A of the *Crimes Act 1958* (Vic) to apply the offence of stalking to situations of serious bullying. The amendments follow the case of a young waitress who took her own life after being subjected to vicious workplace bullying at a Melbourne café. *Victorian Legislation and Parliamentary Documents: Archive* <<http://www.parliament.vic.gov.au/static/www.legislation.vic.gov.au-bills-archive.html>>.

²⁴ *Ibid*.

²⁵ *Naidu v Group 4 Securitas Pty Limited* [2005] NSWSC 618.

²⁶ For example, the plaintiff was given unreasonably long shifts and he was refused permission to collect his wife from hospital when she had to seek medical treatment for her pregnancy.

²⁷ *Naidu v Group 4 Securitas Pty Ltd* [2005] NSWSC 618, 20. The Court awarded damages against Nationwide News for the sum of \$1 946 189.40 and \$150 000 in exemplary damages because the employer knew about the bullying but did not do anything about it.

resulted in injury of a psychological kind, giving rise to perceptible psychiatric illness and that a substantial cause was internal – that is to say, workplace related’.²⁸ These two cases clearly demonstrate the nature of bullying, the harmful consequences of bullying and the implications for employers who fail to provide a safe work environment and take the necessary steps to address bullying behaviour.

Workplace bullying that may cause both physical and/or psychological harm and injury includes the following unreasonable behaviour: intimidation; abusive and offensive language; aggressive communication, unreasonable excessive criticism; excessive scrutiny of work, threatening to withhold promotion or some other benefit; imposing undue pressure and unreasonable workloads; undermining a person’s work performance; withholding information; initiation and pranks; physical abuse and threats; spreading malicious rumors and gossip about a person; and ostracising a person.²⁹ Cyber bullying via email, text messaging and the internet is also a more recent phenomenon in the workplace. Zapf identified five types of behaviour which constitute the most frequent types of workplace bullying, namely (a) changing work tasks, being given demeaning work tasks, withholding job related information, excessive monitoring or removal of areas of responsibility; (b) social isolation; (c) personal attacks by ridicule or insult; (d) verbal threats; and (e) spreading rumours.³⁰

The hazardous nature of bullying and the associated risks to health and safety are well documented in the literature on workplace bullying, and evidenced in case law. The cost of bullying to employers and the harm caused to employees point to an unequivocal need for organisations to proactively address workplace bullying.

²⁸Ibid 20.

²⁹ See, eg, Namie and Namie, above n 6; Tim Field, above n 9; Rigby, above n 16; Kohut, above n 17.

³⁰Dieter Zapf, ‘Organisational, Work Group Related and Personal Causes of Mobbing/Bullying at Work’ (1999) 20(1) *International Journal of Manpower* 70.

Obligations to manage and reduce bullying in the workplace are found in health and safety legislation.

Model Health and Safety Legislation

All Australian jurisdictions have health and safety laws, as well as various regulations and guidelines that are aimed at ensuring a safe and healthy work environment by reducing hazards and managing risks. In January 2012 the model *Work Health and Safety Act* (‘WHS Act’) came into operation.³¹ The aim of harmonising the work health and safety laws was inter alia to significantly reduce the incidence of death, injury and disease in the workplace. The main object of this *Act* is to provide for ‘a balanced and nationally consistent framework to secure the health and safety of workers and workplaces by (a) protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work’.³² Although health and safety legislation in Australia does not specifically mention bullying, it is axiomatic that bullying in the workplace is a hazard that has the potential to harm the health and safety of people, with the most severe bullying leading to suicide, as noted above.

Duty of Care

The *WHS Act* contains general duties to provide a safe workplace. There is a primary duty on persons³³ conducting a business or undertaking (PCBU) to ensure, so far as reasonably practicable, the health and safety of workers³⁴ and others who may be affected by the

³¹Safe Work Australia, above n 5. The new model work health and safety laws commenced in New South Wales, Queensland, the Australian Capital Territory, the Commonwealth and the Northern Territory on 1 January 2012. Western Australia and Victoria have deferred commencement until such time that all the law can be implemented together for all sectors, and Tasmania and South Australia have deferred the debate on the new laws.

³²Model *Work Health and Safety Act*, s 3.

³³ The PCBU is the employer which is broadly defined, see s 5.

³⁴ A person is a worker if the person carries out work in any capacity for a person conducting a business or undertaking, including work as: an employee; or a contractor or subcontractor; or an employee of a contractor or subcontractor; or an employee of a labour hire company who

carrying out of work.³⁵ The introduction of the concept of PCBU is a departure from narrower concepts of duty which fixed the responsibility for workplace health and safety with the employers. The PCBU concept clearly includes employers and various forms of contractors and managers of workplaces and therefore expands the group of persons who might be liable for breaches of workplace safety. The *WHS Act* further places a positive duty on officers³⁶ of a PCBU, for example directors and senior managers, to comply with duties under the *Act* and to exercise due diligence to ensure that the person conducting the business or undertaking complies with the duty³⁷ to establish a healthy and safe environment. Due diligence essentially means to take 'reasonable steps' such as acquiring up-to-date knowledge of work health and safety matters, understanding operations of the business or undertaking and associated hazards and risk, and ensuring appropriate resources and processes are available to eliminate or minimise risks to health and safety, appropriate processes are in place for receiving and considering information regarding incidents, hazards and risks, and responding in a timely way to information and processes for complying with any duty or obligation under the *Act*.³⁸

There are also provisions that require workers and others (whether or not the person has another duty under this Part) to 'take reasonable care for his or her own health and safety' and 'take reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons'.³⁹ The duty to provide a safe environment and take care not to engage in conduct that is likely to cause harm to others extends to preventing and eliminating bullying in the workplace.

has been assigned to work in the person's business or undertaking; or an outworker; or an apprentice or trainee; or a student gaining work experience; or a volunteer; or a person of a prescribed class: *Model Work Health and Safety Act*, s 7.

³⁵ *Model Work Health and Safety Act*, div 2, s 19.

³⁶ Officers are defined as per s 9 of the *Corporations Act* (Cth). It includes officers of corporations and unincorporated associations.

³⁷ *Model Work Health and Safety Act*, s 7(1).

³⁸ *Ibid* s 27(5).

³⁹ *Ibid* ss 28 and 29.

A duty to protect workers from bullying was noted in a New South Wales case in 2004 in which a company was fined when a sixteen-year-old labourer was severely physically and psychologically bullied.⁴⁰ The Industrial Commission reiterated the words of the Chief Industrial Magistrate stating that:

A purpose of the Occupational Health and Safety Act is to eliminate risks to health and safety at the workplace. What occurred on this day is often described as an initiation. It is a polite term for bullying. A bullying culture has been known to exist in some workplaces, often seen as a bit of fun at the expense of someone else. It is a culture that needs to be stamped out. Bullying has no place in the workplace.⁴¹

Moreover the Industrial Commission noted that:

issues of violence and bullying in the workplace require sober and serious consideration. It is imperative, in our view, that the jurisprudence of this Court is unambiguous in its condemnation of such conduct. ... Further, it must be made abundantly clear **that safeguarding health and safety in the workplace extends to protecting employees from bullying and violence from other employees**[emphasis added].⁴²

The employer was fined AU\$24 000 when prosecuted under the New South Wales *Occupational Health and Safety Act 2000*. The two directors, one of whom was in the factory at the time of the incident, were originally fined nominal sums of AU\$1000, but on appeal this was raised to AU\$9000 and AU\$12 000, given the severity of the conduct.⁴³

⁴⁰ *Inspector Maddaford v Coleman* [2004] NSWIR Comm 317 (3 November 2004).

⁴¹ *Ibid* 14.

⁴² *Ibid* 30.

⁴³ The coworkers were also prosecuted and placed on good behaviour bonds, with one worker, Pomente, fined AU\$500.

Risk Management

The *WHS Act* provides that a duty imposed on a person to ensure health and safety requires the person to eliminate risks to health and safety, so far as is reasonably practicable; and if it is not reasonably practicable to eliminate risks to health and safety, to minimise those risks so far as is reasonably practicable.⁴⁴ 'Reasonably practicable' essentially means that which can reasonably be done in the circumstances.⁴⁵ The *WHS Act* interpretative guidelines explain that 'reasonably practicable' is an objective test, which means that a duty-holder must meet the standard of behaviour expected of a reasonable person in the duty-holder's position and who is required to comply with the same duty. To meet this test the duty-holder must first consider what can be done in the circumstances for ensuring health and safety, and then determine whether it is reasonable in the circumstances to do all that is possible.⁴⁶ This requires weighing up all the factors as provided for in s 18, namely assessing:

- the likelihood of the hazard or the risk concerned occurring;
- the degree of harm that might result from the hazard or the risk;
- what the person concerned knows, or ought reasonably to know, about:
 - the hazard or the risk; and
 - ways of eliminating or minimising the risk;
- the availability and suitability of ways to eliminate or minimise the risk; and
- the cost associated with available ways of eliminating or minimising the risk.

⁴⁴ Model *Work Health and Safety Act* s 17.

⁴⁵ *Ibid* s 18.

⁴⁶ Safe Work Australia, *Interpretive Guideline – Model Work Health and Safety Act – the Meaning of 'Reasonably Practicable'* (26 September 2011) <<http://www.safeworkaustralia.gov.au/AboutSafeWorkAustralia/WhatWeDo/Publications/Pages/interpretive-Guideline-reasonably-practicable.aspx>>.

Risk management is important for responding to and managing the risks associated with bullying, including risks to the individuals as well as the organisation in terms of lost productivity, reputation, stress claims and legal claims. Comcare provides an example of a risk management process that gives effect to the risk management provisions under health and safety legislation, and which is effective for creating a positive, bully-free workplace.⁴⁷ The Comcare risk management process for workplace bullying is summarised as follows:

Figure 1: Risk Management of Workplace Bullying

Step 1: Identify the Hazard and Sources of Potential Harm	Identify if workplace bullying is a problem and obtain information about the sources of bullying.
Step 2: Assess the Risk	The information gathered is used to determine the likelihood of bullying occurring and the specific behaviours and circumstances where incidents of workplace bullying might occur.
Step 3: Control the Risk	Develop and implement a comprehensive set of practical measures to control the risk of bullying including senior management commitment, leadership initiatives, workplace culture initiatives, organisational initiatives and early intervention strategies.
Step 4: Monitor, Evaluate and Review	Measure and report against agreed targets and performance indicators and review against strategic goals. The aim is continuous improvement.

Consultation

The *WHS Act* requires that a person conducting a business or undertaking must, so far as is reasonably practicable, consult with workers who carry out work

⁴⁷ Comcare, *Bullying Risk Management Tool* (December 2010) Australian Government <http://www.comcare.gov.au/__data/assets/pdf_file/0015/70422/Bullying_risk_management_tool_OHS_74.pdf>. Comcare is the Commonwealth government agency that oversees and administers the *Work Health and Safety Act 2011* (Cth) and the *Work Health and Safety Regulations 2011* (Cth).

for the business or undertaking who are, or are likely to be, directly affected by a matter relating to work health or safety. Consultation may take place through health and safety representatives, health and safety committees (discussed below) and various informal arrangements. Health and safety matters on which workers should be consulted include when making decisions about ways to eliminate or minimise risks,⁴⁸ when proposing changes that may affect the health or safety of workers⁴⁹ and when making decisions about procedures that include providing information and training for workers.⁵⁰

It follows that consultation is relevant when managing workplace bullying and would include consultation on matters such as:

- adopting workplace bullying policies and procedures;
- reviewing and revising existing workplace bullying policies and procedures;
- determining procedures for managing bullying complaints; and
- providing information and training.

Training and Supervision

One of the duties that is required of a person conducting a business or undertaking to ensure, so far as reasonably practicable, the health and safety of workers and others is to provide any ‘information, training, instruction or supervision that is necessary to protect all persons from risks to their health and safety arising from work carried out as part of the conduct of the business or undertaking’.⁵¹ This is essential when dealing with workplace bullying. People need to be fully informed about matters relating to bullying such as the nature and consequences of bullying, how to manage bullying, and reporting bullying. There also needs to be adequate

supervision to ensure bullying does not take place and does not go unattended.

The importance and relevance of training and supervision have been at issue in a number of cases. In *WorkSafe Victoria v Ballarat Radio Pty Limited*,⁵² a worker at the Ballarat Radio station in Victoria had been verbally abused by a radio announcer who had also subjected fellow employees to verbal abuse and threats of violence while at work on over ten occasions in 2002 and 2003. He had also physically assaulted a colleague. The Magistrate hearing the complaint reported noted that the ‘explosive manner’ of the worker in dealing with other employees was inappropriate.⁵³ He noted that the incidents of bullying were serious, repetitive, and extended over a period of time. The worker was convicted and fined AU\$10 000 for intimidating coworkers and for failing to take care of the health and safety of others in the workplace. The broadcasting company was subsequently fined AU\$25 000 for failing to provide a safe workplace, and AU\$25 000 for failing to provide instruction, training, and supervision in relation to bullying. Similarly, in 2000 a panel beater was fined AU\$25 000 for failing to provide adequate supervision and a safe work environment after an apprentice was subjected to months of verbal and physical abuse by other employees. The directors were personally fined AU\$5000 and AU\$8000.⁵⁴ However, in a case in which an apprentice was bullied and suffered serious burns when ignited with brake fluid, the employer was not prosecuted as there was evidence that the company had reinforced its policy on bullying only a month prior to the incident. On the other hand, the two employee defendants were each fined AU\$5000 and dismissed from their employment.⁵⁵ This further illustrates the

⁵² (Unreported Ballarat Magistrate’s Court, August 2004).

⁵³ *Ibid.*

⁵⁴ CCH Update – *WorkCover v City Edge Panel Repairs*, Melbourne Magistrates Court, 10 July 2000.

⁵⁵ Worksafe Victoria, Third Prosecution after Apprentice Burnt in Workplace ‘Prank’ (News Release, 1 July 2010) <<http://www5.worksafe.vic.gov.au/wps/wcm/connect/wsinter>

⁴⁸ Model *Work Health and Safety Act* s 49(b).

⁴⁹ *Ibid* s 49(c).

⁵⁰ *Ibid* s 49(e)(v).

⁵¹ Model *Work Health and Safety Act* s 19(3)(f).

duty placed on workers not to engage in bullying conduct in the workplace that harms others.

Monitoring and Compliance

The *WHS Act* makes provision for the appointment of health and safety representatives and committees. Health and safety representatives and committees have an important role to play in investigating and resolving complaints about bullying as part of their duties and functions. This may include helping to identify bullying in the work place, responding to and investigating complaints in a prompt and appropriate manner, continually reinforcing bullying policy and procedures, monitoring measures taken by the PCBU to address bullying and providing assistance with training.

The regulator responsible for inter alia monitoring and enforcing compliance of the *WHS Act*⁵⁶ may appoint inspectors who provide information and advice about compliance with this *Act* and who assist with resolving work health and safety issues at workplaces, of which bullying would be a key issue.⁵⁷ The importance of properly trained inspectors in dealing with workplace bullying has been recognised in the Australian Capital Territory with the *WHS (Bullying Amendment Bill) 2011*,⁵⁸ which provides for the appointment of at least three inspectors with expertise in workplace bullying and psychosocial issues. There is also to be a Workplace Bullying Advisory Committee that will monitor the relevant health and safety laws in relation to workplace bullying.

net/worksafe/sitetools/news/third+prosecution+after+apprentice+burnt+in+workplace+prank>.

⁵⁶ Model *Work Health and Safety Act*, Jurisdictional Note 156: A jurisdiction will need to include local provisions to ensure that appropriate arrangements are made for the appointment as an inspector of a person who is an inspector under a corresponding WHS law.

⁵⁷ *Ibid* s 160.

⁵⁸ *Work Health and Safety (Bullying Amendment Bill) 2011 (ACT)*
<http://www.legislation.act.gov.au/b/db_43606/default.asp>.

National Code on Managing Workplace Bullying

Safe Work Australia has released various codes of practice to support the implementation of the *WHS Act*. One such code is the proposed *Draft Code of Practice for Preventing and Responding to Workplace Bullying*, an approved code of practice under s 274 of the *WHS Act*.⁵⁹ The *Draft Code* on bullying sets out practical steps on how to comply with health and safety legislation. It assists in providing a consistent understanding of workplace bullying, what constitutes workplace bullying, the implications of workplace bullying and how to manage workplace bullying. The *Draft Code* incorporates much of what is found in guidance and practice notes on workplace bullying and harassment in the states and territories. Importantly, the *Draft Code* recommends the following:

- systematically identifying and managing the risks in the workplace;
- developing a workplace bullying policy (developed as a specific bullying policy or incorporated into an existing work health and safety policy or handbook);
- developing effective procedures to resolve complaints, including a clear process for reporting bullying;
- providing information and training on workplace bullying; and
- encouraging reporting of workplace bullying incidents.

The *Draft Code* is currently under revision following public comment. There have been mixed responses to the *Code* and much public debate and commentary about the proposed code, in particular in relation to disagreement about the meaning and scope of bullying

⁵⁹ Safe Work Australia, *Draft Code of Practice: Preventing and Responding to Workplace Bullying* (September 2011)
<<http://www.safeworkaustralia.gov.au/sites/SWA/Legislation/PublicComment/Documents/Draft%20Model%20Work%20Health%20and%20Safety%20Codes%20of%20Practice%20Public%20Comment/Draft%20Model%20Codes%20of%20Practice%20for%20Public%20Comment/Preventing-and-Responding-to-Workplace-Bullying.pdf>>.

behaviour, its limitations and the implications for implementation.⁶⁰ Union bodies, such as the ACTU and the Australian Manufacturing Workers Union, are reportedly seeking much tougher rules on workplace bullying. For instance, union officials want examples of bullying to include spreading rumours or innuendo, and for the *Code* to expressly state that ‘single incidents [of unreasonable behavior] can still create a risk to health and safety’.⁶¹ On the other hand, some employer groups are concerned that the *Code* could lead to a substantial increase in ‘bullying claims by those who find their jobs too hard, unpleasant, demanding or boring’.⁶² Businesses, in particular small businesses, have expressed concern about the resources that will be needed to implement the *Code*.⁶³

Conclusion

Creating a safe work environment and eliminating workplace bullying is everybody’s business. In the past, laws in relation to bullying have been reactive in so far as they have provided certain remedies when bullying has been proven and when an employee has been harmed. The *WHS Act* puts in place a more proactive approach to bullying and requires employers, employees and others not to engage in conduct that threatens the health and safety of others and creates an unsafe work environment. Workplace bullying falls within the scope of health and safety legislation and is repeated unreasonable behaviour directed towards a

worker or group of workers that creates a risk to health and safety. The consequences of bullying left unchecked may be severe for the individuals concerned and for the organisation. However, workplace bullying that can be covert, subtle and invisible, often goes unreported and is often poorly managed in organisations. To ensure a safe work environment, organisations have a duty and responsibility under work health and safety legislation to proactively manage risks, which include a comprehensive and systematic approach to identifying, assessing, controlling and monitoring workplace bullying. Importantly, organisations have a responsibility to educate employees about their obligations in relation to workplace bullying and to protect them against the harmful consequences of bullying.

⁶⁰ See eg, ‘Controversy over Proposed New Bullying Laws’, *ABC News* (online), 5 January 2012

<<http://www.abc.net.au/news/2012-01-05/controversy-over-proposed-national-bullying-laws/3760320>>; ‘Union Say Definition of Bullying is Confusing’, *ABC News* (online), 8 August 2012 <<http://www.abc.net.au/news/2012-08-08/unions-give-evidence-into-workplace-bullying/4185930>>.

⁶¹ Annabel Hepworth, ‘Bosses and Unions to Spar Over Bullying as ACTU Pushes New Curbs’, *The Australian* (online), 5 January 2012

<<http://www.theaustralian.com.au/national-affairs/industrial-relations/bosses-and-unions-to-spar-over-bullying-as-actu-pushes-new-curbs/story-fn59noo3-1226236904406>>; ‘Union Say Definition of Bullying is Confusing’, above n 60.

⁶² *Ibid.*

⁶³ ‘Questions over Workplace Bullying’, *ABC News* (online), 5 December 2011 <<http://www.abc.net.au/news/2011-12-05/questions-over-national-code-for-workplace-bullying/3713824>>; ‘Controversy over Proposed New Bullying Laws’, above n 60.

Globalisation – The Challenges for Health and Health Systems

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Abstract

This paper examines the challenge that globalisation poses to health and to health systems. Globalisation has generated significant challenges throughout the world, not the least of which is the ease with which economic risk can be transmitted. One area which has only recently received academic attention is the impact of this risk on health and health systems. This paper argues that health is a progressively realised right, and that because the right to health lacks the protection of a global legal or regulatory structure, with competing and conflicting demands created by the effects of globalised industry, trade, and labour movements, health budgets will become increasingly marginalised. As a consequence the right to health as recognised by a number of international instruments is rendered nugatory. The paper argues that because of the tension between globalisation and health policy issues relating to the prioritisation of health spending, health spending must be considered in light of the concept of health as a human right if the widening in the inequities between the health of rich and poor is to be addressed.

Introduction

Globalisation is a complex, multifaceted concept that has been variously defined,¹ generally in economic terms, with a focus on trade and financial liberalisation coupled with an internationalisation of decision-making – a universal process transcending states and societies, resulting in an interconnectedness or interdependence otherwise known as the modern world community.² As a result of this economic emphasis, the implication arises that globalisation is a positive contributor to the attainment of the economic preconditions for social, economic and cultural human rights by generating wealth, prosperity and employment on the one hand,

and facilitating economic and financial interaction between countries on the other. However, globalisation is seen in a much different perspective by the World Commission on the Social Dimension of Globalisation,³ which argues that globalisation has created a morally unacceptable and politically unsustainable global imbalance, with the wealth that globalisation has created being unequally shared and the benefits not translating to those who are on the margins of the global economy. In other words, rather than providing the ‘market’ basis for the provision of economic, social and cultural rights, some argue that globalisation has generated an ‘at risk’ environment where certain rights have the potential to be traded away when they come into conflict with the market forces which drive globalisation.

¹ See Frank J Garcia, ‘The Global Market and Human Rights: Trading Away the Human Rights Principle’ (1999) 25 *Brooklyn Journal of International Law* 51; Alex Y Seita, ‘Globalization and the Convergence of Values’ (1997) 30 *Cornell International Law Journal* 429; Joseph Stiglitz, *Globalization and its Discontents* (Penguin, 2002); Joseph Stiglitz, *Making Globalization Work* (Penguin, 2004); Claire Turenne-Sjolander, ‘The Rhetoric of Globalization: What’s in a Wor(l)d?’ (1996) 51 *International Journal* 603.

² David Held and Anthony McGrew, ‘Globalization and the Liberal Democratic State’ (1993) 28 *Government and Opposition* 262.

³ World Commission on the Social Dimension of Globalization, *A Fair Globalization – Creating Opportunities for All* (2004) International Labour Organisation <<http://www.ilo.org/fairglobalization/report/lang-en/index.htm>>.

The right to health and its scope has been the subject of much academic discussion and comment and this discussion is neither the focus nor within the scope of this article. However, the status of a right to health under international law is an important component of the debate on the impact of globalisation on health, as it addresses elements of the conflicting obligations facing countries struggling with the impacts of globalisation.

This paper will address globalisation from the perspective of its impact on health and health systems. Firstly, it will discuss the right to health and the obligations of progressive realisation as well as the foundation for the right to the highest attainable standard of health. The paper will then address the issue of the broad impact of globalisation on health, followed by a discussion on the specific challenges of globalised mobility and related health impacts for governments, health organisations and providers, and will conclude with reinforcing the need for a new global approach to addressing health equity and the delivery of health services.

The Right to Health

Human rights and health are two complementary approaches, and, one might suggest, dialogues, to address and advance human wellbeing. The *human rights approach* seeks, by description, to promote and protect the societal-level prerequisites for human wellbeing in which each individual can achieve his or her own full potential, albeit within the constraints of the society in which they live. The *health approach* seeks to provide the health services and systems which address the curative and clinical aspects which address human wellbeing.

In discussions about health and health care, the topic of human rights is rarely raised and certainly in discussions regarding access to health care, human rights considerations have not been the primary or even

secondary focus. It is even argued⁴ that, except where the primary manifestation of an abuse of human rights is damage to health, such as is the case with torture, there has been an absence of health perspectives from human rights discourse.

Explanations for the paucity of communication between the fields of health (specifically public health) and human rights include differing philosophical perspectives, the vocabulary of human rights dialogue, societal roles and methods of implementation. It has also been suggested that a lack of human rights education in public health may be a significant cause of the disparity. In addition, modern concepts of health and human rights are complex and continually evolving, although the definitional basis from which this evolution is emanating seems clearly identifiable.

There may also be the issue that health workers, struggling to meet the basic health needs of populations in underdeveloped or developing countries, see little point, either from a utility perspective or from a position of necessity, of incorporating into their already difficult task, human rights perspectives, which, if we accept the unprovability of human rights, are seemingly of little or no constructive benefit.

Despite the reservations and lack of collaboration, it is clear that health and human rights are equally powerful approaches to the advancement of human wellbeing. Closer attention to where health and human rights intersect should provide practical benefits to those engaged in health or human rights work, and may as a result, help reorientate thinking about major global health challenges.

The right to health under international law has been enumerated in various instruments. The *Universal Declaration of Human Rights* ('UDHR') affirms in

⁴ J M Mann et al, 'Health and Human Rights' in J L Mann et al (eds), *Health and Human Rights – A Reader* (Routledge, 1999) app 7.

art 25(1) that '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including ... medical care and necessary social services.'⁵ In 1996, the United Nations embodied the economic and social parameters of this right in art 12 of the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR'),⁶ being generally considered as the most authoritative statement of this right. Specifically, this Article recognises the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and mandates that all states parties to the *ICESCR* take steps to provide for, inter alia, the creation of conditions which would assure medical services and medical attention to all; the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and the reduction of infant mortality. Despite this mandate, there is little guidance as to the specific scope of the states' legal obligations in relation to this right, and it has been suggested that it is at best an 'imperfect obligation'⁷ on states in their implementation of this right. Further, according to art 2 of the *ICESCR*, a state is only required to operationalise this right 'to the maximum of its available resources, with a view to achieving progressively the full realization of the right[s].' Given this qualification, states may justify their actions in implementation, based on political will, economic resources and other perceived prevailing social and economic demands. Provided it can be shown that a state is moving 'as expeditiously and effectively as possible towards the full realization of Article 12',⁸ no state can be held accountable for its failure to achieve healthy conditions within the state.

⁵ *Universal Declaration of Human Rights*, GA Res 217A, UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) <<http://www.un.org/en/documents/udhr>>.

⁶ *International Covenant on Economic, Social and Cultural Rights*, GA Res 2200A (XXI), UN GAOR, 9993 UNTS (entered into force 3 January 1976) <<http://www2.ohchr.org/english/law/cescr.htm>>.

⁷ Michael Kirby, 'The Right to Health Fifty Years On: Still Skeptical?' (1999) 4(1) *Health & Human Rights* 7, 13.

⁸ United Nations Committee on Economic, Social and Cultural Rights, *The Right to the Highest Attainable Standard of Health: General Comment No 14*, 22nd sess, UN Doc E/C12/2000/4 (2000) para31.

Other international and regional instruments which address the right to health include the 1981 *Convention on the Elimination of All Forms of Discrimination Against Women* ('CEDAW');⁹ the 1990 *Convention on the Rights of the Child*;¹⁰ the 1969 *International Convention on the Elimination of All Forms of Racial Discrimination*;¹¹ the *African Charter on Human and Peoples' Rights*,¹² and the *Cairo Declaration on Human Rights in Islam* of 1990.¹³

The World Health Organization in the preamble to its Constitution¹⁴ recognises the right to the highest attainable standard of health as one of the fundamental rights of all people, and that governments have a responsibility for the health of their peoples, irrespective of race, political belief, religion, economic or social conditions. However, as noted above,¹⁵ the right to the highest attainable standard of health is subject to the constraints of progressive realisation and resource availability, both of which have significant implications for any health system, and even more so when considered within the context of the impact of

⁹ *Convention on the Elimination of All Forms of Discrimination Against Women*, GA Res34/180, UN GAOR, 34th sess, Supp No 46, UN Doc A/34/36 (entered into force 3 September 1981) art 12.1 <<http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm>>.

¹⁰ *Convention on the Rights of the Child*, GA Res 25 (XLIV), UN GAOR, 44th sess, Supp No 49, UN Doc A/RES/44/25 (entered into force 2 September 1990) art 24 <<http://www2.ohchr.org/english/law/crc.htm>>.

¹¹ *International Convention on the Elimination of All Forms of Racial Discrimination*, 660 UNTS 195 (entered into force 4 January 1969) art5e(iv) <<http://www2.ohchr.org/english/law/cerd.htm>>.

¹² *African Charter on Human and Peoples' Rights*, OAU Doc CAB/LEG/67/3rev5 1999 <<http://www1.umn.edu/humanrts/instree/z1afchar.htm>>.

¹³ *Cairo Declaration on Human Rights in Islam*, UN Doc A/45/421/5/21797 (5 August 1990) <<http://www.oic-oic.org/english/article/human.htm>>.

¹⁴ World Health Organization, *Basic Instruments* (WHO, 3rd ed, 1986).

¹⁵ And also Paul Hunt and Gunilla Backman, 'Health Systems and the Right to the Highest Attainable Standard of Health' (2008) 10(1) <<http://www.hhrjournal.org/index.php/hhr/article/view/22/69>>, being a shortened and revised version of the Report of the *UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UN Doc No A/HRC/7/11 (2008).

globalisation on the power, resources and social structure of countries. It is to this issue that this article will now turn.

Globalisation and Health

As previously mentioned, globalisation has been variously defined, but a key aspect or dominant characteristic of globalisation is the introduction of an expansion of risk beyond national borders. This risk is manifested in various ways, from financial contagion and debt, to environmental degradation, the illegal trade in drugs and arms, human trafficking, and in the emergence or re-emergence of infectious diseases.¹⁶ This exposure to risk, it is argued, exacerbates existing patterns of advantage and disadvantage, systematically marginalising the more vulnerable in society and disproportionately benefiting countries with greater resources and the power to shape the rules which address these risks.¹⁷ Schrecker, Labonté and De Vogli,¹⁸ for example, argue that globalisation is ‘inherently disequalising’ in character, meaning that it tends to reinforce divergences in wealth, income and opportunity, with this tendency reinforced by substantial disparities in the ability to change the rules and institutions of the global marketplace.

According to Chapman¹⁹ the past 25 years of globalisation has seen a growth in health inequalities between wealthy and poor populations, the weakening of health systems in middle and low-income countries and higher rates of illness and premature death. This critical view of the weakening of health systems is

reinforced by the World Health Organization which notes that in many countries, health systems are on the point of collapse or are accessible only to particular groups in society.²⁰

The World Health Organization’s Commission on Social Determinants of Health (‘CSDH’)²¹ stated that the reduction in health inequalities is an ethical imperative, a view supported by Schrecker, Labonté and De Vogli,²² noting however that support for health equity at an international level will demand a shift from the self-interest of the world’s largest and most powerful countries, and the ability to overcome the expected resistance of the large globalisation players, being the transnational corporations and the global economic elite.

Globalisation has a complex influence on health, but if properly managed can lead to significant health gains if, in conjunction with political will, the regulatory institutions in domestic markets are strong, addressing equality of income distribution, the provision of social safety nets, and ensuring the progressive realisation of economic, social and cultural rights, such as the provision of, and access to, health services. However, as argued by Cornia,²³ the international and domestic conditions for successful globalisation have been met in relatively few countries, driving income inequality, poverty and reduced availability and access to health

¹⁶ Allyn L Taylor, ‘Governing the Globalization of Public Health’ (2004) 32(3) *Journal of Law, Medicine and Ethics* 500; Moisés Naím, ‘The Five Wars of Globalization’ (2003) 82(1) *Foreign Policy* 29.

¹⁷ Ronald Labonté and Ted Schrecker, ‘Globalization and the Social Determinants of Health: The Role of the Global Marketplace (Part 2 of 3)’ (2007) 3(6) *Globalization and Health*
<<http://www.globalizationandhealth.com/content/3/1/6>>;

Audrey R Chapman, ‘Globalization, Human Rights, and the Social Determinants of Health’ (2009) 23(2) *Bioethics* 97.

¹⁸ Ted Schrecker, Ronald Labonté and Roberto De Vogli, ‘Globalisation and Health: The Need for a Global Vision’ (2008) 372 *Lancet* 1670,1671.

¹⁹ Chapman, above n 17.

²⁰ World Health Organization, *Everybody’s Business: Strengthening Health Systems to Improve Health Outcomes* (2007)
<http://who.int/healthsystems/strategy/everybodys_business.pdf>.

²¹ Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health (Final Report)* (World Health Organization, 2008)
<http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf>.

²² Schrecker, Labonté and De Vogli, above n 18.

²³ Giovanni Andrea Cornia, ‘Globalization and Health: Results and Options’ (2001) 79(9) *Bulletin of the World Health Organization* 834.

care, and thus exacerbating disparities in health between rich and poor.²⁴

Central to the discussion on the relationship between globalisation and health is the acceptance that there are underlying social determinants of health which include financial resources, employment, access to clean water and sanitation, an adequate supply of nutritious food, social stability, freedom from violence and discrimination, and healthy environmental conditions.²⁵ In other words, social determinants of health are those conditions in which people live and work that affect the opportunities they have to lead healthy lives.²⁶

In 2000, when reviewing the scope and restrictions of art 12 of the *ICESCR*, the Committee on Economic, Social and Cultural Rights ('CESCR') noted that there was a collective framework within which the individual right to health was required to operate. The Committee found that national population health programs were potentially abrogating their responsibilities under art 12 by asserting by conduct rather than words that health was the responsibility of the individual. In response to these shortcomings, the Committee issued *General Comment 14*,²⁷ which promulgated governmental responsibilities to address what it called the 'underlying determinants of health'. The *General Comment* noted that the right to health extended the obligations of state responsibilities to communities, groups, and populations, on underlying determinants of health 'such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and

information, including on sexual and reproductive health.'²⁸

Notably, many signatories to this instrument have constitutionally recognised a right to health and in doing so, have adopted wording which reflects aspects of the underlying determinants noted in *General Comment 14*. Whilst this constitutional recognition is admirable, it does not guarantee that states' responsibilities under art 12 will not be abrogated, and in fact there is clear evidence of abrogation of these obligations by many signatory governments. China, with respect to forced sterilisations, abortions and the denial of health care to Tibetans, is a clear example of such abrogation and has been the focus of ongoing concern not only by international non-government organisations, but also by the International Commission of Jurists.²⁹ The fact that abrogations can and do occur, and can be legitimised from a resources perspective, provides little incentive for health workers and organisations, struggling to meet the basic needs of populations, to approach health from a right to health perspective. Often the responsibility for advancing health as a human right is left to non-state actors such as NGOs, for example Physicians for Human Rights and Médecins Sans Frontières, who work on improving the structural enforcement of human rights at the local and national levels to achieve better health outcomes.³⁰ The unsuccessful attempt of the Red Cross in 2012 to intervene to provide medical supplies, food, milk powder and other supplies to the Baba Amr district of Homs in Syria is an example of a non-state actor addressing the health and wellbeing needs of a population being denied their basic and constitutional rights.³¹ It is suggested that the impact of globalisation on health can be seen most clearly when one focuses on

²⁴ Benjamin Mason Meier, 'Advancing Health Rights in a Globalized World: Responding to Globalization through a Collective Human Right to Public Health' (2007) 35 *Global Health Law, Ethics, and Policy* 545.

²⁵ *Ibid.*

²⁶ Ronald Labonté and Ted Schrecker, 'Globalization and Social Determinants of Health: Introduction and Methodological Background (Part 1 of 3)' (2007) 3(5) *Globalization and Health* 1.

²⁷ United Nations Committee on Economic, Social and Cultural Rights, above n 8.

²⁸ *Ibid* para 11.

²⁹ See: International Commission of Jurists, *Tibet: Human Rights and the Rule of Law* (ICJ: 1997).

³⁰ Lance Gable, 'The Proliferation of Human Rights in Global Health Governance' (2007) 35(4) *Journal of Law, Medicine & Ethics* 534.

³¹ Constitution of Syria (adopted 13 March 1973) arts 46 and 47 <http://www.mideastinfo.com/documents/Syria_Constitution.htm>.

the issue of mobility under globalisation and it is to this issue that this paper will now turn.

Mobility and Health

Another aspect of the relationship between globalisation and health that deserves consideration is that health concerns have moved beyond domestic boundaries and have become transnational, and so pose serious concerns for governments and international health bodies, such as the World Health Organisation and the International Red Cross, as well as domestic health care organisations.

Mobility has been argued to be a crucial characteristic of globalisation, encompassing not only mobility in cross border trade, investment capital and debt, but importantly also in people and disease. Taylor³² notes that a dominant characteristic of globalisation is the introduction or expansion of risks to health that transcend national borders in either their origin or impact. She notes that since 1984, outbreaks of virulent strains of many old diseases as well as over thirty newly recognised pathogens, including SARS, human H3N2 and avian H5N1 influenza, have jolted global awareness and given rise to a new appreciation of the interconnectedness between domestic and international health. Whilst the knowledge of this global impact is not necessarily new, the significance of the impact of globalisation upon expanding the interconnectedness between national and international health policy is only now becoming clearly understood. Dodgson, Lee and Drager³³ assert that the dramatic growth in both geographical scope and the speed with which trans-border health risks have emerged has effectively challenged established systems of health governance. Accordingly, the practical ability of sovereign states to address these new health challenges through unilateral action alone has amplified the need for a health

governance structure which transcends traditional national approaches. As Taylor³⁴ states:

The momentum of globalization is such that governments must turn increasingly to international cooperation to attain national health objectives. Globalization has increased the need for new, formalized frameworks of international collaboration, including conventional international law, to address emerging global health threats and to improve the health status of poor states that have not benefited from globalization – the so-called ‘losers’ of globalization. Global health governance is, therefore, not about one world government, but about institutions and legal practices that facilitate multilateral cooperation between sovereign nation states.

These new health challenges requiring this new multilateral cooperation should not be underestimated. Just as during the global financial crisis the ‘ripple effect’ of contagion was clearly evident through the global financial system, so too is the ‘ripple effect’ driven by the globalised mobility in health now clearly evident, posing serious risks for health care and health systems. Frenk and Gómez-Dantés³⁵ found that not only is there increased mobility in disease transmission, people, and material goods, but also in ideas and lifestyle. For example, in relation to tobacco they note that a successful legal or regulatory battle against tobacco companies in one country only shifts the focus and incentive of these companies to look for new markets with less stringent regulations in which to promote their products. This in turn promotes the global spread of tobacco products through advertising and promotion, smuggling and agricultural diversification, thus subverting any program to restrict the health implications of smoking. In another example, pharmaceuticals, careful regulation of access to prescription drugs in one country may equally be subverted by another country which allows unrestricted

³² Taylor, above n 16.

³³ Richard Dodgson, Kelley Lee and Nick Drager, ‘Global Health Governance: A Conceptual Review’ (2002) (Discussion Paper, Centre on Global Change Health, London School of Hygiene and Tropical Medicine, 2002).

³⁴ Taylor, above n 16, 501.

³⁵ Julio Frenk and Octavio Gómez-Dantés, ‘Globalization and the Challenges To Health Systems’ (2002) 21(3) *Health Affairs* 160.

purchase of antibiotics, leading to the development and global spread of drug-resistant microbes.

The mobility of disease and poverty driven by migration, famine and warfare, are global realities and it is arguable that the wealth benefits of globalisation to industrialised countries will be undermined if they remain unaddressed.³⁶ Whilst much of the developing world lacks the institutional and infrastructural capabilities, and medical staff and health staff to meet health needs, the consequences for developed countries are significant as those who lack access to basic services such as health in developing countries will seek legal and illegal methods to 'migrate' to where these services are perceived to be available, or at least where the health outcomes are perceived to be better, even if this is just from access to clean water, nutritional food, and security from discrimination and violence.

The impact of the economic and financial demands imposed on developing countries by the World Bank, the International Monetary Fund, and the World Trade Organization have the capacity to exacerbate these problems and further impact on the ability of health care organisations to garner the resources necessary to deliver programs and services. In recent years, health improvements in developing countries have become more reliant on external private sources, such as the Bill and Melinda Gates Foundation, but much of the funding from these sources is directed at specific diseases, such as malaria, tuberculosis and polio, rather than at the broader needs of health care organisations. The consequences, as Chapman notes,³⁷ are that the strengthening of the overall health infrastructure is sacrificed for short-term targets. It has even been suggested that some governments use these short-term private funded projects as an excuse not to deliver health care services to the population, excusing

themselves from their responsibilities on the basis that programs are already being delivered.³⁸

Conclusion

Health equity and the ability of health policies and organisations to meet the social determinants of health barely have any impact or significance in globalisation debate. Governments are too diverted by financial and economic problems, trade talks and global security issues to give focus to health equity. At best, health policies are directed at the provision of basic health services and the prevention of specific infectious diseases, but there is little argument that the underlying social determinants of health have failed to be addressed by the global community within the context of globalisation. It is true that governments in developed countries have largely acted to address the social determinants of health due to a stronger political will and commitment to social justice.³⁹ However in those countries where the impact of globalisation has seen a decrease in the standard of living, tightening government revenues through austerity measures and cuts in social welfare programs, and increasing unemployment, health equity is ignored and health providers and organisations are left to providing at best limited and largely ineffective health services.

While the role of the World Health Organisation is undoubtedly important as an independent provider of knowledge and evidence in relation to global impacts on health, there needs to be a considerable strengthening of our understanding of the linkages between globalisation and health. This includes a full impact analysis of international agreements and measures that either directly or indirectly impact on health, and an assessment of the likely trade-offs between conflicting health demands so as to develop international

³⁶ Derek Yach and Douglas Bettcher, 'The Globalization of Public Health, II: The Convergence of Self-Interest and Altruism' (1998) 88(5) *American Journal of Public Health* 738.

³⁷ Chapman, above n 17.

³⁸ See Shalini Randeria, 'Globalization of Law: Environmental Justice, World Bank, NGOs and the Cunning State in India' (2003) 51 *Current Society* 205.

³⁹ Michael Marmot et al, 'Building of the Global Movement for Health Equity: From Santiago to Rio and Beyond' (2012) 379 *The Lancet* 181.

mechanisms to systematically resolve these conflicting demands.⁴⁰ Much more research needs to be done to identify what these mechanisms may be and in what form.

The challenges for health policy makers, health care organisations, NGOs and governments are enormous. Globalisation has expanded boundaries, borders, and obligations but in the absence of a global legal and regulatory framework to address health equity and the social determinants of health, the objective of the highest attainable standard of health for all in this globalised world will remain elusive and the health consequences for an increasing number of the world's population will be dire.

⁴⁰ David Woodward et al, 'Globalization and Health: A Framework for Analysis and Action' (2001) 79(9) *Bulletin of the World Health Organization* 875.

PNG Provincial Hospital Boards' Compliance with Statutory Financial Reporting Obligations

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Abstract

This article employs textual analysis to examine the financial statement reporting by provincial hospital boards in Papua New Guinea ('PNG') as they attempt to comply with mandatory financial statement reporting. Hospital boards in PNG are established under the *Public Hospital Act 1994* (PNG), which requires the boards to satisfy the accounting, financial management and reporting requirements indicated under the *Public Finances (Management) Act 1995* (PNG). The existing literature on hospital board reporting compliance has previously focused on developed countries with sound governance systems and developed infrastructures. In contrast, this paper provides an examination of hospital boards that operate in troublesome governance systems. This information could be of assistance to public entity stakeholders (for example, tax payers, donors and provincial and national governments) in future decision-making. Knowing the extent of reporting compliance allows stakeholders to assess both the performance and accountability of these health organisations.

Introduction

This paper looks at the financial reporting compliance of the provincial hospital boards of Papua New Guinea ('PNG'). Much of PNG's health care is provided by the government and church health providers through provincial hospital boards. Generally, PNG's health system is marked by fragile administrative and management structures, deficient financial management, scarce funding, inadequate information systems and restricted access.¹ Entities operating in PNG lean

towards a traditional (oral communication) and Western-narrow (some written financial statements) style of reporting and do not always comply with mandatory written reporting.²

Hospital boards in PNG work with the National Department of Health, National Aids and the Nursing Council, and operate under the Public Hospital Board.

¹ As detailed in A Asante and J Hall, *A Review of Health Leadership and Management Capacity in Papua New Guinea* (Human Resources for Health Knowledge Hub, University of New South Wales, 2011) and further in Australian Agency for International Development (AusAID), 'Australian Aid to Health Service Delivery in Papua New Guinea, Solomon

Islands and Vanuatu' (Commonwealth of Australia, June 2009) and also in M Foster, R Condon, S Henderson, K Janovsky, C Roche, and B Slatyer, 'Papua New Guinea Country Report' (Working Paper No 1, Australian Agency for International Development, 2009).

² For a full discussion of the typology of accounting reporting see A M Brown and G Tower, 'Traditional and Western Accounting Disclosure Models for Pacific Island Countries' (2002) 14(1) *Pacific Accounting Review* 43.

They are established under the *Public Hospital Act 1994* (PNG), which provides that the *Public Finances (Management) Act 1995* (PNG) is applicable to the boards on matters regarding accounting, financial management and reporting. PNG's hospital system includes 19 provincial hospitals (sometimes referred to as district hospitals in the literature). HIV and AIDS are leading causes of hospitalisation, with HIV/AIDS patients accounting for 60 per cent of bed occupancy at Port Moresby General Hospital.³

In light of the mandatory reporting milieu, this study considers the level of compliance by PNG hospital boards with financial reporting as audited by PNG's Auditor-General. More specifically, this paper poses the following research question: To what extent do PNG hospital boards comply with the requirements of the *Public Hospital Act 1994* (PNG) and the *Public Finances (Management) Act 1995* (PNG) on financial statement reporting?

This is an important paper because it looks at financial reporting compliance of public bodies in a developing country environment. Many compliance studies focus on hospital boards in developed countries with sound governance systems and developed infrastructures.⁴ By contrast, this paper focuses on hospital boards that operate within troublesome governance systems.⁵ It is important that reporting compliance is examined in all environments, not just within sound governance systems. Those who work in the field of foreign aid delivery, non-government organisations with a working relationship with PNG and governments involved in the

management and administration of public services should know how effectively the legislation in the *Public Finances (Management) Act 1995* (PNG) is complied with on the ground. Knowing the extent of compliance allows stakeholders to assess both the performance and accountability of these health organisations.

The study is structured as follows. Following a review of the literature on the reporting system of hospitals in PNG and financial reporting compliance, the paper's methodology is presented, elaborating on the study's use of textual analysis and the applied data sources. The results of the textual analysis are then reported, followed by conclusions and implications drawn from the study results.

Overview of the Relevant Legislative Requirements and Standards

Hospital boards in PNG were established by the *Public Hospitals Act 1994* (PNG) and are generally run by chief executive officers who are appointed by each of the provincial hospitals and report directly to the Minister of Health.

In Papua New Guinea, the purpose of financial reporting, as expounded by those accounting practices generally accepted in PNG, is to assist stakeholders of a reporting entity to make informed decisions about it and to determine whether that entity has complied with the directives and policy statements of financial reporting standards developed by the Accounting Standards Board of Papua New Guinea ('ASBPNG'), a regulatory body corporate established under pt IX, div 5 of the *Companies Act 1997* (PNG). Through ss 205, 206 and 207 of the *Companies Act 1997* (PNG), the ASBPNG sets and enforces accounting standards and policies in PNG, and through ss 180, 181 and 183 the ASBPNG examines whether annual returns made by reporting entities comply with the approved reporting standards. These standards are based on the International

³ AusAID, above n 1.

⁴ Such as those examined in R K Aggarwal, M E Evans and D Nanda, 'Non-Profit Boards: Size Performance and Managerial Incentives' (2012) 53(1-2) *Journal of Accounting and Economics* 466 and in R A Kearns, R J Barnett and D Newman, 'Placing Private Health Care: Reading Ascot Hospital in the Landscape of Contemporary Auckland' (2003) 56(11) *Social Science and Medicine* 2302.

⁵ Windybank and Manning refer to PNG as a 'failed state'. S Windybank and M Manning, 'Papua New Guinea on the Brink' (Issue Analysis Paper No 30, Centre for Independent Studies, 2003).

Accounting Standards (or International Financial Reporting Standards) established by the International Accounting Standards Board, which have been generally adopted as part of PNG's generally accepted accounting practices.⁶

A PNG reporting entity's compliance with financial reporting obligations is also subject to external audit. Under ss 213 and 214 of the *Constitution of Papua New Guinea* and the *Audit Act 1989 (as amended)* (PNG), the Auditor-General is given the power to inspect and audit the public accounts of PNG including departments of the public services; agencies of the national government; provincial governments and their arms, agencies and instrumentalities; and bodies established by statute or act of the national executive. The Auditor-General is also required to report annually to Parliament on the audits. Section 63(4) of the *Public Finances (Management) Act 1995* (PNG) requires public bodies to submit their financial statements for audit. Under pt II of the *Audit Act 1989 (as amended)* (PNG), the Auditor-General then reports to the public body's Minister. Section 63(4) also obliges the public body, before 30 June each year, to present to its Minister those financial statements, with a report on its operations, for the year ended 31 December preceding.

Under the *Public Hospital Act 1994* (PNG), hospital boards in PNG are expected to follow the provisions of the *Public Finances (Management) Act 1995* (PNG) in matters dealing with accounting, financial management and reporting. Under s 117 of the *Public Finances (Management) Act 1995* (PNG), hospital boards are instructed to prepare their financial statements in a financial statement format that is used by all trading and non-trading entities. The *Public Hospital Act 1994* (PNG) also requires the *Audit Act 1989 (as amended)* (PNG) to apply to hospital boards. In performing the annual audits of the financial statements of the hospital

boards, pt 3, s 8 of the *Audit Act 1989 (as amended)* (PNG) requires the Auditor-General to report on those audits to the Minister of Health and the Minister of Finance.

Hospitals are required to prepare their financial statements in accordance with a financial statement format for non-trading public entities. The accounts are prepared under the cash basis of accounting with the financial statements consisting of: statement of revenue and expenditure, statement of changes in net cash asset, schedule of capital assets and liabilities, and accounting policies. Under the *Public Finances (Management) Act 1995* (PNG), if the hospital board does not meet the deadline for submitting financial statements, the Minister may withhold half of the grants appropriated to that body for the following fiscal year.⁷

The *Public Hospitals Act 1994* (PNG) lays down strict compliance rules in terms of reporting expectations. In developed countries, compliance may be imposed by strong regulatory enforcement, backed up by penalties or sanctions, or some form of accommodating self-regulation, supported by gentle persuasion.⁸ Regulatory enforcement or accommodating self-regulation influences the response of regulatees (in this case, the hospital boards) to regulations (*Public Hospitals Act 1994* (PNG) and *Public Finances (Management) Act 1995* (PNG)).⁹ Regulatees often weigh up the benefits and costs of regulations.¹⁰ Noncompliance may occur if

⁶ Certified Practising Accountants of Papua New Guinea, *Five Year Plan (2007 -2012)* <<http://www.cpapng.org.pg/about-cpapng/five-year-plan>> ('CPAPNG, 2012').

⁷ Auditor-General's Office of Papua New Guinea, *Report of the Auditor-General 2008 on the Control of and on Transactions with or Concerning the Public Monies and Property of Papua New Guinea: Part III* (AGO, 2009).

⁸ See K Murphy, T R Tyler and A Curtis, 'Nurturing Regulatory Compliance: Is Procedural Justice Effective When People Question the Legitimacy of the Law?' (2009) 3(1)*Regulation and Governance* 1.

⁹ See D Thornton, R A Kagan and N Gunningham, 'Compliance Costs, Regulation, and Environmental Performance: Controlling Truck Emissions in the US' (2008) 2(3) *Regulation & Governance* 275.

¹⁰ For example, K Ko, J Mendeloff and W Gray, 'The Role of Inspection Sequence in Compliance with the US Occupational Safety and Health Administration's (OSHA) Standards: Interpretations and Implications' (2010) 4(1) *Regulation & Governance* 48.

the regulatee perceives the regulation as unreasonable,¹¹ but compliance may improve if regulation is seen as fair and impartial.¹² Self-regulation appears to work well if it is supported by enforcement strategies¹³ such as persuasion, warning letters, civic penalties, criminal penalties, licence suspension and licence revocation or encouragement. Thus, the flow of information between the regulator (in this case, the Parliament of PNG) and regulatee (hospital board) is important.

Parker¹⁴ advocates the nurturing of compliance professionalism. Braithwaite¹⁵ suggests that regulatees constantly evaluate and re-evaluate regulators in terms of their performance¹⁶ and adopt different motivational stances towards the regulator through capitulation, commitment, disengagement or resistance.¹⁷ Both capitulation and commitment demonstrate little social distance between the regulatee and the regulator. Capitulation indicates the complete acceptance of the regulator as an authority, and commitment reflects the desirability of, and obligation to the regulations.¹⁸ In contrast, both disengagement and resistance suggest a relatively greater distance between the regulatee and regulator, as disengagement implies a stepping out of the regulatory system by the regulatee, and resistance reflects doubt about the regulator and a call for the regulatee to be watchful of the regulator. In this context, this paper is an exploratory study of the reporting

compliance of hospital boards operating in a developing country.

Textual Analysis

Textual analysis was employed in considering the textual material, written in English, of audits prepared by the Auditor-General's Office ('AGO') of Papua New Guinea regarding hospital boards of PNG. The Auditor-General's reports covered the years ending 2007 to 2010.

The audits of the 19 provincial hospital boards of PNG were analysed. These included the hospital boards of Boram, Modilon, Angau, Vanimo, Alotau, Kerema, Daru, Popondetta, Kimbe, Nonga Base, Kavieng, Lorengau, Buka, Kundiawa, Mount Hagen, Goroka, Mendi, Wabag and Port Moresby. This study does not examine the Port Moresby Private Hospital Limited although it does study the public hospital board of Port Moresby.¹⁹ This paper does not examine private hospitals as they are a different type of entity from public sector hospitals. Private hospitals are expected to generate profits for their shareholders, whilst public sector hospitals are essentially not-for-profit entities. Provincial hospitals are public sector hospitals and thus fall within the ambit of this paper.

Results of Textual Analysis

The AGO²⁰ found that provincial hospital boards generally had difficulty with s 63(3) of the *Public Finances(Management) Act 1995* (PNG) which requires that hospital boards present their financial statements in a form approved by the Minister. The AGO²¹ noted that the Ministry of Finance did not approve the financial statements of many hospital boards because they did not conform to a financial statement format for trading and

¹¹ J D Unnever, M Colvin and F T Cullen, 'Crime and Coercion: A Test of Core Theoretical Propositions' (2004) *Journal of Research in Crime and Delinquency* 244; Murphy, Tyler and Curtis, above n 7.

¹² T R Tyler, *Why People Obey the Law* (Princeton University Press, 2006); Murphy, Tyler and Curtis, above n 7.

¹³ I Ayers and J Braithwaite, *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, 1992).

¹⁴ C Parker, 'Compliance Professionalism and Regulatory Community: The Australian Trade Practices Regime' (1999) 26(2) *Journal of Law and Society* 215.

¹⁵ V Braithwaite, 'Dancing With Tax Authorities: Motivational Postures and Non-Compliant Actions' in V Braithwaite (ed) *Taxing Democracy* (Ashgate, 2003) 15.

¹⁶ *Ibid.*

¹⁷ *Ibid.*; V Braithwaite, 'Games of Engagement: Postures Within the Regulatory Community' (1995) 17 *Law and Policy* 225.

¹⁸ Murphy, Tyler and Curtis, above n 7.

¹⁹ Kramer Ausenco, *Port Moresby Private Hospital* (2012) <http://www.kramerausenco.com/icms_docs/74369_Port_Moresby_Private_Hospital.pdf>.

²⁰ AGO (2009), above n 6.

²¹ AGO (2009), above n 6.

non-trading public entities. Generally, the AGO²² found that all public hospitals experienced difficulties in preparing and submitting financial statements for audit within the requirements of the *Public Finances (Management) Act 1995* (PNG), yet despite this, sanctions had never been imposed. Failure to prepare or submit annual reports makes it difficult for regulators and supervising bodies to know whether the hospital board is a going concern. This lack of accountability leaves open the question of whether the hospital board is, in fact, operating. Consequences of non-reporting might result in an ‘empty hospital’²³ or recurrent ‘funding for just being a hospital’.²⁴

Common difficulties with the hospital boards’ financial statements were that the records of accounts receivables, accounts payables, advance registers, asset registers, capital commitments, contingent liabilities and medical supplies were either simply not maintained or were inadequately prepared.²⁵ Non-maintenance of these documents has far-reaching impacts. Without a record of accounts receivable, hospital boards are unlikely to track each of their debtors and the corresponding amounts they owe. This can lead to overdue accounts and thus rapid increases in expenses relating to bad debts and debt collection. Similarly, non-maintenance of accounts payable could lead to late payments to creditors, missed discounts offered by the creditors, late payment penalties on past invoices, duplicate payments, payments to unregistered suppliers and deteriorating relations with, or losses of, suppliers and vendors. The risks of not being repaid a loan advance could also increase if a record of an advance register is not

maintained. It would also be difficult for hospital boards to budget for vital equipment or track plans for property, plant and equipment if a record of capital commitments is not kept. In a legal sense, without a record of contingent liabilities, internal and external stakeholders of hospital boards will have little idea if hospital boards are facing impending litigation. Theft, loss and deterioration are also not uncommon in cases where records of medical supplies are not maintained.

Textual analysis of the AGO²⁶ audit of provincial hospital boards reveals three patterns of financial report submission for the years ending 2006, 2007 and 2008. One group, including four hospital boards – Daru, Nonga Base, Kavieng and Lorengau – did not submit any financial statements for audit. This group is titled ‘hospital boards not submitting financial reports’. Another group, comprising six hospital boards – Kimbe, Buka, Kundiawa, Mount Hagen, Goroka and Wabag – submitted some financial statements for audit (‘hospital boards submitting some financial reports’). A final group, consisting of the hospital boards of Angau, Modilon, Boram, Vanimo, Alotau, Kerema, Popondetta, Mendi and Port Moresby, submitted all financial reports for audits (‘hospital boards submitting financial reports’).

Hospital Boards Not Submitting Financial Reports

Daru Hospital Board

The AGO²⁷ noted that Daru Hospital Board had not submitted its 2005 and 2006 financial statements and, thus, audits were carried out. The 2007 and 2008

²² Auditor-General’s Office of Papua New Guinea, *Report of the Auditor-General 2009 on the Public Accounts and the Control of and on Transactions with or Concerning the Public Moneys and Property of Papua New Guinea: Part IV* (AGO, 2010).

²³ BBC, ‘The Empty Hospital’ (2007) *Yes Minister* <<http://www.youtube.com/watch?v=Eyf97LAjjcY>>.

²⁴ J Snobelen, ‘Yes Minister, Hospitals Should Provide Services’, *Toronto Sun* (online), 24 March 2012 <<http://www.torontosun.com/2012/03/23/yes-minister-hospitals-should-provide-services>>.

²⁵ AGO, above n 6.

²⁶ AGO, above n 6; Auditor-General’s Office of Papua New Guinea, *Thirty-First and Thirty-Second Combined Annual Report in Terms of Section 19 of the Organic Law on Certain Constitutional Office Holders and Section 27 of the Audit Act 1989: Years 2006 and 2007* (AGO, 2007); Auditor-General’s Office of Papua New Guinea, *Report of the Auditor-General 2007 on the Public Accounts and the Control of and on Transactions with or Concerning the Public Moneys and Property of Papua New Guinea: Part IV* (AGO, 2008); Auditor-General’s Office of Papua New Guinea, *Report of the Auditor-General 2008 on the Public Accounts and the Control of and on Transactions with or Concerning the Public Moneys and Property of Papua New Guinea: Part IV* (AGO, 2009).

²⁷ AGO (2008), above n 25.

financial statements were also not submitted.²⁸ Interim audits of 2007 and 2008 found that Daru had not prepared or maintained the following: budget estimates for the years 2007 and 2008, revenue ledgers for the years 2005 to 2008, bank statements for the years 2005 to 2007, a register for accountable forms (including receipt books) for the years 2005 to 2008, the filing of bank statements from 2005 to 2007, an assets register for the years 2004 to 2008, advance register from 2005 to 2008, nor bank reconciliation from 2005 to 2008.²⁹

The impact of a lack of budget estimates may have far-reaching effects on Daru Hospital Board's planning for capital and non-capital works, with the blurring of capital and current expenditure items leading to inefficient allocations. It is difficult to enforce expenditure limits and meet deficit targets when budget estimates are not maintained. By failing to keep revenue ledgers, Daru Hospital leaves itself open to the risk of not knowing its sources of funding, which, in turn, can lead to poor planning. Internal controls are also weakened if bank statements and receipt books are not maintained or kept properly.

More generally, there was inadequate maintenance of bank statements, debit notes, human resource files, motor vehicle registrations, registration/ownership files, and the petty cash float book. Receipts were issued on an ad hoc basis, cheque books were not locked away, the filing system was unsystematic, many accounting documents were not filed, receipt books with serial numbers were not registered, payments of accounts were seldom recorded into their respective ledger accounts, some staff lacked qualifications and experience for record keeping leading to irregular payments, and clear land titles for the Hospital's location had not been transferred from the Health Department in 1994.³⁰ In addition, there was no corporate plan to establish long term objectives or set

priorities or targets, and no associated financial, asset management, human resource, information technology, risk management and divisional operating plans.

Nonga Base Hospital

The Nonga Base Hospital also did not submit its financial statements from 2005 to 2008.³¹ The AGO's³² audit report of the control environment for 2007 found missing cash fund certificates, no estimates of revenue and expenditure for the year, inadequate maintenance of cash books relating to the operating and hospital fees trust accounts, no proper segregation of duties between revenue collection and banking, no independent verification of banking, some payment vouchers not certified, no tenancy agreements between the Hospital and a local church, no reconciliation of the payroll assets register and no periodical stocktakes.³³ The Nonga Base Hospital did not have a corporate plan.

As with the Daru Hospital Board's lack of accounting records, Nonga Base Hospital suffers from internal control weaknesses within its accounting milieu. The lack of periodical stocktakes, for example, can increase the risk of theft, loss and deterioration of medical stock. Stock records are important to for the ordering of medical supplies and medical drugs. Lack of medical stock may lead to patient deaths.

Kavieng Hospital Board

Similarly, the Kavieng Hospital Board did not submit financial statements for the period 2006 to 2008. The AGO testing of the control environment for 2007 found no corporate plan to identify the Hospital's mission and goals; no documented internal finance and administration policies and procedures for hospital financial management activities and internal control; no formal review processes to monitor the performances of the Hospital's divisions; no quarterly reports compiled for the Management and the Board; trust funds used for

²⁸ AGO (2009), above n 6.

²⁹ AGO (2009), above n 6.

³⁰ AGO (2009), above n 6.

³¹ AGO (2009), above n 6.

³² AGO (2009), above n 6.

³³ AGO (2009), above n 6.

expenditures not specified under the Trust Instrument; no estimates of revenue and expenditure; and no proper accounting procedures to account for the monies either transferred or used to pay for expenses under the operating account.³⁴ Further, control over decision-making within the Hospital management for financial matters was undocumented. There was also a lack of proper reporting processes for revenue collections. The Board failed to maintain an inward remittance register to register every incoming valuable in cash, cheques or donations. Other revenues posted in the cashbooks were not accounted for in either a register or a revenue ledger. No debtor ledgers were maintained to account for uncollected revenues. There were difficulties in bank reconciliations, no fixed assets register was maintained, there were no proper housing policy guidelines in place to facilitate eligibility, rental, maintenance, and terms and conditions for staff housing. Wages sheets were not checked by appropriate officers to ensure that the rates, period, deductions, additions, and other information were accurate and that the correct persons were being paid. Substantial overtime payments were paid without prior approval. Some Hospital staff received rental allowances as well as rent-free accommodation.

Clearly the reporting milieu of Kavieng Hospital Board is so poorly controlled that in many instances it would be difficult to track records of expensive medical fixed assets and monetary assets. Kavieng Hospital Board's internal control weaknesses in the area of wages leaves it open to theft and misappropriation of funds.

Lorengau Hospital Board

The Lorengau General Hospital had not prepared its financial statements from 2004 to 2008. Results of a substantive audit review of the Hospital's 2007 operations were deemed 'unsatisfactory'.³⁵

Hospital Boards Submitting Some Financial Reports

In contrast to the previous four hospital boards, the six following hospital boards did provide *some* financial reports.

Kimbe Hospital Board

The audit of Kimbe General Hospital financial statements for the year 2007 was 'unsatisfactory' with a disclaimed audit opinion being issued. The Hospital did not maintain an asset register, kept inadequate inventory records and maintained scant records of drugs and medical supplies.

Buka Hospital Board

Similarly, the AGO issued a disclaimer of audit opinion on Buka General Hospital's financial statements for the year ended 2007. The Auditor-General found that Buka General Hospital did not maintain assets, did not conduct stocktaking and was unable to obtain confirmation of salaries and wages totalling K3 392 617. Internal revenue collections could not be relied on as collectors' statements had not been prepared, collections were not banked on a daily basis, no independent verification was performed, and no proper segregation of duties existed between revenue collection and banking. Furthermore, no advance register had been maintained, quotations were not sought when purchasing, no delivery dockets/consignment notes were sighted to confirm delivery, there were no valid invoices of payments, the administration officers were paid overtime allowances without prior approval by the management, and certain staff leave fares were paid directly to them instead of the airline or travel agent.

Kundiawa Hospital Board

The audit of Kundiawa General Hospital financial statements for the year ended 2007 was similarly found to be 'unsatisfactory' with a disclaimed audit opinion being issued. The AGO found that the Kundiawa General Hospital did not maintain accounting records

³⁴ AGO (2009), above n 6.

³⁵ AGO (2009), above n 6.

and asset registers, did not maintain an expenditure ledger to record expenditure under the various notes as a basis for the production of the financial statements, and had no system of control over the collection of hospital fees.

Mount Hagen Hospital Board

The results of the audit of Mount Hagen General Hospital financial statements for the years ended 2005 and 2006 were unsatisfactory with disclaimed audit opinions being issued. The financial statements for the year ended 2007 were yet to be submitted for audit. For the 2006 financial statements, Mount Hagen General Hospital did not maintain accounting records and assets register for fixed assets, had no system of control over the collection of hospital fees and there was an absence of satisfactory records of salary advance payments.

Goroka Hospital Board

The AGO³⁶ noted that Goroka General Hospital improved in the areas of corporate governance, budgetary control and calculation and payment of salaries and wages. However, the financial statements were qualified.³⁷ Financial statements for years ending 2004, 2005 and 2006 were unaudited and dispensed. Goroka Hospital did not update the asset register or undertake an annual stocktake. There were inadequate inventory records as well as a lack of effective in-built systems and procedures (checks and balances) to ensure receiving, storage, issue and usage of drugs and medical supplies were recorded and controlled. Cashbook and bank account reconciliations were not prepared in the prescribed format, there was no segregation of duties maintained between the recording of the cash transactions and preparation of bank reconciliation statements, the bank reconciliation statements were not checked or verified for their validity and accuracy by an independent person, there were delays in the banking of collected revenue, some delivery dockets from suppliers

and goods received from recipients were not sighted, no works report was provided on the maintenance and upgrading of hospital facilities, and a register of Board members' attendance at Board meetings was not produced. Furthermore, control procedures exercised over the repayment of salary advances were poor and ineffective.

Wabag Hospital Board

The audit of the Wabag General Hospital's financial statements for the year ended 2007 was unsatisfactory with a disclaimer of audit opinion being issued. Wabag General Hospital did not maintain general ledger accounts, and cashbooks for both the operating and trust accounts were not updated on a daily basis. Furthermore, the internal revenue of K450 949, representing nine per cent of the year end revenue, could not be relied upon because collector's statements had not been prepared. Banking of cash collection was not done on a daily basis, there was no safe custody of cash collected, no segregation of duties to reduce the risk of fraud, and no registers were maintained at various revenue collection centres. Discrepancies occurred in the payment of accounts because there was no proper appointment of an enquiry officer, registration officer, commitment or examiner officer. Quotations were not sought when purchasing, tenancy agreements were not provided, the asset register for other equipment lacked vital information such as serial numbers, dates of purchase, location, etc, no physical stocktakes were undertaken, no advance register had been maintained and the acquittal of advances had no supporting documentation.

Although Kimbe General Hospital, Buka General Hospital, Kundiawa General Hospital, Mount Hagen General Hospital, Goroka General Hospital and Wabag General Hospital did provide some financial reports, there appeared to be major internal control weaknesses that might impact on their accountability to the government, other resource providers, suppliers,

³⁶ AGO (2009), above n 6.

³⁷ AGO (2009), above n 6.

creditors, debtors and patients. In comparison to the four hospital boards of Daru, Nonga Base, Kavieng and Lorengau, the six hospital boards of Kimbe, Buka, Kundiawa, Mount Hagen, Goroka and Wabag are providing greater accountability to their stakeholders. However, it appears that operational and financial impact of partial financial reporting leaves them open to the risk of loss of current and capital assets.

Hospital Boards Submitting Most Financial Reports

The hospital boards of Angau, Modilon, Boram, Madang, Wewak, Vanimo, Alotau, Kerema, Popondetta, Mendi and Port Moresby all attempted to produce timely financial reports for audit.

Port Moresby Hospital Board

For year ending 2007, the AGO³⁸ found an absence of complete and enabling records of drugs and medical supplies, inadequate inventory records, and bank balances were not reconciled with cash books. The Operation Open Heart PNG account and Donors Special Project account were not made available for audit review, there was no proper vehicle register and there was no proper register of Board of Director details. The Hospital Board did not keep a Minutes of Meetings book, there were significant weaknesses in controls over payroll and staff wages. There were no checks and balances in place to ensure that pays were made only to individuals who worked for the Hospital. Put another way, the Auditor-General was confronted by a number of internal control issues that the Hospital Board needed to correct.

Boram Hospital Board

The Boram Hospital's 2003 to 2007 financial statements were disclaimed because they did not contain adequate notes to the financial statements. Details of accounting policies were not disclosed, in particular, the basis upon which the financial statements were prepared, and accounting treatment of various financial statement

items was not provided to the Auditor-General's office. Bank reconciliations were not well maintained, cashbooks with running balances for both operating and trust accounts were not maintained, there were details lacking in some of the key accounts. Boram Hospital Board did not maintain accounting records nor a proper assets register and did not conduct an annual stocktake. Funds allocated annually through the national budget were not expended in accordance with the *Appropriation Act 1991-1992* (PNG). The duties of the collectors and receivers of public monies were not defined. Reporting processes for revenue collections, comparative analysis and reconciliation were lacking. There was no proper procedure for the checking of balances established for kiosk sales and preparation of summary sheets at the cash office. There was no inward remittance register, resulting in missing cheques. Donations were also deposited without proper recording in the books. There were a number of accounts opened by the Hospital without required approvals. Some accounts were not disclosed in the financial statements. Manual cashbooks for the operating account and kiosk account were not kept and maintained. Neither a cashbook nor a ledger was maintained for the Trust and the other accounts.

There were no delegated responsibilities constructed for the requisition officer and financial delegates, resulting in claims not being examined properly. Not enough quotations were obtained. Estimates of revenue and expenditure were not compiled. Proper and up-to-date information on the value of assets and the useful life of asset items was lacking. Although an assets register was maintained, the value of assets was in most cases not registered and an extensive portfolio of fixed assets was not effectively managed nor appropriately safeguarded through performance of asset stocktakes or insurance. There was no effective monitoring or reporting system in place to assess damage, servicing, and registration of vehicles, leading to an ineffective and poor monitoring system. Furthermore, vehicle damage, theft, and major

³⁸ AGO (2009), above n 6.

services were not reported or registered. Operational logbooks and service registers were also not maintained. No proper housing policy guidelines were in place to detail eligibility, rental, maintenance, and terms and conditions for staff housing. The Hospital provided accommodation for the staff in institutional houses, quarters, compounds, and rented accommodations at the expense of the Hospital. No charges or rental were received. Officers on employment contract received a double benefit at the expense of the Hospital.

The management of advances lacked compliance. There was no registration of advances paid to holders and also no acquittal process. Jobs were not properly described and defined. There was a lack of staff capable of providing accounting or financial management. Officers responsible for preparing wages sheets could not be identified. Wages were prepared by unauthorised officers and not checked by senior officers. There was no corporate plan to identify the Hospital's mission. Quarterly reports were not compiled for management or the Board.

Kerema Hospital Board

The AGO's audit reports of Kerema Hospital's 2004 and 2005 financial statements were disclaimed.³⁹ Revenue and individual ledger accounts were not maintained systematically for prompt identification, classification and recording of revenues. Records of grants from the national government, interest, hospital fees, hospital rental, donor corporate grants and other grants were not maintained. Deficiencies and irregularities occurred in the processing of receipts, collectors' statements, revenue summary reports and deposit slips. There were delays in banking of revenue collection. The control environment was weak and thus susceptible to misappropriation and fraud. There were discrepancies in paid vouchers in relation to doctor airfares, mental health allowances and travel allowances. Doctors were being paid housing

allowances whilst being accommodated in institutional houses as well as having their rent paid for by the Hospital's management. Some overtime was paid without proper timesheets being prepared, there was no independent verification, and some overtime claims were prepared by the claimants themselves. There were lapses in advance management practices. In terms of asset management, biomedical equipment was excluded from total assets and equipment owned by the Hospital. The value of all assets was not disclosed in the financial statement in a schedule.

Modilon Hospital Board

An audit of Modilon's General Hospital accounts and internal control systems was conducted for the year ended 2007 but no mention was made of earlier reports. In terms of the budget, the revised appropriation total was K7 700 200 while year to date expenditure under the expenditure items was K8 030 141. There was no explanation accounting for the difference, and no remedial action taken by management in rectifying the control weaknesses relating to collection, receipting, banking and reporting of hospital user fees that were highlighted in previous reports. There was no inward mail register maintained to record details of money received by mail prior to being forwarded to the cashier for banking. Delays in banking continued to exist in 2007. A dishonoured cheques register was not maintained. Some medical fees were collected directly by Medical Officers and not properly brought to account. Debtor's ledgers were not maintained. The signatories to the two bank accounts were also financial delegates who authorised expenditure. Proper procurement and tender procedures were not followed. Payments were not supported by work-in-progress or job completion reports. Proper individual ledgers were not maintained for the various landlords/properties that the doctors were occupying to record details of all invoices issued and payments made. Rental payment schedules were not adequately updated. An assets register was not maintained and no stocktake was

³⁹ AGO (2009), above n 6.

conducted during the year. Furthermore, advance registers were not maintained, salary history cards were not updated, and salaries and wages tax declarations lodged by the employees were not kept. Current signed employment contract agreements were not kept. The Modilon General Hospital did not have a corporate plan.

Alotau Hospital Board

The Alotau General Hospital 2004 financial statements received a disclaimer of audit opinion and the financial statements for 2005 to 2007 received a qualified opinion. The AGO found that a register for accountable forms including receipt books and chequebooks had not been maintained since 2004. Official revenue receipt books, debit notes, trust account cheque books and operating account cheque books were not properly locked away in safes and, additionally, were not recorded in a register. Collector's statements were seldom prepared for cash collections. Banking was not done on a daily basis, there were bank reconciliation difficulties, quotes were not sought for purchases, delivery consignment notes were not sighted to confirm delivery and invoices for payments were missing. Since 2004 the assets register had not been updated in a timely manner. Some land titles for the Hospital's location had not been obtained. The motor vehicles register had not been adequately maintained and the human resources records were not systematically maintained. An expatriate dental officer attached to the dental section had no contract of employment; sometimes he was on the payroll and other times he was off the payroll. The AGO could not ascertain the nature of his employment due to lack of documentation.

Angau Hospital Board

The Angau Hospital Board submitted their financial statements for the period 2002 to 2007 for audit in January 2008. Disclaimers of audit opinions were issued for all the mentioned reports in December 2008. In 2007, salaries and allowances paid during the year totalled K6 832 460, well in excess of the appropriated

amount. At times doctors were raising and collecting fees directly from hospital patients. The Ageing Debtors Report, which records debts which have not been paid up for a considerable time, revealed no follow-up action taken by the administration to recover the long outstanding debts. Receipts collected from the dental services were never remitted. Bank reconciliations were not checked and certified by a senior officer. Contract documents for various different security firms for security services were not provided. There was no register of properties rented by the Hospital for doctors and senior staff. Sometimes the Hospital had made double payments of rent. Lease agreements were missing. Significant monthly telephone bills were not accounted for. Some leave fares payments were made directly to the individual staff and not to airline or shipping companies. There was no asset register and no regular periodical stocktakes.

Popondetta Hospital Board

The auditing of Popondetta Hospital Board's 2007 and 2008 financial statements was still to be undertaken. Popondetta Hospital Board's control environment was considered in 2007.

Vanimu Hospital Board

Vanimu Hospital Board's financial statements for 2007 received a disclaimer of audit. The Hospital lacked documented policies and procedures to address internal control issues. The appointment of requisitioning and approving officers was not documented. There was inadequate reporting of financial information (budgets/cash flow) and performance measurement of achievements. There were budgetary irregularities in the hospital fees trust account. Collector statements were not properly filed but were placed loosely in folders. The cash book was missing. Bank reconciliations were not checked by the Director of Finance and Administration to ensure accuracy of the process. A comprehensive assets register was not maintained and no annual stocktake of assets and inventories was taken.

Mendi Hospital Board

Mendi Hospital Board's 2008 financial statements received a qualified audit. The Chief Executive Officer did not sign the financial statements. The cashbook and bank accounts for both the operational and trust accounts were not properly reconciled. Some official receipts were not kept. Monthly bank reconciliation statements were not properly prepared and as a result, the cash book balances did not agree with the reconciled balances. There was no segregation of duties maintained between the recording of the cash transactions and preparation of bank reconciliation statements.

The bank reconciliation statements were not checked or verified for their validity and accuracy by an independent person who was not directly involved in collection and recording of cash. The Hospital seldom obtained three quotations from appropriate suppliers. Delivery dockets from suppliers and goods were missing. The organisation and storage of drugs and medical supplies was poor. There was no register maintained to keep record of cleaning detergents, chemicals, tools and other sundry items. Additionally, there was no segregation of duties in relation to the custody of records, or the receiving and issuing of goods. The cash advance and travel allowance registers were incomplete. The Hospital did not maintain an advance acquittal file to keep records of receipts, reports and summaries of cash advances acquitted. Some cash advances were not recorded in the cash advance register. There was no Board in the year 2008 and the Hospital operated without a Board in breach of s 6 of the *Public Hospitals Act 1994* (PNG).

Although the hospital boards of Angau, Modilon, Boram, Madang, Wewak, Vanimo, Alotau, Kerema, Popondetta, Mendi and Port Moresby all attempted to produce timely financial reports for audit, there was not a single hospital that was fully accountable for its operations. The impact of this on all the hospital boards

is that it produces more work for employees to rectify accounts and recordings that are incomplete. Further, the lack of full reports and accounts leads to a loss of a sense of priorities for each respective hospital board, leading to frustration in planning, monitoring and targeting of hospital human resources and assets.

Conclusion

The findings of this study show that many hospital boards struggled to prepare financial statements for audit. When financial statements were prepared, they were inadequate and the AGO was compelled either to disclaim the statements or qualify them. Common difficulties with the hospital boards' financial statements were that the records of accounts receivable, accounts payable, advance registers, asset registers, capital commitments, contingent liabilities and medical supplies were either not maintained or were inadequately prepared, and opening balances of the cash-at-bank account did not correspond to closing balances from the previous year.⁴⁰

In terms of compliance, it appears that the practice of not sanctioning hospital boards is not working. Ayers and Braithwaite's⁴¹ suggestions of persuasion, warning letters, civic penalties, criminal penalties, licence suspension and licence revocation or encouragement may need to be considered. The Minister has the power to withhold half of the national grants appropriate to a hospital board for noncompliance. The Minister might consider using this power.

Further research might consider the perspective of hospital boards on the reporting regulations and consider the boards' reasons for noncompliance. It should be noted that chief executive officers of hospital boards are given an opportunity to respond to the AGO's comments. This opportunity, however, is rarely taken up. Further research might seek to determine the

⁴⁰ AGO (2009), above n 6.

⁴¹ Ayers and Braithwaite, above n 12.

perspectives of multilateral aid donors on reporting noncompliance and could consider whether donor funds might be specifically earmarked to improve hospital board reporting compliance.

Information for Contributors

All articles should emphasise an aspect of law or taxation. The target audience should be people in business or government. All articles should identify why the target audience should know the law or taxation that is dealt with in the article.

The articles should each be approximately 1000-4000 words. Book reviews of a shorter length are to be published. Case notes and notes on recent statutes may be included.

All articles will be blind refereed. This means they will be sent to a person for review, with no indication to the reviewer of who the author is. It also means there is no indication to the author who the reviewer is, unless the reviewer consents to being identified. Submissions made persons within the School of Business Law, Curtin University will be reviewed by persons outside the School.

For further information see:

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- E-mail address; and
- An indication of why people in business or government should know the law or taxation that is dealt with in the article

An abstract is required:

- The page after the cover sheet should contain an abstract of not more than 100 words.
- The abstract should be structured in short sentences.
- The abstract should contain an indication of the main legal topic, the names of any significant legislation, and any significant cases addressed in the paper.
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