Speech By

Ros Bates

MEMBER FOR MUDGEERABA

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HEALTH AND OTHER LEGISLATION AMENDMENT BILL (NO. 2)

Ms BATES (Mudgeeraba—LNP) (3.32 pm): I rise to make my contribution to the Health and Other Legislation Amendment Bill (No. 2) 2023. I will start by making the following observation. This bill was referred to the former Health and Environment Committee for consideration when it was introduced to the House on 30 November last year. It was due to report back this Friday, 8 March and yet here we are now debating the bill—a bill that was not even meant to be out of committee until Friday this week. Up until last Friday, the committee's website, the parliament's website, was still saying that the committee report was due three days from now, but we all know what the Miles government thinks of parliamentary convention and parliamentary processes. They treat parliamentary committees like some political plaything and an inconvenience—a nuisance even.

Without a house of review, committees are there to scrutinise and assess, a vehicle to hold the government to account. They are there to listen and consult, but not those opposite. We are just pawns in the big political game they are playing. Those opposite hold parliamentary committees in such high regard that they decided to let the member for Miller chair one now. Good heavens! Actions speak louder than words and putting the member for Miller in that position tells us everything we need to know about the Miles government and how they treat these committees. It says everything about their view of accountability, scrutiny and transparency. With his history of accountability and transparency it makes the member for Thuringowa look like a saint.

Honourable members can imagine the poor old member for Thuringowa getting the call on this bill we are debating today, 'Mate, we need this committee report done early. It could be politically convenient for us. Rush it through. Never mind about the time line that we originally set, just get it done,' and so here we are today, like I said, debating a bill that was not even meant to be out of the committee yet. By rights it should not have been in the House until the end of the month given the original time line the minister gave.

For those opposite it is not about outcomes or results; it is about imagery. It is about how it all looks and it is about the narrative—yes, the narrative. No doubt the timing of this debate, the second reading of this bill, somehow fits in with the health minister's review of the narrative. How is that for wrong priorities, reviewing a narrative before achieving an actual outcome? This is made even more disappointing because of the very serious policy issues which are addressed in this bill.

Those opposite should not be playing games with issues like patient safety or matters of reporting clinician misconduct or the termination of pregnancy. They are serious issues. I think Queenslanders would be upset to learn that issues like these are not being dealt with in a considered way. Instead, with the Miles government they are looked at through the lens of whether or not it suits the narrative and I think that is really disheartening and really disappointing. Noting the government's lack of it, the opposition is going to take a measured and respectful approach to the issues in this bill, and I will deal with each in turn during my contribution today.

To begin, the changes to be made to the Public Health Act 2005 seem to be common sense and uncontroversial. The changes will exempt medical practitioners from duplicate reporting of dust lung diseases to the Queensland notifiable dust lung disease register where there has been a notification already to the national registry. The opposition will not oppose these changes nor will it oppose the changes to the Mental Health Act 2016 which clarify how Mental Health Court expert reports and transcripts may be released and used.

The changes to the Hospital and Health Boards Act 2011 will also not be opposed by the opposition. I do wonder if it were not for some opposition agitation whether some of these changes would ever have been made, particularly those around patient safety. Part of the changes relate to establishing ratios for nurses and patients, and midwives and patients, including that a newborn baby should be counted as a patient. The opposition does not oppose these changes, though it notes there is considerable work for the government to do before we see where and the finer detail of how these ratios will be applied. We will watch this with interest.

The other changes to the Hospital and Health Boards Act 2011 are centred around patient safety and reporting inappropriate clinical conduct. The opposition see the decision to share appropriate information and learning from root cause analysis reports to facilitate better clinical education and health outcomes as a positive one.

Then there are the changes to the clinical reviews and health service investigations. These are effectively changes without being changes at all. These new provisions allow for the chief executive, after considering a report from a clinical review, a part 6 review, or health service investigation, a part 9 investigation, to take the action the chief executive considers appropriate, whatever that might mean. It is window-dressing, to be blunt. As far as I can tell there is still no requirement for a health service chief executive to actually inform the director-general—or the minister for that matter—that a health service investigation is underway or complete. It is important to remember that the report that uncovered the shocking and tragic state of affairs at the Mackay Hospital obstetrics and gynaecology service was a part 9 investigation. I would ask that the minister today confirm how many of these part 9 investigations have taken place since 2015 and at what hospitals.

While the opposition will not stand in the way of these changes, we believe this does not go far enough in ensuring accountability and transparency across the system and driving better patient safety outcomes. We do acknowledge that there is a balance to strike between ensuring patient safety and not allowing vexatious complaints to burden clinicians. We acknowledge the feedback that has been received by a number of stakeholders on that issue.

I will now turn my attention to the components of the bill that deal with the Termination of Pregnancy Act 2018 and the Criminal Code. As opposition members of the committee rightly pointed out in their statement of reservation, the issue of termination of pregnancy is a highly sensitive one. Having been a healthcare professional my entire adult life, I feel my occupation has shaped my own views about how delicate an issue this is. Queenslanders from all walks of life hold many and varied views about the termination of pregnancy and Queenslanders are entitled to those views. They should be shared in a dignified and respectful way. That is how I intend to conduct myself while talking through the opposition's position on these changes.

The proposed changes to the Termination of Pregnancy Act 2018 and Criminal Code are designed to have three desired effects, according to the government. The first is to allow additional health practitioners to perform an early medical termination of pregnancy through the use of a registered termination drug in response to recent changes in prescribing restrictions made by the Therapeutic Goods Administration, the TGA. At this juncture it is important to note that the changes made to prescribing restrictions by the TGA were brought about following the Australian Senate's Community Affairs References Committee report titled *Ending the postcode lottery: addressing barriers to sexual, maternity and reproductive healthcare in Australia*. This report was handed down on 25 May 2023. The second effect is to make consequential amendments to the offence provision which is outlined in the Criminal Code to align with the proposed changes in allowing additional practitioners to perform early medical termination. The third is to replace references to 'woman' with 'person' throughout the legislation.

Just like a number of stakeholders who provided feedback to the committee, the LNP has two main concerns with the issues that deal directly with the medical termination of pregnancy outlined in the bill. The first is in relation to which practitioners should be given permission to prescribe, administer or give a treatment dose of the termination-of-pregnancy drug MS-2 Step, and I note the amendments circulated by the minister. The second is the availability, or lack thereof, of health services in regional, rural and remote Queensland to provide the necessary care for women who may suffer complications

following their decision to terminate a pregnancy under the changes being proposed. They are both legitimate concerns that were heard throughout the committee's inquiry and as an opposition we, too, share those concerns. I will elaborate on each a little more.

The additional registered health practitioners who will be authorised to prescribe medical termination-of-pregnancy medications under the bill will be nurse practitioners and endorsed midwives. Registered nurses and midwives who work under an extended practice authority, an EPA, will be authorised to administer and/or provide a treatment dose of MS-2 Step without the requirement for a prescription. The authority to give the treatment dose is provided under their EPA. Not all registered nurses or midwives work under an EPA, which would mean a practitioner not working under an EPA would require a prescription from an authorised prescriber such as a doctor or, under these new rules, a nurse practitioner or endorsed midwife. For the benefit of the House, I think it is important to outline that nurse practitioners, registered nurses, endorsed midwives and midwives each operate under a different scope of practice.

Earlier in my contribution I mentioned the Australian Senate's Community Affairs References Committee report titled *Ending the postcode lottery: addressing barriers to sexual, maternity and reproductive healthcare in Australia*. That report was begun at the request of, and reported to, the Albanese Labor government. As I stated earlier, the recommendations of that Senate inquiry brought about prescribing restriction changes by the TGA. Effectively, that report was the catalyst for the legislation that we are debating today. That was an extensive inquiry of nearly eight months, and I think it is significant that that point is made. Recommendation 20 of that report states—

The committee recommends that the Therapeutic Goods Administration and MS Health review barriers and emerging evidence to improve access to MS-2 Step, including by:

- allowing registered midwives, nurse practitioners, and Aboriginal Health Workers to prescribe this medication ...

What members will note in that recommendation is that there is no mention of registered nurses, yet in this legislation we are debating today there is. This same point was identified by the Australian Medical Association Queensland, and I note Dr Yim's contribution to the public hearing held by the committee on 1 February where he made the following observation—

... the Senate committee also recommended extending those practitioners authorised to prescribe MS-2 Step to registered midwives, nurse practitioners and Aboriginal health workers. It did not likewise recommend it extend to registered nurses. That is because the practitioners specified by the Senate committee already have requisite training and experience to safely prescribe these medicines. They also work within suitable settings, including private teams, to ensure safe treatment.

Dr Yim went on to say—

... AMA Queensland urges the current committee to recommend the Queensland government only make those amendments in the bill that would enact the Australian Senate committee's recommendations. Those recommendations were based on broad and comprehensive consultation with a range of independent research bodies and appropriately qualified stakeholders.

I am not going to stand here and pretend to talk for all registered nurses, but, being one, I can say that I personally would not feel comfortable to administer and/or provide a treatment dose of MS-2 Step without the requirement for a prescription, just like I would not be comfortable giving any drug that I am not trained to give and not trained to deal with complications that may arise from the administration of a drug. It is important to note that registered nurses are not midwives and their areas of expertise differ. Whilst there are registered nurses who are also registered midwives, the majority of midwives are midwives and not registered nurses. Like I said, I am not here to talk for all registered nurses; I just know that there will be different views from registered nurses on this. What I will say is that I respect the process and the work of independent authorities, and what the TGA and other independent experts concluded through the Senate committee's inquiry was that other practitioners are best placed to do this work. I respect that call.

There is a reason that decision has been made, and my honest opinion is that it is not a reflection on the capability of any registered nurse—not by any stretch—but it is a reflection on the capability of the broader health system which surrounds those nurses. That brings me to my second point on why the LNP has reservations with these provisions of the bill. We already know that health services in regional, rural and remote Queensland are stretched extremely thin—so thin, in fact, that many basic services are already absent—basic services like birthing. I am not suggesting that the clinical practice around childbirth is easy, but in a modern society like ours here in Queensland it is rightly an expectation that local hospitals should be able to provide birthing services.

The way I look at it is, when it comes to delivering health services, you have to get the fundamentals right first and you build up from there, so let's be frank about it: for many in our regional and rural towns the fundamentals are not there. For goodness sake, Queensland had a region with

60,000 people who were without a birthing service for a year, and that was when Gladstone Hospital infamously went on maternity bypass. Honestly, that was a travesty and that is not getting the fundamentals right. Our priority is getting the fundamentals right, and I would argue that that should be the priority of the government as well.

I think it is very poignant that there were concerns about women suffering from complications who have opted for a medical termination of pregnancy in a regional, rural or remote area of Queensland. I am not going to get hung up on the numbers of how many women suffer complications after taking MS-2 Step—I know the committee heard some different figures at different times—but with that said, what I think we can all agree on is that complications do happen and they can be potentially dangerous and potentially fatal. I do not think there would be anyone in this chamber willing to argue against that. If that happens to a woman in a community where there are already limited or no supporting services, that could have quite severe consequences. That very point was put to Dr Yim at the hearing by my colleague the member for Glass House. His response was—

We do not want to see women needing to travel four or six hours to get emergency care. That is not acceptable. There needs to be a pathway to ensure they receive emergency care in those small number of cases where things do not go well.

He went on to say—

... we need to ensure the backups are in place before we expand further.

That is a very legitimate and rational position to take.

I note that the QNMU and the organisation Children by Choice also made their position clear: that the proposed legislative reform needs to be supported by appropriate implementation activities such as education, training and safety procedures. My concern with all of this is that the minister is putting the cart before the horse. I think that is evident in the explanatory notes for this bill where on page 16 the following is stated—

... some stakeholders, including some professional medical bodies, provided feedback in relation to the need for appropriate education, support and resources to support successful implementation of the amendments and to ensure patient safety. Queensland Health will undertake a gap analysis to identify elements of the framework that need to be enhanced or strengthened to ensure that additional health practitioners can safely perform early medical terminations of pregnancy. The gap-analysis will consider what support and resources are needed for the workforce delivering termination-of-pregnancy care, as well as information for consumers.

Even when the minister introduced this bill to the House, neither she nor her department were sure about where there were gaps in support and resources across the system. I must say, I find that unsettling. Apparently the gap analysis has been completed, but, even with that, Queensland Health say they are still considering what education and training is needed to support the nursing and midwifery workforce to safely and effectively deliver termination-of-pregnancy care and how best to make this available. I would have thought that before rushing in to making legislative changes the minister and the government might have actually thought to work through these issues in a considered and judicious way. I wonder whether the minister would table the gap analysis that is supposedly finished so that Queenslanders might see what issues exist across the system and can judge the government on whether it has the capacity and capability to fill those gaps. I doubt that the minister will be as transparent as that, but we live in hope. Again I note the clarifying amendments that have been circulated by the minister.

I also want to place on record my disapproval of the decision to replace references to ‘woman’ with ‘person’ throughout the Termination of Pregnancy Act 2018. I fundamentally disagree with these changes. I acknowledge that there are many in our community who may struggle with gender dysphoria. I certainly do not dispute that this is a challenge that many Queenslanders and their families go through, but there is this point: being a male or being a female is part of the human condition, other than in some exceptionally rare and very difficult circumstances. As human beings, only the female sex is able to carry a child and give birth. Being a mother is a special role. Carrying and birthing a baby is extremely precious and not every woman will choose or be able to give birth, and that is okay, that is also part of the human condition. But being a mother, carrying and birthing a baby, those very things are unique to being a woman and that should be reflected in the way legislation is written, particularly in legislation which deals directly with pregnant women and their babies. To make changes to the Termination of Pregnancy Act 2018 to replace language like ‘pregnant woman’ to ‘pregnant person’ I nor my colleagues are able to support.

I note that we are not the only ones who share this view. It is not an inflammatory view as it crosses political and cultural divides. Stakeholders, including the Queensland Nurses and Midwives’ Union, the Australian College of Midwives Queensland Branch, Queensland Aboriginal and Islander

Health Council and the Royal Australian and New Zealand College of Obstetricians and Gynaecologists, raised reservations in one form or another with this provision in the bill. The QNMU said in its written submission—

> The removal of the term 'woman' in legislation that is targeted at a population level has the potential unintended consequence of making biological sex less visible and more difficult to clearly explain in healthcare education.
>
> The QNMU argues that statutory language needs to be specific to the context and the cohort of people upon which it is focussed. We therefore recommend that term 'woman' is retained in the legislation

The Australian College of Midwives Queensland Branch made the following statement in its written submission—

> The language change and impact may hinder the ability to understand and action the unique health care needs and challenges faced by women. Clear, precise, and consistent language ensures that reporting and collection of statistical data remains reflective and consistent.
>
> Decades of statistical data will be lost with the proposed language change, marginalising women in society. The Australian College of Midwives Queensland committee strongly disagrees with the removal of the word 'woman' and replacing this with the term 'person'.

Those views are quite ardent and the LNP share those views. Based on what I have outlined, the opposition will vote against all the provisions of the bill which make amendments to the Termination of Pregnancy Act 2018 and Criminal Code. We cannot support those changes. We have arrived at this position after a careful and considered review of the committee's deliberation on this bill, noting the stakeholder feedback provided through written submissions and appearances before the committee by interested parties across several hearings. I do note that there are no changes to the existing conscientious objection provisions already in the Termination of Pregnancy Act 2018 in this bill. That means the rights of health practitioners and students to conscientiously object to performing or assisting to perform a termination are maintained in this legislation. That is a good thing because health practitioners are entitled to their own views and beliefs. That right should be upheld and maintained and I appreciate that that is still the case.

I round out my contribution by saying the LNP does not oppose the changes in this bill made to the Hospital and Health Boards Act 2011, the Public Health Act 2005 and the Mental Health Act 2016. However, we will be voting against all of the changes to the Termination of Pregnancy Act 2018 and Criminal Code when the bill reaches consideration in detail.