Speech by

Miss FIONA SIMPSON

MEMBER FOR MAROOCHYDORE

Hansard 15 October 2003

HEALTH LEGISLATION AMENDMENT BILL

Miss SIMPSON (Maroochydore—NPA) (11.30 a.m.): This is a wide-ranging piece of health legislation that amends more than 10 acts of parliament, so the policy objectives are varied. Many of the amending provisions within the Health Legislation Amendment Bill are not controversial, but there are some significant exceptions, particularly in one area, dental health. Under these changes the children's dental health program in schools will face potentially an exodus of school dental therapists. Another group that has expressed considerable concern are dental technicians, who are faced with quasi-deregulation, despite having their own registration act. I will be outlining some of these matters of concern and others during the course of this debate.

The explanatory notes state that the bill will not have any significant financial impact on the government. I query the minister as to the accuracy of this statement. If school dental therapists cease to work solely in the public dental program, this will have a significant impact. Admittedly, the impact may be that the government is not paying school dental nurses anymore because they will potentially leave the system and there will be a deficit of workers. But it raises the spectre of how the government is going to fill that hole that will be left by this exodus and what it will cost.

Many people in the industry are saying that they are not opposed to career paths for appropriately trained school dental therapists, but they strongly question whether the public policy issues, or the impact upon the school dental program, have seriously been examined. I would like to quote from a letter that I received from the Australian Dental Association Queensland Branch President, Don Anning, in August. In it he states—

... are a number of concerns that ADAQ has with the new legislation. These concerns are outlined below.

The effect on the School Dental Service

One of the significant changes that is of concern to ADAQ is the removal of the restriction on dental therapists working only in the School Dental Service. If passed, this legislation will allow school dental therapists to work in private practice. ADAQ has no philosophical disagreement with this position. However, we are deeply concerned about the impact this will have on staffing levels in the School Dental Service. This Service is already significantly undermanned and stretched to the limit.

In our view, the passage of this legislation is likely to mean the end of the School Dental Service as we know it. Many school children will not receive treatment or parents will be forced to seek this dental treatment for their children in the private sector. Although this is a situation that will be of financial benefit to our members, it is hardly an outcome that would satisfy the much touted public benefits test.

In other states the demand for dental treatment in school age children is significantly reduced by the benefits of water fluoridation. It is my firm belief that in Queensland, where 5% or less of the population drink fluoridated water, the situation will quickly become unmanageable. The likely demise of the School Dental Service highlights the dangers of adopting policies that have been introduced in some other states without carefully considering the circumstances that apply locally.

To consider removing the restriction on school dental therapists working in the public sector without the introduction of water fluoridation is inviting disaster.

I put those comments on the record because, as I said, the issue of people having career paths outside the public sector philosophically is one that people do not disagree with, but there has been no policy answer provided by the government as to how to deal with the pending exodus of these workers from the system.

Already in the past 12 months 51,000 fewer Queenslanders received public dental treatment, despite the government claiming to have spent eight per cent more on the public dental service. Already in the past 12 months we have seen a cutback in school dental treatments. School dental treatments have always been provided by the state government. In the next 12 months this Beattie Labor government expects to treat 10,000 fewer schoolchildren in the public system. But if we look back over three years, how many fewer children will the government have treated? Fifty thousand fewer children will be treated in a given year. To me, that rings alarm bells about children's health and children's oral health. That is my concern about this legislation, dealing only with these issues of allowing dental therapists to move into the private sector without providing a proper policy solution—unless, of course, there is an intention to remove adequate supervision of the way in which people operate.

In the briefing that I received from the department I asked about how the supervision provisions currently operated with school dental therapists. While I thank the officers for their briefing, it became apparent that there was not a clear answer about how the supervision provisions of these school dental therapists operated in relation to qualified dentists. My concern is that these supervision provisions, as they are translated into this legislation, will mean that the government will not in fact have school dental therapists with adequate levels of supervision as they go out into the private sector and expand their scope of practice.

Part of that expansion of scope in the private sector is to stop treating only children and to start treating adults. On average, adults have far more complex dental needs than do children. Obviously, they have lived for more years, their other health issues can be more complex and their dental health needs can become more complex. That is why there has been concern about the scope of practice for dental therapists.

According to this explanatory note and the briefing, there will be codes of practice, but those codes of practice have not yet been developed. But I go back to when I asked about the existing supervision provisions, realising that there is supposed to be under legislation strict supervision by qualified dentists of what dental therapists can do. I did not get a straight answer as to the type of supervision and the level of that supervision in the existing system. I am most concerned that, given the pressures and the demands for more dentists not only in the public sector but also in the private sector, the lack of supervision of dental therapists will mean that the government will have them performing levels of work that should be appropriately performed only by qualified dentists in a one-on-one situation. That protection is removed by this legislation.

When we are dealing with the types of work that is performed on people's teeth and their mouths, work that could potentially have a permanent impact upon their lives—sometimes for good and, if it is not done right, for bad—it is absolutely essential that the appropriate clinical standards are provided and that there is a strong regime within legislation.

Mr DEPUTY SPEAKER (Mr Mickel): Order! I would ask the House to recognise the students and teachers from the Kingsthorpe State School in the electorate of Darling Downs.

Miss SIMPSON: I challenge the minister to explain how children will be treated in the public dental service and the level of that service, given that in this government's own budget papers it anticipates that 10,000 fewer schoolchildren will receive public dental treatment in the next 12 months. That treatment is the responsibility of a state government—always has been—and I am most concerned that children's oral health has really fallen off the plate in terms of the policy objectives of the government and, certainly, any significant initiatives that we have seen brought forward.

Another significant issue within this legislation is the deregulation of dental technicians. Though there will continue to be legislation restricting the use of the title, under this legislation the type of work they perform will no longer be restricted to dental technicians. It leaves them in a quasi-deregulated state, which is obviously of great concern not only to those who have those skills but also to those who want to see a certain quality of services continue to be provided in the community.

I think it is appropriate that I read into *Hansard* some of the comments from dental technicians on this very issue. They are the ones who are performing this work. They are the ones who have questioned the recommendations accepted by this government to move for this quasi-deregulation and removal of restrictions upon their occupation. Stephen Griffin, the President of the ACDLA, said in August 2003—

On Wednesday 30th July a crisis meeting of Representatives of Australian Dental Prosthetists Association, Australian Commercial Dental Laboratories Association, Liquor Hospitality and Miscellaneous Workers Union and Dental Technicians was convened to discuss the pending demise of the Dental Technology Industry in Queensland.

The 'Health Acts Amendments Bill' being presented by your Government—

referring to the Health Minister—

for the second reading in the next sitting of parliament removes the necessity for people working within the dental technology industry to be suitably Qualified and Registered.

From previous discussions with your office we have had indications that the motivation for this change is to introduce competition to reduce the cost of dentistry to the public, a proposition we strenuously question. The access to cheap technical work, referred to in the Price Waterhouse Coopers, 'Review of the Restriction on Practice of Dentistry' and quoted by the minister, has been available to the profession for many years through off shore laboratories in South East Asia and has not reduced the cost of dentistry to the public of Queensland. The review also appears to have a very narrow view of the role of Dental Technicians in the dental team. Dental Technicians construct appliances i.e. Osteo-integrated implants, fixed ceramic and gold crown and bridge appliances, orthopaedic and orthodontic functional appliances, cast metal partial dentures, acrylic partial and full dentures as well as maintaining, repairing and adding to these appliances. These appliances are constructed in consultation with oral surgeons, orthodontists, perodontists, medical practitioners, physiotherapist, dentists and prosthetists. Dental technicians provide major input in the areas of material selection, appliance design, treatment planning and aesthetic considerations.

Griffith University has recognized the importance of Dental Technicians and their role in the dental team by creating a degree course in Dental Technology to commence in 2004 as part of their new school of Oral Health. Our industry is concerned about the long-term viability of this course if deregulation of dental technicians occurs.

We are concerned for the well being of the public of Queensland and the possible health effects of unregulated operators using dangerous materials i.e. Lead solders, Beryllium alloys and cancer causing plastics, none of which can readily be recognised by Dentists, Prosthetists or the general public but are highly dangerous to patients.

These are some of the concerns that are coming forward about the changes in this legislation. The move to give broader scope of practice for some elements of the dental industry while restricting others is interesting.

Another issue was raised by the Scrutiny of Legislation Committee's *Alert Digest No. 8* of 2003. It asked the question: does the bill sufficiently subject the exercise of delegated legislative power to the scrutiny of the Legislative Assembly? While the committee appears to have brought to the minister's attention a matter relating to subsections 101A and 101C, which are inserted by clause 81 and relate to codes of conduct and the Nursing Act, these codes of conduct also apply across other health professional acts. The minister replied to that by saying that it was appropriate for these, being more administrative than legislative in nature, to be in this type of format. However, significant powers attach under these codes of conduct.

I have already mentioned my concern in relation to another issue, which is the level of supervision required for dental therapists, for example—it will no longer be one-on-one supervision—and that issue being brought back under the code of conduct, as I was advised during the briefing, as I recall. The level of supervision for somebody performing significant work upon somebody is extremely important, otherwise we will see a downgrading of quality, and that is of concern.

Those issues are not required to be within a regulatory instrument which can be disallowed by this House. The issue of the codes of conduct not ever coming back by way of a regulation, where they can be potentially scrutinised by parliament, was raised by the Scrutiny of Legislation Committee. I believe it is a very relevant issue. There has been a tendency in recent times to take all of the standards, holus-bolus, out of the legislative and regulatory process and the scrutiny of parliament and place them into these instruments that do not come back before the parliament. While there are some issues which may not need to come back on a regular basis, I suggest that there are significant issues to do with the level of practice that people perform. I think too much has been taken away from the scrutiny of parliament. I draw the attention of the House to the performance of the Scrutiny of Legislation Committee in providing that scrutiny.

The other issue I want to raise is rather an interesting one. It relates to the amendment to the Health Services Act 1991. The state National-Liberal coalition strongly supports the existence of district health councils, and in fact has a policy to strengthen their roles, in providing effective community participation in local health services. This is something we had a strong hand in establishing and championing. This bill amends the Health Services Act 1991.

According to the minister's second reading speech, this change is only to provide more flexible membership requirements for district health councils to accommodate periodic vacancies and to ensure the functions of a district health council are not affected merely because of a vacancy. I wonder what the minister defines as a periodic vacancy from a health council. I wonder whether she considers as a periodic vacancy the fact that there has been no operational district health councils for the Royal Brisbane Hospital and Royal Women's Hospital for the last seven months.

It is clearly a requirement under the act that there be district health councils, yet for seven months we have not had an operational council for the Royal Brisbane district, nor have we had an operational council for the Royal Women's Hospital. The members of these councils were told that the councils were to be amalgamated and that they could reapply and possibly be appointed to the new amalgamated council. They understood that the councils had been dissolved, so they have not been meeting for the last seven months, as I understand.

Where is the minister on this issue? Truly, if the government is serious about community engagement and involvement in the health system of this state, the biggest hospital in this state should have a district health council. I am more than a little suspicious about the provisions in this act and the fact that it has not been mentioned that the biggest hospital in the state has not had a district health

council operating. I think we need to actually read a section of the Health Services Act, which this bill is amending, to understand the importance of district health councils. The act states—

(8) Functions

(1) The functions of a council are to—

(a) identify and assess the health service needs of people living in the council's district or who may use public sector health services delivered in its district; and

(b) participate in the development of the department's strategic plans for the delivery of public sector health services in the district; and

(c) monitor compliance with the strategic plans and health services agreements by the manager for the district; and

(d) monitor compliance by the manager for the district with the budgets for the district; and

(e) monitor the quality of public sector health services delivered in the district, and

(f) decide priorities for minor capital works, and monitor the programs for the works and asset management, for the district ...

There is a range of these very important roles that councils are to perform. Furthermore, they are also to participate in the selection of senior executives.

What have we seen with the Royal Brisbane Hospital? In recent months we have heard of budget blow-outs of up to $20 million or carrying debts over and issues with which they have apparently had to struggle in regard to meeting budget. They have had changes at the senior executive level. They have had significant issues as far as delivery of services, and there is no community interface. For the last seven months the district health council has not been operational, with members told they were to be amalgamated with another district health council. Clearly this has not happened or those members have not been advised it has happened because I understand a number have sought advice, and still we are waiting to see when this council is to be established.

The act clearly says that there is to be a district health council for each district. We have not had a district health council meeting in this area for the last seven months at least, and yet they are supposed to meet every two months. So the department is clearly in breach of its own act. This is important when we consider that once again this is one of the biggest hospitals in the state. The government is big on talking about accountability in community engagement but the procedures for doing that have been undermined or people have been misled as to that process.

I note that there are provisions within the existing act to deal with vacancies, and there are some amendments before the House to require that when people resign their resignation is given to the minister. I would certainly welcome her advice as to why there has been no operational district health council for the biggest hospital in the state for the last seven months and why people have not been advised of what is happening. I think it is a disgrace. I think it is an example of a minister who has already retired. Clearly, there are people in the community who want to be involved in these district health councils and who want to be part of the legislative requirement of monitoring compliance of the quality issues as well as the budgets in our hospitals.

I would ask how many other districts are also in such a situation. In this particular case we know that members were asked to dissolve the council. Whether that is the formal terminology used I do not know, but certainly council members were of the understanding that those councils were no longer required because they were to be amalgamated into one, and for the last seven months nothing has happened. So we need a please explain from the minister in that regard.

Other provisions of this act cover the Health Rights Commission, and I will read the provisions in regard to this. The bill amends the Health Rights Commission Act to clarify the powers of the Health Rights Commissioner and to ensure the effective operation of the Health Rights Commission. According to the explanatory notes, the amendments will enable referral of public interest issues to registration boards after successful conciliation, clarify the commissioner's powers to decide not to take action after an unsuccessful conciliation, enable a conciliator to discuss confidential complaints matters with a colleague and clarify that a matter may be referred from investigation to conciliation.

One of the issues being raised with me time and again is the need for the Health Rights Commission to be resourced in order to provide a true scrutiny of the Health Department. It is extremely important that we have statutory bodies such as this one that have that role. I am disappointed that there is nothing within this amendment to deal with what is a significant issue—and that is the need for the Health Rights Commission's budget to not come through the Health Department. It would be more appropriate for it to sit with the Premier's Department to deal with some of the issues of the perceived independence of the Health Rights Commission.

I also believe there needs to be a review of the powers of the Health Rights Commission and the way that it is performing its duties, because there are internal conflicts within a department the size of the Health Department. Not only is the Health Department and its chief executive officer—the director-general—responsible for the budget; they are also responsible for the standards that they

deliver. We need an independent arm that has the strength and the ability to look at not only grievances but also quality issues within a department the size of Queensland Health. That is good process but it is also good for the patients. I raise that issue now because I know that the Health Rights Commission currently needs appropriate and additional funding. It also needs more teeth to do the job that needs to be done. It needs to do the job considering the issues of quality which are being raised.

This is not a criticism of staff but a recognition that on quality issues we need to have proper systems in place, proper checks and balances and proper accountability. If Queensland Health was truly accountable under this government, it would also be submitting the Health Department to audit by the Auditor-General. It is interesting that New South Wales does. That is another very important way of providing some statutory oversight. In fact, the last report by the Auditor-General in New South Wales is on the Internet.

Mrs Edmond: Queensland Health is audited by the Auditor-General.

Miss SIMPSON: With respect, this is performance auditing, which is not occurring. What is happening in other states like New South Wales is that they are still doing performance auditing. It is time there was performance auditing as well as financial auditing. There are other issues to do with benchmarking, clinical indicators and the consistency of those clinical indicators. It is interesting that this has been recognised as a standard that needs to be moved to in another state—albeit a Labor state. It is time we saw independent auditing of performance indicators, benchmarks and how those benchmarks are met. To date, it is all done in-house. If we are going to have a system that serves not only the patients but also those working in the system to achieve those clinical outcomes, we need some accountability in the way that is undertaken.

There is a range of other amendments, including amendments to the Nursing Act. I have previously raised the issue publicly of ensuring that people applying for nursing registration do not have a criminal history that affects their duties. This bill seeks to amend the Criminal Law (Rehabilitation of Offenders) Act 1986, and I acknowledge that. I have been on the record as saying that there are still loopholes within the law, despite these amendments, that have been brought to my attention. Through complaints from a constituent, I know of people who have a criminal history and who have still not declared it. So there are people who are already registered who are still working in the system. They may only be a minority, but that is why we bring in legislative changes—to provide some safeguards.

People in these health professions, particularly nurses and doctors, are in a position of power over people who are vulnerable. They are in a position of power over someone who is elderly or someone who is frail and infirm. Therefore, it is necessary that there are good regulatory statutory frameworks to deal with issues of registering only those who have a clear history in regard to criminal offences. I also believe there is still an issue about those who already have registration and the fact that they have failed to notify. We still need checks upon existing registrants and their criminal history. I do not feel this issue will be addressed by this amendment, even though this amendment is better than the previous act, and I draw that to the attention of the House.

In closing at this time—because I will have more comments during the committee stage of the bill—I will focus on the estimated costs to the government for implementation. As I have mentioned, I believe that this bill has not assessed what the impact will be financially, particularly with regard to oral health services for children and public dental services. Children's oral health services in the public sector are already failing under this government. There is no allocation mooted or talked about to address the fallout of people who are moving out of that sector. If we are to provide these career paths which, as I said, people do not philosophically disapprove of, there is still a responsibility to provide alternative ways of dealing with it. I believe that these issues have not been addressed by the government and there is a cost. The cost is not only financial; the cost is in terms of people's health, particularly the health of children.