Speech by

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MEDICAL BOARD (ADMINISTRATION) BILL; HEALTH SERVICES AMENDMENT BILL

Mr LANGBROEK (Surfers Paradise—Lib) (7.40 pm): I rise to speak to the Medical Board (Administration) Bill 2006 and the Health Services Amendment Bill 2006. I would like to thank the departmental staff for their briefing on the bills in the last sitting week. The Office of the Health Practitioner Registration Boards provides administrative support to health practitioner registration boards to assist them in discharging their statutory functions. The office also assists the boards in processing a professional's application for registration.

This bill will establish a new and specific Office of the Medical Board. In the same way the Office of the Health Practitioner Registration Boards supports the health practitioner registration boards, the Office of the Medical Board will support the Medical Board of Queensland in its process of registering medical practitioners. As such, the Medical Board (Administration) Bill essentially replicates the Health Practitioners Registration Boards (Administration) Act 1999. Hopefully, the new office will lead to a more timely and thorough processing of medical practitioners seeking registration. This move recognises that the processing of medical practitioners seeking registration often requires more resources than other health practitioners and, of course, acts to avoid another Patel scandal.

We know, too, that previous measures brought in this year with regard to quality and timeliness put the onus on the Medical Board to get medical practitioner registrations right. The coalition has concerns that the Premier's promise to create a new Office of the Medical Board came out of questions arising from problems that arose during the election campaign with regard to the registration of a doctor in Rockhampton. The coalition also has concerns about the cost of implementing this legislation and how much creating the Office of the Medical Board will cost. That amount has not been disclosed.

The minister stated in his second reading speech that the new Office of the Medical Board will have the following benefits—

It will provide more effective scrutiny of persons seeking registration as doctors in Queensland thereby avoiding inappropriate registrations, and the new office will have a dedicated focus on the quality and timeliness of registrations and to ensure a thorough check of each candidate's credentials;

It will facilitate improvement in administrative arrangements and promote more efficient service delivery to the board; and

It will allow the Office of the Health Practitioner Registration Boards to concentrate on less complex registration processes associated with the other 12 health practitioner registration boards.

This is nuts and bolts legislation. The Queensland coalition has no problems with its provisions and accepts its objective. This side of the House notes the consultation undertaken to compile the Medical Board (Administration) Bill.

As this bill relates directly to the processing of registration applications of medical practitioners, I would like to use this opportunity to inform the House of recent developments in the United States that I believe would be worthy of consideration. Part of the registration processing includes reference checks in order to confirm the good or suspect standing of applicants.

Recently, the US court has dealt with the issue of when negligent representations are provided in references—an issue that came to light during the Patel issue. In layman's terms, the court held that a hospital has a duty to disclose and to supply correct information in its referral letter arising from the special relationship between a practitioner and their employer hospital. The court's decision is not directly applicable under Australian law as it is a US decision and the law of negligent misrepresentation also differs between jurisdictions. However, the 2005 US case is indicative of judicial approaches to a hospital's duty to disclose all information relevant to a medical practitioner's competency to practise. A finding of liability in negligence for failure in credentialling processes which led directly or indirectly to patient harm, both of which were illustrated during the Bundaberg commission of inquiry, is also possible in Australia. Strengthening the power of the Medical Board and the new office in screening references may be something that the government would care to legislate.

I would particularly like to note the extensive transitional provisions of the Medical Board (Administration) Bill. Part 5 of the legislation sets out procedures and time frames for negotiating the first service agreement entered into between the executive officer and the board after the commencement of the act. These procedures and associated time frames are designed to facilitate the prompt implementation of the administrative arrangements established by the act and to minimise any potential disruption to board services that could arise if negotiations between the executive officer and the board become protracted during the implementation phase. These transitional provisions are worthy of note and support.

I turn to the Health Services Amendment Bill. This bill amends the Health Services Act 1991. The bill will implement structural changes to the administration of Queensland Health following the announcement that Queensland's 37 health districts are to be reduced to 20. The bill does not reduce the number of health districts from 37 to 20 yet, as one may be led to believe; it just effects changes to the administration. The minister effectively noted this in his second reading speech when he stated—

I intend to initially establish 37 Health Community Councils to reflect existing communities represented by current district health councils.

I will address the issue of health community councils in due course. It is appropriate to note that I have received conflicting advice regarding the plan to reduce the current number of health districts from 37 to 20. But it is undeniable that, to date, the number of levels in the organisational structure of Queensland Health has promoted fragmentation between policy development, governance and, most importantly, service delivery. The Beattie government has left its 37 health districts insufficiently integrated to provide a comprehensive health service for Queensland. Therefore, the restructuring of the health districts is something that the Queensland coalition will ultimately support. We on this side of the House will not continue to allow the diminution of health services to the community, which has been happening over the last number of years, to continue to occur.

The Forster review stated—

If any restructuring is contemplated, it should take place for the right reasons and strive to achieve a demonstrated enhancement to health service delivery, the services received by consumers and patients, and ultimately improved health outcomes.

Labor's spin doctors weaved this theme into the minister's second reading speech for this bill. In his second reading speech the minister stated—

The benefits of these changes will flow through to improved health service delivery.

He went on to state in relation to this transition phase—

There is no intention to reduce services, particularly to rural and regional Queenslanders.

Whenever the minister says that he has no intention of something bad happening, warning bells go off in Queensland coalition ranks. We cannot help speculating that the minister knows that things are just about to get worse. However, the minister knows that he can point to the *Hansard* and say, 'I only said that I had no intention and intentions are not actualities when health service outcomes fall short.'

Despite what the explanatory notes refer to as the 'continued implementation of the current health reform agenda' of the Beattie government, in actuality the reduction of services is still happening. The most glaring illustration of that this past month has been at the Royal Brisbane and Women's Hospital—the state's largest hospital. Almost 20 per cent of operations scheduled were cancelled for the remainder of the year, despite earlier claims by the Beattie government that the closures were caused by maintenance for three months from the beginning of the year. One hundred and fifty-three operating lists affecting over 500 patients have been cancelled in the lead-up to Christmas. During the first nine months of the year, the number of people waiting for the most urgent category 1 operations has increased by more than 60 per cent.

What hope do our rural and regional friends have when we have mass cancellations at the RBWH in Brisbane? The government did not intend to have delays past three months at the RBWH but this month has proved that intentions are not reflected in a Queensland Labor government's reality.

This bill relates to changes to the administration of Queensland Health in anticipation of the state's 37 districts being reduced to 20. It is worth recalling what features Forster noted would be in an improved structure of Queensland Health. He stated—

While arguments could be made for major changes to both district and zonal boundaries, it is considered that a major restructuring of the districts would result in minimal savings and would divert attention away from patient-centred improvement and the effort required for the implementation of the major reform agenda to change the direction of Queensland Health.

The recent episode of cancellations at the RBWH have proven that statement to be true. In looking through the Forster report, I was drawn to page 73 and recommendation 5.1, which states—

The current 37 Health Service Districts are retained.

Yet we see that the minister is planning to reduce these 37 districts to 20. It seems to me that the government is pleased to cloak itself in some aspects of the Forster and Davies reports, but then in other cases chooses not to. The Beattie government's reform agenda should not be accepted as following the recommendations arising out of the Forster review or the recommendations that came out of the inquiry into Bundaberg Base Hospital, which it often tries to blanket itself in. The government has just taken from those reports some of the bits that it likes and left others behind.

One point the government has picked up is aligning the Health Services Act's organisational provisions to Queensland Health's new structure as proposed by the Forster review. The bill sets out the respective roles of the chief executive being statewide strategic direction and leadership, area general managers as leadership within their respective health service areas and district managers who manage public sector health services within their respective districts. These role explanations are welcomed. The recent damning report on Health by the Auditor-General noted that, since the adoption of some of the Forster recommendations, which have led to organisational restructuring and recruitment drives, the department should give priority to clearly redefining and documenting roles and responsibilities. This is a move in recognition of this failing.

This bill also creates a Health Executive Service, a model taken from the Public Service Act's Senior Executive Service, incorporating area general managers, district managers and other senior Health executives who are not part of the Public Service. The new Health Executive Service is intended to promote effectiveness and efficiency in the delivery of public sector health services by attracting, developing and retaining a core group of health executives. One has to accept this as part of the reform agenda that the government has decided it is going to implement. However, what makes these provisions hard to swallow is that the Beattie government has not stopped the growth of bureaucrats in Queensland Health elsewhere. One year ago Forster recommended that Queensland Health slash central office bureaucracy. However, in an answer to a question on notice this month, the health minister presented data that showed the recruitment of bureaucrats was keeping pace with the recruitment of medical staff. This is what I mean by the Beattie government picking up some things in Forster's report and not others.

The government has attempted to develop Queensland Health's leadership and management capacity by creating a health executive board as suggested by Forster and Davies but has not cut down on bureaucrats elsewhere, as was also suggested by Forster and Davies. This haphazard adoption of the reviews' recommendations makes the good things the government decides to follow through with not as good as they could be. It is the Beattie government's haphazard and shotgun adoption of Forster's recommendations that led to the recent damning report by the Auditor-General. The Auditor-General's 2006 report found overall workforce planning systems and processes were only partially implemented and that data integrity issues, paramount to any sort of proper planning, were identifiable. The Beattie government has jumped on recruitment as the be-all and end-all solution to the workforce crisis in Queensland, but the government has forgotten about the importance of workforce planning.

The report found that the processes currently in place were more in line with workforce management as opposed to workforce planning. The Auditor-General's report recommended a shift from its current focus on short-term recruitment and training issues to a greater focus on longer-term workforce issues, including analysis of future workforce gaps and strategic planning. The report also noted how Health conducts short- and long-term forecasting, which is supported by documented assumptions. However, this forecasting is conducted on a reactive rather than systematic basis. Responsibility for workforce planning should be allocated to these new bureaucrats to rectify the report's findings. I look forward to clarification and/or the expansion of the responsibilities provided in this bill in the near future from the minister.

The bill will replace district health councils with health community councils. The explanatory notes state that health community councils will focus on community and consumer engagement and monitoring quality and safety in hospitals. This is a welcomed move, although we have concerns about the fact that there are going to be 37 health community councils reporting to only 20 health districts, which seems to raise concerns as to the relevance of the health community councils in some of these areas where they are a long way from where the district central office is based. The move is quite ironic in terms of recognising that health services belong to the community when we realise that Queensland Health has not engaged in any consultation with the medical community over this bill. The lack of consultation is justified in the explanatory notes where it is stated that because this bill focuses on the organisational arrangements of

Queensland Health there has been no consultation with the community in relation to the bill. I thought that this irony was worthy of being pointed out.

The health community councils will act as community based advisory bodies and should make the health service more responsive to the local communities' needs. This move is welcomed in light of the latest report from the Centre for Rural and Remote Area Health. This joint research centre of the University of Southern Queensland and the University of Queensland recently sent me its report *Key issues in rural health: Perspective of health service providers in rural Queensland*, which states—

There was a view among participants that community perceptions and expectations are not in alignment with the model of care that is provided. There is a constant lack of consultation between policy makers and consumers.

The report continues—

Also the criticism was levelled that even where there are consultations they result in either no outcomes or unsatisfactory outcomes.

That reminds me of the feedback that Forster received at, for example, the forum I attended when Forster came to the Gold Coast last year. That is what consumers were saying anecdotally about their experiences when dealing with health outcomes. This is what the Beattie government has made an art form of. The government consults the people to make them think that the government is listening, make everyone watching think that we are doing the right thing but not actually follow through with anything. That is what I find so tragic about the announcement of yet another task force to look at the use of the deadly drug ice while at the same time rejecting, in our last sitting and before schoolies, a coalition proposal to ban the public display, sale and promotion of ice pipes and other illegal drug utensils to the public and our children. The Queensland coalition thinks that the notion of health community councils is a good idea. In fact, we believe that their proper use is the only way a reduction in services in rural areas will not occur. The Queensland coalition believes wholeheartedly that consultation lies at the heart of good government, but whether that will be achieved under the Beattie government is another question.

The bill enables the creation of statewide health services by Executive Council approval to operate across districts and areas. It is this sort of flexibility across districts and boundaries that lies at the heart of what Forster suggested we do to improve the structure of Queensland Health, not necessarily by reducing the number of districts to 20. Statewide health services might be employed to address high-profile issues such as statewide chronic disease or cancer services or in the provision of initiatives in Indigenous health, which needs a concerted effort to ensure Indigenous communities take up the services that are made available to them.

I suggest that the Executive Council uses its new scope to help address the workforce crisis that the Beattie government does not seem to fully grasp. I believe there is a real opportunity here, through statewide projects, to offer attractive and stimulating work to health professionals just as the Commonwealth government did in January this year. Then Minister Abbott announced the development of a new Medicare item for antenatal services provided by appropriately trained and qualified midwives, nurses and Aboriginal health workers on behalf of medical practitioners in rural and remote areas. This is one of a number of measures developed by the Australian government to improve access to medical services for people living in rural and remote communities. It is just one example of an innovative strategy to maximise the skills and availability of the clinical workforce that Forster proposed would assist to reform the workforce. The harnessing of the scope of the Executive Council will be something I will be watching with much interest.

The bill also inserts a set of guiding principles into the act that reflect recommendations from the Forster and Bundaberg Hospital reviews. The principles include making the best interests of users of public sector health services the main consideration of and for decision making; a commitment to quality and safety; being responsive to the needs of users of public sector health services and service delivery; being open and transparent in the provision of information to the community in relation to public sector health services; a commitment to creating workplaces that are free from bullying, harassment and discrimination where staff are respected and diversity is embraced; openness to complaints; collaborating with clinicians in the planning, developing and delivering of public sector health services; and promoting opportunities for training and development that are real. The bill also expands the objects of the act to include health promotion and protection.

The Queensland coalition supports these changes and supports these bills. However, the opposition remains wary of the impact on services the transition to the new structure will have, especially in the light of compelling new evidence showing that more Queenslanders are waiting on the waiting lists than ever before, that more Queenslanders are waiting longer on these waiting lists than recommended and that the workforce crisis is only being addressed by the Beattie government through recruitment drives without complementing workforce planning to manage the very health organisation it is restructuring. I ask the minister to stop blanketing himself with the Forster review as justification for the government when the impacts of those recommendations will only be achieved if recommendations are implemented at the same time as others and not on a haphazard basis. I accept that the minister does not intend for there to be a negative impact on health services. However, I also accept that intentions are often not health actualities under the Beattie government.