Speech by

Hon. WENDY EDMOND

MEMBER FOR MOUNT COOT-THA

Hansard 24 November 1999

HEALTH LEGISLATION AMENDMENT BILL

Hon. W. M EDMOND (Mount Coot-tha) (Minister for Health) (3.01 p.m.), in reply: I thank all honourable members for their support in trying to address the ongoing and difficult problem of equity for rural residents. I join with the member for Gregory in acknowledging the wonderful work done by doctors in the bush. As a classic example of the wonderful work that they do, I note that Dr Ariotti delivered Neil Roberts at the Charleville Hospital in 1955—something for which all honourable members are very grateful.

Mr Roberts: One of his great contributions to society.

Mrs EDMOND: What a great contribution to society.

Mr Schwarten: Who did he deliver?

Mrs EDMOND: Neil Roberts.

Mr Schwarten: He's got a lot to answer for.

Mrs EDMOND: I do not think it is fair to hold all of the doctors in the bush responsible for certain other deliveries.

It is important that we all join together in recognising the problems that we have in getting doctors out of the south-east corner. The Federal Government tells us that there are too many trained doctors. I dispute its number crunching, because I do not think it has taken into account the changing work force and the fact that 50% of medical graduates are now women, many of whom work only part time. I am not knocking them for that. I think it is wonderful that they can do so. However, the Commonwealth still counts them as full-time qualified doctors, even though they may be working one day a week. This contributes to the problem of finding doctors who are prepared to go out of the south-east corner and into regional and bush areas. I thank all honourable members for their support.

I wish to touch on a bit of the history of this legislation. In my summing-up, I wish to give fairly detailed answers to a lot of the questions raised—and there were many genuine questions involving fine detail—because honourable members have supported the Bill so wholeheartedly. This program was proposed by Queensland to the Commonwealth after we read in the newspaper—it was not made available to us before that—of a partial scheme being announced by Western Australia. However, the Western Australian scheme was targeted only at overseas-trained doctors, the tiny minority of whom already had postgraduate qualifications. The number of doctors involved would have been only about five. The number of people who were prepared to come to Queensland who already had postgraduate qualifications was so small that we recognised that we needed to make a significant change to that proposal. I was also determined that we were not going to disadvantage Australian-qualified doctors who were prepared to go to the bush. However, we wanted to create an opportunity whereby all suitably qualified doctors who were prepared to go to the bush could speed up getting their postgraduate qualifications and their provider numbers.

I now understand that, following Queensland putting forward this proposal to the Commonwealth, when I verbally briefed the Minister in May, just before I announced it—it took till September before we actually got a written response—the Minister spoke to the National Farmers Federation and a number of other groups, praising the Queensland scheme and urging other States to follow suit. I understand also that Western Australia has now decided to adopt Queensland's more

comprehensive proposal. However, that also means that it will need to go ahead with legislative changes in the new year. We welcome the support of the Commonwealth for Queensland's proposal. We would welcome it in an even more tangible form, such as ongoing funding to help provide the program. Unfortunately, we do not have that. However, we certainly feel encouraged by its verbal support.

Any discussion of doctors being poached by other States is highly emotive. However, we need to look at some of the facts. The only way that we can judge the number of doctors moving interstate is to look at registration numbers. If we look at the registration numbers for the 12 months up to June 1999, we find that only 11 doctors gave registration in Queensland as the basis for their mutual recognition application in Victoria. However, 124 doctors gave recognition in Victoria as the basis for their mutual recognition application in Queensland. Those figures show that the ratio of doctors coming to Queensland versus those going to Victoria is at least ten to one.

I wish to remind honourable members that the limits on GP training places were not imposed by the State; they were imposed by the Commonwealth in the belief that there are too many trained doctors. The number is limited to 400 Australiawide. Seventy-nine training places have been identified for Queensland. However, even those places are under threat, because they are determined at a national level by the Royal Australian College of GPs. Recently, about half of those positions were handed over to New South Wales, Victorian and South Australian graduates ahead of Queensland graduates. I kicked up one hell of a fuss about that, and I hope that all honourable members support my doing that. I found that outrageous. If the number of postgraduate training positions in Queensland is limited to 79 or 80, I think those places should be available to Queensland graduates who want positions in country hospitals. Although this is being managed at present in a fairly cumbersome way, there is still a major concern that it will continue to undermine Queensland GP numbers if the Commonwealth and the Royal Australian College of GPs allow it to continue. I have put a proposal through the department and directly to the Royal Australian College of GPs for a way around that so that this State gets its fair share of Queenslanders into Queensland training positions. Unless we do this, we will always miss out by virtue of greater numbers going to Victoria and New South Wales.

That little stunt came very closely on the heels of an attempt by the Commonwealth Minister for DEETYA to defund the University of Queensland by 20 medical places for the next two years on the basis that we were going to be opening up the James Cook University Medical School next year. But it did not take into account—and it is the same old problem that we always face; down in Canberra they think the world stops at the outskirts of Canberra—the fact that the James Cook University Medical School is planning to run a six-year program. The University of Queensland has a four-year program. If the number of people going into the University of Queensland program is cut next year and the year after, that would mean that there would be two years when we would be down 20 places each year before James Cook University came on stream. Luckily, urgent action was taken in the media by me and other players. We acted vigorously in response to that outrageous move and managed to overturn it.

Underresourcing is a constant problem facing Queensland. Historically, under Federal Governments from both sides of politics, we have been underresourced by about 40 medical places a year. That has had a considerable impact over time. It means that Queensland is by far the biggest player in trying to attract overseas trained or interstate doctors to Queensland to fill our positions. Each year about 400 or more places around this State are filled by overseas-trained doctors or temporary visa doctors, compared with the situation in Western Australia where the number is about 80. I think in Victoria it is negligible; their idea of rural and remote is an hour and a half outside of Melbourne. So the issues that we face in Queensland are far more serious.

Certainly tackling the difficulties of health practitioners in rural areas is a key issue for me and my Government. This legislation is just one reform, along with the recommendations of the nursing task force that we accepted yesterday, for example, rural scholarships for nurses, which will help encourage people from rural areas into nursing, and also to have them bonded so that they go back to rural areas after they finish training.

I suggest that the member for Maroochydore really needs to do more than read the headlines of the Courier-Mail. If she read the article in the Courier-Mail, as the member for Gladstone rightly acknowledged and had done, she would have known that the Beattie Government has never threatened to not treat patients. The article actually indicated that, while that was an option, it was not one that the Beattie Labor Government would ever pursue, and it went on to give other ways the problem should be addressed. If the member is interested, she should obtain a copy of the submission to the Senate inquiry which details the very legitimate argument put forward by the Queensland Government and the effect that this has on Queenslanders, especially rural Queenslanders,. I know a lot of other members on the other side of the House are very interested in supporting that.

I thank members for their support for the legislation in relation to restriction of smoking by juveniles. In introducing this legislation, I actually found out a lot more than I ever needed to know or

ever did know about herbal cigarettes. I actually did not know that there were already a range of varieties out there in the marketplace, even though they were not advertising in such an outrageous way as the Ecstasy ones, which led to this legislation being introduced.

I am pleased to say that this legislation will pick up all of the other types of non-tobacco type smoking products. There is one called beedies. If anyone knows how to pronounce that better than I do, I accept that. As a non-smoker in a family of non-smokers, I have to rely on the written information. It was raised with me that many kids think that beedies are safe because they are called herbal cigarettes. In fact, some researchers have found that as many as half of the kids smoking them were not aware of the high nicotine and tar content. Some of them were even using them to help them stop smoking. In fact, the impact of smoking them is just as dangerous as smoking cigarettes.

We also know that, because they often come from Third World countries, they do not have the same safeguards in terms of residues of toxic substances, etc., in them and have very, very poor quality control. A point to remember when we are tackling the issue of children smoking is that, according to statistics from the United States, teens who smoke are 22 times as likely to use cocaine, eight times as likely to smoke pot and three times as likely to drink alcohol. They are probably very similar statistics to what we would have in Australia.

I thank the member for Western Downs for his support for the legislation. I assure him that the quality of services in his area will be maintained. He at least seems to understand that significant changes in practice have taken place as a result of technology advances and that change is part of a progressing world, instead of just opposing it. I understand and I know of the issues he has with the Injune doctor and the difficulties of attracting doctors there. I understand that negotiations are taking place at a very high level to work out a fair response to that situation. He also recognised the difficulties of attracting professional people to remote areas, and it is not just a case of funding; it is as much about social and professional isolation issues as anything else.

The member for Mansfield expanded on the need for further legislation to restrict juvenile smoking, and I indicate to him that there will be a campaign on smoking awareness early next year. It will also let retailers know of these new legislative changes.

I thank the member for Warrego for his support. Some of the members opposite have been quite outspoken in their local media in expressing their support for this legislation, and I thank them for that. I acknowledge that there is no magic wand to solve all the problems, but this legislation is a significant step forward.

I also thank the member for Callide for his support. I note that communities can also help to attract doctors to their area by making doctors who do go out in the bush feel welcome as part of the community and, of course, to actually use them. Sometimes people want to have a local doctor in there area, but then they continue to go to another doctor in another town. Of course, if they are not going to use the local GP, it may not be economically viable for that doctor to stay there. We have certainly seen examples of that. The doctor at Howard leaving was one of those situations. The people of Howard wanted a doctor, but they continued to go to Maryborough or Hervey Bay and see the doctor there when they did their shopping.

I also note that this proposal for Doctors in the Bush is only part of a whole range of incentives. These incentives for rural doctors and specialists outside of Brisbane were significantly boosted by the former Deputy Premier when he was Health Minister. The benefits and support for doctors in rural and remote areas of Queensland are, I think, by far the widest ranging in Australia for any State.

I agree with the support of the member for Callide for multipurpose health service centres for rural communities. I have seen in the past a ridiculous situation where—

Mr Mickel: Remember Monto?

Mrs EDMOND: The member for Logan reminds me of Monto, where the plan was to put a nursing home at the opposite end of town to the hospital. That would have led to the ridiculous situation where the ambulance would have been going backwards and forwards between the aged facility and the hospital.

Multipurpose service centres provide a really excellent way of keeping the aged people in rural communities and providing health services. It is a pity to see the very topic of them misused as a fear campaign in some rural areas. People say that they are a wonderful initiative where they are actually up and running, and it has been a longstanding part of Labor Party policy to support them. It is a program that I have vigorously pursued with the Commonwealth.

As an example of some of the difficulties I have to face here, I would like to draw the attention of the member for Callide—even though he is not in the Chamber, if he hears this he will be amused—to the fact that the Commonwealth actually announced its agreement to the Mundubbera proposal on 26 October 1999, some many months after it had been completed, opened and operating and, I think, indeed full. I am sure that everybody would agree that that was a tad tardy. However, I will

keep on trying. I do think that they are the model for country areas. I think that Gin Gin is another area for which we should pursue this model.

Some members have also mentioned the Commonwealth medical students scholarships and seem to be unaware of the more extensive Queensland scholarships. For the information of those members, I point out that in this year's Budget we increased the scholarship fund from $1.088m to $2.443m, and the introduction of four-year scholarships to ensure longer bonded periods will result in 30 medical scholarship holders graduating each year. These benefits include a living allowance of $7,000 per academic year, a tertiary grant of $3,500 and an annual travel allowance of $500. So they are quite significant, they are very popular and, of course, we rely on them very heavily to get bonded doctors out into rural areas. I do welcome any assistance and support given by the Commonwealth, but I thought that honourable members should have some of those details of the Queensland scholarship scheme and encourage young people in rural areas to take them up.

The member for Lockyer has supported the legislation, and I thank him for that. He mentioned the fact that he was keen that it did not discriminate against Australian trained doctors. I hasten to assure the member that is not to be the scheme. Certainly that was one of the things I wanted to make sure did not happen, because that was part of the Western Australian scheme; it was very much directed at overseas trained doctors only and did not support Australian doctors. The component of the scheme which involves practitioners working in rural and remote areas for five years in return for benefits such as permanent resident status and an unrestricted Medicare provider number will clearly be relevant only to overseas trained doctors. However, other elements of the scheme will benefit participating Australian graduates by providing them with the opportunity to undergo their training for the fellowship of the Royal Australian College of GPs in the rural or remote location where they are working without the need to travel to metropolitan centres for that training.

This was one of the issues that was raised with me repeatedly when I went around the State when in Opposition. Rural doctors often felt that they were discriminated against when they came back to urban areas. If they wanted to continue their training, the work they had done in the rural areas was discounted. They were basically told that they had to go back and do another year or two at a major hospital before they could continue. So they felt they were doubly disadvantaged compared to their peers in terms of access to training. I also thank the member for Lockyer for his support relating to the smoking and juveniles issue.

With regard to questions about quality assurance legislation, it is a very difficult area when walking that fine line of protecting patient confidentiality and, at the same time, ensuring access to inform professionals so they can monitor standards. It has been very carefully considered. I draw the member's attention to the report in today's media—although it has been ongoing, there have been a number of reports in the media over the last few months—about the Bristol paediatric cardiac surgery disasters and the need for constant surveillance and maintenance of quality assurance standards. It is a difficult issue. It is something I will address further in detailed notes later on. I also thank the member for his support on continuing to restrict smoking by juveniles.

The member for Gladstone also supports the legislation, and I recognise that support. To inform her, Queensland Health is supporting training through 150 telemedicine sites across the State, which is probably the biggest network of telemedicine anywhere in the world. The member also raised some very real issues dealing with quality assurance, which I will be addressing later. But I understand that one of her concerns was about the use of areas of need in city areas. What the honourable member said she said rather amusingly about Brisbane and the Royal Brisbane, but I understand that the Commonwealth does recognise urban areas after-hours services as areas of need and allows overseas trained doctors on short-term visas to fill those positions. That is not what our legislation aims to do.

Many members raised the ongoing problem of specialists in regional centres as another ongoing concern. I have been having regular meetings with the specialist colleges in an attempt to address these issues. I am pleased to say that the vacancies of specialists in regional areas across Queensland is currently lower than ever before. There are now only somewhere between 30 to 40 vacancies compared to 126 just a couple of years ago. I have to say that that is despite the fact that we have added another 30 new specialist positions over the last year or two, particularly in psychiatric services and emergency physicians.

I am also working in a collaborative way with the colleges to address training positions in trying to come up with more novel solutions of how we get people training in regional centres who, hopefully, will then stay there. With regard to doctors in regional centres, we need to look at other ways to attract both GPs and specialists. The communities also need to work with local, State and Commonwealth Governments to attract them. Again, I know that some communities and local governments are making rent free space available for surgeries and things like that to make it more attractive for GPs to go there.

One of the things we have to recognise when there is a shortage and it is difficult to get people is that each town, each city and each locality is competing for these doctors. They all have to work together to sell their community and the benefits of living in those communities. Recently I encouraged

Mackay to send out videos of what it was like living in Mackay, with its advantages and attractions, to all the physicians they could find to try to attract applications. From my understanding, that has worked very well. It is a beautiful place to live. Overseas trained doctors constantly remark about that, yet we were not using that initiative to sell those positions. Again, the community can do much to make them welcome and remove the barriers so the community is not forced to go elsewhere for medical care.

I now turn to a few of the particular questions that were asked, such as how many positions will be filled by Australian graduates and how many will be filled by overseas trained doctors. Some of these are particulars we are still working through with the Commonwealth. The process of identifying the communities that will be covered by this scheme is still in progress. Until this process is completed, the number of available positions will not be known. In the case of each position that is identified, it will be filled with an overseas trained doctor only if there is no local graduate available for the position.

In terms of the funding that has been provided, while the State is funding the positions, the infrastructure, support for training and the ongoing funding, the Commonwealth has indicated that it will only provide a one-off payment of $300,000. It is disappointing that, despite all the rhetoric, the Commonwealth has not been prepared thus far to provide ongoing funding for what is an ongoing problem and an important initiative, particularly for rural families and residents.

In relation to whether I as Minister have the power to determine that any town or centre will be covered by this scheme, to qualify under this scheme communities will be assessed under two tests: the remoteness test and medical work force test. It would be most unlikely that, for example, provincial centres would satisfy the remoteness test for which communities will be assessed for inclusion under the scheme even though the provincial centre may satisfy the medical work force test. That is the current situation in Bundaberg, where it is recognised under that work force test that there is a shortage.

The Commonwealth has made it clear that rural and remote communities are to be given priority under this scheme. Given that the Commonwealth has the responsibility for granting permanent residency status and an unrestricted Medicare provider number to doctors who fulfil their obligations under this scheme, this scheme can only operate if the Commonwealth is satisfied that the intent of the scheme is being observed.

I was asked about what other strategies there are to address doctor shortages in the bush. Just to summarise, there is the scholarship scheme, which I have already outlined. There is also funding to rural health training units to train registrars in rural medicine, the indemnity subsidy for rural procedural GPs and relief arrangements for Queensland Health rural doctors. I was also asked about training support for doctors. For overseas trained doctors, assistance in preparing for the fellowship of the Royal Australian College of GP's examination will be provided. I think that is one of the real things that makes this proposal so different from the one put forward by Western Australia. At this stage, the focus is on filling vacant positions in rural and remote areas. The details about training support are still being worked out in collaboration with the relevant training bodies.

I was asked about the number of specialist training positions being created by Queensland Health. The answer I have here is that there are 584 specialised registrar training positions for the year 2000, of which 570 have been filled. These are for most specialties in line with the Australian Medical Work Force Advisory Committee's recommendations.

Another question related to who is going to make recommendations to me as Minister about this and who is going to be on the project committee for Doctors in the Bush. There will be people who are already very much involved, such as the Queensland Health General Manager of Health Services, Dr John Youngman, the Queensland Rural Medical Support Agency, representatives from the Rural Doctors Association of Queensland, the Australian Medical Association of Queensland and consumers in rural and remote Australia.

The member for Lockyer asked in particular about the exemption of section 63, the confidentiality clause, and why it was necessary. It should be noted that information does not need to include a person's name to be potentially identifying, particularly in a small area such as Lockyer. In practice, quality assurance committee members are more likely to consider aggregated data that has been de-identified by a person acting under the direction of the committee. Consequentially, an exemption to the duty of confidentiality is necessary for employees to provide the raw data—the patient identifying data—to such a person if that is necessary. The sort of thing we are looking at here is that committees approved under the Act will need to access patient records to carry out their functions if they are following up such things as wound healing data, infection rates, negative indicators and all that sort of thing which needs to be followed through. In some areas it will be difficult to keep it absolutely confidential, but the people who will be accessing this information will also be bound by the confidentiality legislation of their own professions.

The exemption can be applied only to giving that information to committees that have met the strict public interest test for committee approval. Additionally, the provision is qualified by the requirement that the giving of the information is to enable the committee to perform its functions.

Furthermore, once a committee gathers the information necessary to perform its functions, the legislation will prevent the committee from making available any information that discloses the identity of a person who has received a health service. The confidentiality of patient information is effectively preserved through those measures.

The member for Gladstone also asked about confidentiality and about whether patients will know that their records may be accessed by quality assurance committees. This will be dealt with administratively. Patients admitted to public sector facilities are provided with information about the service, including confidentiality policies. Any amendment to this information to include the work of approved quality assurance committees would not be difficult. It must be stressed, though, that a committee is not permitted to disclose the identity of an individual who has received a health service unless the individual has consented in writing to that disclosure.

Why is there no legislative provision for the destruction of quality assurance committee records? Legislative provision is not necessary because there are already adequate administrative arrangements and policies in place to deal with this. The destruction of public records is provided for under the Libraries and Archives Act, the whole-of-Government information standards and also departmental policy and corporate clinical records. The departmental policy deals with accountability for retention and management of records, record security, and retention and disposal of records. If deemed necessary, the Act has existing legislative provisions for making regulations about the manner in which committees are to exercise their functions.

Time expired.
