Speech by

Andrew Powell

MEMBER FOR GLASS HOUSE

Hansard Wednesday, 28 October 2009

HEALTH AND OTHER LEGISLATION AMENDMENT BILL; HEALTH PRACTITIONER REGULATION NATIONAL LAW BILL

Mr POWELL (Glass House—LNP) (4.22 pm): I rise to contribute to this cognate debate on the Health and Other Legislation Amendment Bill and the Health Practitioner Regulation National Law Bill. I will address the Health and Other Legislation Amendment Bill first and focus on four main issues: smoking, mandatory reporting, confidentiality disclosure and changes in the role of nurse practitioners.

I would like to commend the government for continuing its tough stance on smoking. The implementation of the clauses in the bill might be a bit clunky, confused and definitely difficult to police, but the intent is positive. Smoking is an insidious addiction and the effects of smoking are dreadful. It is now a long-established fact that smoking is a primary contributor to the development of a range of cancers, including lung cancer. Those who never smoke have a one in 200 chance of getting lung cancer as opposed to a one in 10 to one in 20 chance for those who smoke. New South Wales health reports also demonstrate that smoking doubles the risk of heart disease, heart attack and strokes. Quite simply, smoking is a killer. As the explanatory notes highlight, some 3,400 Queenslanders die each year as a result of their smoking.

I am particularly passionate about this issue because, like most families in Queensland, mine has suffered from the consequences of smoking related death. Both of my maternal grandparents died of smoking related disease: my grandfather from throat cancer, my grandmother from respiratory difficulties. As tragic and distressing as their deaths were for me, as an impressionable teenager it was the best form of deterrence. I can still vividly picture the dramatic decline of my once fit and fun-loving grandfather. My last image of him was as a wheelchair-confined invalid, bloated and grey from constant treatment, unable to speak other than through the expressiveness of his eyes. If I needed a reason to avoid ever touching cigarettes, I had it.

But smoking has other, more broad community consequences. It is an excessive burden on the healthcare system. As the explanatory notes state, smoking related hospital admissions cost the state $217 million per annum. We continue to see 276,000 smokers with children under the age of 16 in Queensland, which raises the spectre of environmental tobacco smoke, or passive smoking as it is more commonly referred to. Passive smoke contains 250 toxic chemicals and increases the risk of bronchitis, pneumonia, asthma, ear infections, lung cancer, heart disease and SIDS. The Addictive Behaviours 2008 survey also demonstrated the link between passive second-hand smoke exposure in cars and nicotine-dependence symptoms. Therefore, the proposal to prohibit smoking in a motor vehicle where there is a child under the age of 16 is a great idea. But, as I said, how it is implemented appears to be a bit cumbersome and confusing.

In addition to reducing the effects of passive smoking in cars, I also support the push to limit smoking in all public spaces. This bill brings Queensland into parity with other states, such as Tasmania, which brought in similar legislation in 2007, and New South Wales, which brought in similar legislation earlier this year. This push to limit smoking in all public spaces is also consistent with broad community approval, with—as other members have noted—89 per cent of Queenslanders being in support of tougher

smoking laws. Overall, the ban on smoking in cars with children under the age of 16 will help protect the community and, in particular, the immediate and future health of young children and babies.

I turn now to the amendments that relate to mandatory reporting. I agree that it is good policy to protect Queensland patients from professional misconduct. I also realise that it is necessary to strengthen the community's confidence in health services. No-one in this House, nor in Queensland as a whole, needs to be reminded of the consequences of misconduct in the health profession.

According to the explanatory notes, the amendment to the Medical Practitioners Registration Act 2001 will make it obligatory for a doctor to notify the Medical Board of Queensland if the doctor is aware that another doctor has engaged in misconduct in the practice of the profession. I understand that a doctor's report of another doctor's misconduct will make it easier for the Medical Board to intervene and take appropriate action, thereby protecting the public.

Although the intent is positive, there are concerns about this amendment. For example, the Medical Indemnity Industry Association of Australia—or the MIIAA—is opposed to mandatory reporting. It believes that the legislation will have a negative impact on health professionals as it will limit disclosure of issues and create a punitive atmosphere and culture of fear; that health professionals will no longer be willing to openly discuss medical errors; that the amendments have the potential to prevent an open, trusting and learning environment—an environment that benefits patients—and that the legislation will not enhance the Medical Board's ability to identify serious misconduct.

Interestingly, mandatory reporting has been instituted in New South Wales. However, in introducing it, the New South Wales health minister reported that it was—

... based on public perceptions not any evidence that it would improve medical standards.

In fact, the New South Wales Medical Board advises that the level of reporting by practitioners since that time—2005—has not altered significantly at all. The AMAQ also expresses some reservation about certain models of mandatory reporting, calling it 'more harm than good'. Although the Medical Board is not opposed to the amendments, it is concerned that the amendments may deter impaired doctors from seeking help from their treating doctor for fear of being reported.

In view of the position of these three respected health entities alone, I suggest that we rethink the amendments and consider the extreme effects of mandatory reporting, including the potential for counterproductivity. Overall, although it is good to improve patient protection and care, it should not come at a cost of creating an unstable environment for patient caregivers. If medical professionals do not feel safe to discuss medical issues, they will not give proper care. I agree with the LNP's suggestion that if mandatory reporting is adopted, it should not include issues related to clinical care. Rather, it should be limited to practising while intoxicated through drugs or alcohol or to sexual misconduct.

On the matter of confidentiality disclosure, I agree with the intent of this legislation to enable the release of confidential information for the protection, safety and wellbeing of the child. While I recognise that patient privacy is important, I agree with the government that a provision should be made for those willing and able to support a child in circumstances where a child may be placed at some risk. My previous experience in the Department of Child Safety has certainly led me to agree with the government that anything that we can do to make it easier to share information that will protect a child is certainly worth doing.

I would like now to address the proposed amendment recognising the role of the nurse practitioner. As stated in the minister's second reading speech, nurse practitioners will often be the first point of contact for patients with work related injuries who present at primary healthcare facilities and emergency departments for initial diagnosis and treatment. However, while nurse practitioners are able to provide the necessary health care for certain non-complex, work related injuries, referral of these patients to a medical officer is often required for the sole purpose of attaining a workers compensation medical certificate. I fully support the initiative to be more efficient, especially in busy healthcare facilities and emergency departments. Therefore, if those stakeholders consulted deem it efficient for nurse practitioners to issue a workers compensation medical certificate for minor injuries at a patient's initial attendance then I add my support to this amendment.

Mr Lucas: The member for Currumbin obviously wasn't listening to you.

Mr POWELL: I take the Deputy Premier's interjection. The difference between this side of the House and that side of the House is that we can actually have differences of opinion. I would, however, like to see this kind of recognition extended to other nursing specialisations and even allied health, although I know my views are not supported by some in the medical community. In particular I would like to see better support and resourcing for midwives. Midwives are highly qualified and often their skills are not fully utilised. I realise many women require the specialist care of an obstetrician, but even more do not. I would love to see a proliferation of one-on-one midwife based birthing centres in all rural and regional hospitals throughout the state. Imagine the efficiencies and cost savings such a move would deliver, let alone the care and personal outcomes for the new mothers?

On a separate matter, my wife is a trained physiotherapist and she often expressed frustration in the medical system, particularly when she was working in the hospital system in the ACT, that many of the things that she was trained to do she was unable to do because it required a doctor to perform that duty. It would be good if over the coming years—preferably months—we can look at freeing up some of those other allied health professionals who have the ability to do some of those duties. I realise that doctors and some of the medical professions may not necessarily support that approach, but in the interests of getting greater efficiencies and better care in our hospitals I think it is worth looking at.

If I can now turn to the Health Practitioner Regulation National Law Bill, I would briefly like to focus on one omission. From the outset I acknowledge that the Deputy Premier has also identified the problem and has addressed it in part in his second reading speech. I also note his comments recently to the member for Nanango. I must admit that I am rather incredulous that we are the only state that registers speech pathologists. That comes as a surprise. The sooner we nationalise it and bring in some consistency across the states and territories, the better. Having acknowledged that the Deputy Premier is aware of this issue I will spend a moment reading a letter that I received, as probably no doubt others did around the state, from a speech pathologist in my electorate by the name of Karen Malcolm who writes—

I wish to draw to your attention a matter of grave concern to me, which also has major implications for the whole community. It is with great disappointment that I have learned through my professional body, Speech Pathology Australia, that the Speech Pathology profession will still not be included in the National Registration and Accreditation Scheme, despite there being a revised decision through AHWMC (of 27 August) to include a further profession, Occupational Therapy, as of July 2012.

Mr Lucas: We got one out of three.

Mr POWELL: We have got one out of three. We have a bit of work to do. She continues—

Speech pathologists practising in Queensland currently require registration and it is the profession's collective view that this should be applied nationally. Given the criteria of the Intergovernmental Agreement (IGA) for regulating health professions, it is our profession's persistent strong view that speech pathology meets these criteria and in not regulating the profession nationally there will be no consistent protection of the public against possible risks inherent in a range of speech pathology practices and a lack of assurance of quality and safe care.

Ms Malcolm goes on to state—

Speech pathology will stand out as a clear omission from what is generally recognised as the core group of allied health professions. 'Physio, OT and Speech' is the key allied health team who contribute to health outcomes of patients across acute hospital, sub-acute, rehabilitation and community health settings.

I mentioned before that my wife is physiotherapist. We found it relatively easy, as we moved back from the ACT to Queensland, to transfer over her registration. Obviously this bill will make it a bit easier. But as I said at the start, I cannot see why we cannot be doing the same for 'speechies'. Ms Malcolm continues—

Not including speech pathology in the National Registration and Accreditation Scheme will lead to an inconsistent and disproportionate system of governance and regulation of the health professions.

Ms Malcolm concludes—

I trust that you will raise this issue in parliament and directly with the health minister.

Yours sincerely,

Karen Malcolm

Mr Lucas: Well, we agree with her.

Mr POWELL: I am glad to hear that, Deputy Premier, and look forward to it being addressed as soon as possible to bring the rest of the states and territories in line.

Finally, it would be remiss of me in a debate on health legislation to not make some comment on what is clearly the biggest disappointment for Sunshine Coast residents. As members are well aware, a university hospital was scheduled to be built on the Sunshine Coast by 2014. According to Dr Wayne Herdy, Vice President of the Local Medical Association, when a new Sunshine Coast public hospital was promised five years ago; the planning figures then showed we needed another 650 beds on the coast. Despite this desperate need, the government has decided to postpone the building project for another two years, to 2016. While I respect the financial undertaking for this hospital project, I point out that the delay reflects poorly on the Bligh government's 2020 vision of making Queenslanders the healthiest Australians. According to the Australian Institute of Health and Welfare, the number of public acute hospital beds on the Sunshine Coast is about half the Australian average and half the Queensland average. To even meet the national average, and to again quote Dr Herdy, we need an additional 330 beds today. That does not even count the influx of tourists who access health services on the coast throughout the year, particularly during peak holiday periods.

If we focus for a moment on the emergency departments of Sunshine Coast hospitals, over the five-year period of 2004 to 2009, the average wait time in the emergency departments increased from five hours to 7½ hours, a 50 per cent increase. From 2008 to 2009 the outpatient consultation increased by

12 per cent. Quite simply, the existing Sunshine Coast hospitals have already maxed-out in terms of emergency department throughput and bed occupancy. Due to this increase in hospital demand, by 2016 it is projected that Sunshine Coast and Wide Bay residents will occupy the equivalent of 127 overnight beds at the Royal Brisbane and Womens Hospital, 71 beds at Prince Charles Hospital, 38 at Princess Alexandra Hospital and 70 beds outside the district. All of this will create additional problems for hospitals throughout South-East Queensland, particularly overcrowding, where a patient must wait for more than eight hours to receive a service.

Studies show that overcrowding is not only inefficient, but also directly linked with mortality. One study in Canberra, reported in the *Medical Journal of Australia*, suggests 43 per cent more deaths in an overcrowded cohort of emergency patients compared with a non-overcrowded cohort. Patients are also likely to receive a lower quality of care because the available resources are stretched too thin. Another study done by the AMA in Perth showed that patients admitted to an overcrowded emergency department had a 30 per cent increase in mortality by day two. Professor Sprivulis, Associate Professor of Emergency Medicine, says delays and errors occur more often when systems are stressed by constraining resources. Other effects of overcrowding are that patients may leave the emergency department untreated or inpatients may be placed in the wrong ward where staff are less familiar with standard service guidelines for particular patient care or clinical cues associated with potential adverse events.

To this, and all the data I have presented, I say we need more hospital beds on the Sunshine Coast, and we need them now. But there is more at risk here, because beds are just one component of a healthy, continuously improving health system. Such a system also needs a skilled workforce, improved processes and ongoing research. Professor Cameron of Monash University says that there is presently a shortage of virtually every type of skilled worker in the healthcare sector which is why a university hospital will take care of this challenge, by welcoming and introducing some of the most skilled and talented practitioners from around the globe and training future generations of health practitioners. Research into improved hospital management systems will also be crucial to resolving the health crisis on the coast and have spin-off benefits to the broader health system.

Building a hospital of the proposed magnitude of the Sunshine Coast University Hospital has other significant benefits. Approximately 3,500 direct jobs and 1,750 indirect jobs will be created, which is crucial given the Sunshine Coast is one of 11 unemployment hot spots in the state. Its existence will lead to new infrastructure, including the public transport corridor. It will expand the Sunshine Coast University, increasing the prestige of local education. As stated, the Sunshine Coast will become synonymous with world-class health research and education through attracting larger pools of talented practitioners.

In conclusion and to quote the editor-in-chief of the *Sunshine Coast Daily*, Mark Furler—

The government has said it can't afford to build the hospital, we say we can't afford not to build it.