Speech by

Dale Shuttleworth

MEMBER FOR FERNY GROVE

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HEALTH AND HOSPITALS NETWORK AND OTHER LEGISLATION AMENDMENT BILL AND HEALTH LEGISLATION (HEALTH PRACTITIONER REGULATION NATIONAL LAW) AMENDMENT BILL

Mr SHUTTLEWORTH (Ferny Grove—LNP) (5.47 pm): I rise today to speak in the cognate debate of the Health and Hospitals Network and Other Legislation Amendment Bill 2012 and the Health Legislation (Health Practitioner Regulation National Law) Amendment Bill 2012. Hospital boards were in operation throughout Queensland from 1936 to 1991, when, under Labor's administration, they were abolished. Throughout the later years of the operation of the hospital boards the Queensland hospital system was the envy of the nation.

In the relatively short period of 20 years, our health system has suffered a seismic shift in terms of the level of consumer confidence. Through the myriad Labor led ordeals—with recent examples such as the Bundaberg Hospital fiasco, the Health payroll system blunder and the elevation of a new 'royal'—Queenslanders have lost faith in the system's capacity to deliver. More importantly, they feel that the overly bureaucratic system of health is unlikely to ever deliver the reforms we desire.

Like any large organisation with a centralised head office and subordinate branch structure, the regional areas of Health feel isolated and forgotten. Many areas are frustrated by the hamstrung nature of a centralised command, with fair criticism directed at the command for their lack of understanding of the needs and wants of their regional cousins. Conversely, it is difficult to hold to account someone who is centralised in a city but who has oversight of the needs of a region.

The regions often employ generalists who have greater capacity to improvise and adapt to difficult circumstances, while cities can afford to employ specialists who focus their efforts within a narrow band. Logistics and the tyranny of distance mean that regions must improvise to deliver outcomes. On my drive to parliament this morning I was listening to ABC 612 when this very issue was being discussed, and thankfully at this time the program for training and assignment of regional doctors is oversubscribed by doctors wanting to gain the experience this diversification provides in the regions. In essence, this bill ensures there is greater scope provided to the regions to self-assess and administer their own requirements to ensure that the needs of a region are met.

The bill outlines the renaming of the act to the Hospital and Health Boards Act 2012 and proposes to change the name 'local health and hospital networks' to 'hospital and health services' and from 'governing councils' to 'hospital and health boards'. These name changes are reflective of the expectations we place upon our healthcare system and encapsulate the total provision of health to our community through both acute hospital care and primary health care and identifies the state's continuing role in the provision of the hospital and health services.

In addition to the clarity provided to the health outcomes, this bill also proposes that hospital and health boards will have increased powers that allow the hospital and health services to buy and sell land

and other assets. The management of this and other activities will be undertaken through the executive committee established by each hospital and health board. This measure will ensure that, as I outlined earlier, the regional boards will have an increased capacity to assess their own needs and to manage the requirements of their region to ensure that the health outcomes are effective.

This strengthening of local control through the ownership of land and buildings and through the empowerment of local communities to buy and sell assets to ensure that the needs of their local communities are met will provide those communities with the capacity to better manage and deliver effective outcomes within their region. This will not be a mass transfer or transition of assets immediately come 1 July 2012. Instead there will be a gradual transfer of assets to the health and hospital services that demonstrate their capacity to effectively manage their land and building assets.

From that point forward, the board of that health and hospital service will have the capacity to manage those assets with a regional focus to ensure effective and efficient delivery of health outcomes in that region. In all cases, to allay fear in the community, for asset or building purchases and sales or leases of property and land both the Treasurer and the minister must approve the transaction unless it is of a type such as short-term or routine leases that are exempt from the approval process. The bill also includes amendments to the act to enable a hospital and health service to directly employ health service employees. To overcome concerns, the board and executives of the hospital and health service must ensure that these appointments are undertaken with the retention of the relevant state-wide enterprise bargaining agreement or award.

Another significant component of the bill is the incorporation of the funding arrangements agreed by COAG and outlined within the National Health Reform Agreement. The national health funding pool will receive Commonwealth funds and activity based funding. These funds will be allocated through the state managed fund to the hospital and health services and other providers. To enable the state to effectively manage these funds, this bill will insert a new component into the act to ensure improved transparency and accountability. The amendments will establish a state pool account, a state managed fund and allow for the creation of a position of administrator. Collectively, the proposed changes are designed to ensure that the health system can deliver the expectations of the public in a more cost-effective and efficient manner. To indicate why there is this perceived need, I will outline a couple of key performance indicators.

In 2009-10 the available beds per thousand people indicated that Queensland is now equal last in major cities with 2.3 beds per thousand, second last in regional hospitals with 2.6 beds per thousand and second last with an overall national average of 2.5 per thousand. This is well below the national average as reported by the steering committee for the Review of Government Service Provision in the *Report on government services 2012* in Chapter 10 titled 'Public Hospitals'. When compared to the 1989-90 period—during the time of the previous hospital boards—those same measures as undertaken by the Australian Institute of Health and Welfare's Health Services Series No. 3 indicated better outcomes throughout Queensland where it was reported at 3.6 beds per thousand in metropolitan hospitals, which was the third highest, and 3.7 per thousand across the state, which was slightly higher than the national average.

In terms of recurrent expenditure, in 2009-10 the states on average were spending 4.42 times what they were spending in 1989-90. On the other hand, in 2009-10 Queensland spent 6.39 times what was spent in 1989. There are two ways to view this expenditure. One is to say that we were spending more on health systems, which is a fantastic outcome. Unfortunately, the other way to look at it when comparing the KPI measures I have mentioned is that we clearly lost our way and were expending far more to produce less. To present that more succinctly, one would say that we had become inefficient.

It was perhaps this deduction that was in the minds of the many health professionals whom I spoke with throughout the campaign. One particular practice that I met with with the then shadow minister for health and member for Caloundra expressed great enthusiasm for the reintroduction of hospital boards. Throughout the meeting, which included representatives from a number of allied health professions, GPs and input from Medicare Local, they saw this initiative as not simply being a better way but the best way to ensure that health systems could be improved. Their view and that of other doctors, medical centres, community groups and individuals I have spoken with stems from the belief that health practitioners are best suited to provide the interface to local communities. They are best suited to make the assessment of their environments, of their case loads and of their deficiencies and are best positioned to react to these needs. In fact, to undertake this assessment from a centralised bureaucracy was, in their view, not just inefficient but largely ineffective.

To compare and contrast the Queensland Health measures in 1989-90 with 2009-10, there is an apparent decline in operations which can at least in some part be attributed to the model of administration. Through the reintroduction of the hospital board, I think it is fair to deduce that we will see some improvements in these areas.

The policy objectives of the Health Legislation (Health Practitioner Regulation National Law) Amendment Bill is to abolish duplication and effort associated with the state registration of medical practitioners and transition to the National Registration and Accreditation Scheme. As part of the requirement and commitments undertaken at the Council of Australian Governments—or COAG—in July 2006, the objectives of the agreed scheme is to provide protection of the public by ensuring that practising practitioners are suitably trained and qualified, to facilitate workforce mobility, adequate and timely review of overseas trained professionals, and to facilitate effective continuous educational development.

The bill proposes that the established medical framework, the professions of occupational therapists and medical radiation practitioners will be added to the National Registration and Accreditation Scheme from 1 July 2012. From 1 July the NRAS boards will be responsible for the registering of practitioners and students, handling complaints investigations and disciplinary hearings, overseas trained accreditations, standards and guidelines for each profession, and approval of qualifications and eligibility criteria for practising professionals.

The Ferny Grove electorate is fully encapsulated within the Metro North Hospital and Health Service, which in its entirety covers an area of 4,157 square kilometres extending from the Brisbane River north to Kilcoy. Included within the Metro North Hospital and Health Service are the Royal Brisbane and Royal Women's Hospital, the Prince Charles Hospital and the Caboolture, Redcliffe and Kilcoy hospitals. There are also a number of residential facilities included within the Metro North Hospital and Health Service. Throughout the hospital and health service the population of almost 900,000 people could also access oral health, child health, school health, aged care and rehabilitation, palliative care, chronic disease management and management of substance dependencies. Included within the area are also a number of superspeciality services such as heart-lung transplants at the Prince Charles Hospital, and genetic health and burns at the Royal Brisbane and Women's Hospital. The hospital and health service also includes tertiary referral teaching facilities at the Royal Brisbane. The hospital and health service will continue to provide a major role in research, education and training through links with our major tertiary institutions throughout Queensland.

I am very pleased at this point to highlight to the House that the board chair for the Metro North Hospital and Health Service is Dr Paul Alexander. While I have not had the pleasure of meeting Dr Alexander, the discussions I have had recently with health practitioners and professionals throughout the electorate of Ferny Grove since his appointment to this position have resulted in great praise of his previous roles and acknowledgement that his appointment to this position could only be a great outcome for the region. Dr Alexander has over 30 years of experience across various clinical positions, with board experience in military, private practice, commercial and not-for-profit organisations. Having joined the Australian Army in 1976, Dr Alexander commenced his full-time military service as a Regimental Medical Officer of the 3rd Battalion Royal Australian Regiment in Woodside, South Australia. He went on to become the RMO at the SAS regiment in Perth. Dr Alexander has been posted to a number of operational deployments with the Army and the United Nations such as Bougainville and East Timor. In 2004 Dr Alexander was promoted to Brigadier and assumed the position of Assistant Surgeon General of the Australian Defence Force—Army. In 2008 he resumed his full-time service and was promoted to Major General. In 2011 Dr Paul Alexander was made an Officer in the Military Division of the Order of Australia. I am certain that all in this House wish Paul and the other appointed chairs the very best for the challenge that lies ahead in restoring Queensland Health to the position it owned in the late 1980s as the shining light of Australian health care.

Finally, I want to congratulate the minister for the presentation of these bills which will provide the people of Queensland with renewed levels of faith in their government's capacity to deliver reforms and improved outcomes for the health sector, which has for many years under Labor suffered a slow decay. I acknowledge also the support of the Health and Community Services Committee secretariat and fellow committee members for their input and assistance. Thanks must also go to the departmental representatives who provided their time and expertise to the committee. I commend these bills to the House.