



Speech by

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MEMBER FOR CURRUMBIN

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HEALTH PRACTITIONER REGULATION (ADMINISTRATIVE ARRANGEMENTS) NATIONAL LAW BILL

Mrs STUCKEY (Currumbin—LNP) (4.27 pm): I rise to speak on the Health Practitioner Regulation (Administrative Arrangements) National Law Bill that was brought into the House by the Minister for Health on 29 October 2008. I would like to commend my colleague the honourable member for Caloundra and shadow minister for health for his all-encompassing contribution. It is very clear that he has listened to health professionals across this great state who will be affected by this legislation. As members have also heard, the LNP will be opposing the bill in its current form.

From the outset, I wish to place on record the fact that I am a former registered nurse and I am married to a general practitioner with our own medical practice. This is of course mentioned in the pecuniary interests register. As the explanatory notes state, the objective of this bill is—

... to provide for the adoption of a national law, hosted by Queensland, that will facilitate the development and implementation of the new national registration and accreditation scheme for health practitioners (the national scheme).

The Scrutiny of Legislation Committee's *Alert Digest No. 12 of 2008* explains that the national scheme is to initially apply to 10 health professions. Those 10 include the nine health professions registered in each state and territory—which are medical, nursing and midwifery, pharmacy, physiotherapy, dental, psychology, optometry, osteopathy and chiropractic—and podiatry, which is registered in every jurisdiction except the Northern Territory.

I would ask the minister to explain in his reply what the term 'initially' means in this legislation. Does this mean that other allied health industries will be added and, if so, which ones and when? The use of the word 'initially' certainly suggests there will be other health workers included in this scheme. Not all of these professions endure the same training or have the same standards within their own bodies, and there would be some issues raised by bundling them all together in this manner. Again, I ask the minister for clarification in this regard.

In order to implement the scheme, legislation will be introduced into the Queensland parliament in two stages. The COAG agreement is encompassed in the first stage. The second stage, which is not proposed for introduction to the Queensland parliament until August 2009, will cover matters where further work and discussion is required beyond the terms of the COAG agreement. These matters include registration of members' arrangements; accreditation arrangements; complaints conduct, health and performance arrangements; privacy and information-sharing arrangements; and, interestingly, other matters. Perhaps in his reply the minister would also explain what these other matters might include.

The LNP asks: why the rush to debate this bill in November 2008 when it is not due to be adopted fully on a national level until July 2010, and stage 2 in Queensland not until August 2009? I note that in the Scrutiny of Legislation Committee *Alert Digest No. 12 of 2008* this bill is described as template legislation to be adopted or copied by all other jurisdictions. Perhaps this is more about the minister's ego, wanting to get a first for Queensland, than bringing in practical legislation to improve our health service delivery. I

admit it would be a refreshing change, but being first for first's sake is not good government. In fact, it is downright irresponsible government. Bunging registration and accreditation of health practitioners together under a national scheme is not considered by those in the field as a very good or a very safe idea at all. In reference to the Productivity Commission's report entitled *Australia's health workforce*, the minister in his second reading speech states—

The commission was confident that these measures would positively deal with workforce shortages and pressures faced by the Australian health workforce, increase their flexibility, responsiveness, sustainability and mobility and reduce red tape.

I have to admit that this does all sound very well intentioned and good common sense, until you realise that this is not what the major health professional stakeholders believe will work at all, nor do they believe it will be in the best interests of the patient, who after all is the person at the receiving end. My office has received correspondence from key health stakeholder groups objecting to some aspects of this bill—not all but some. No doubt other honourable members in the House have also received information from a number of these who have documented some well-founded concerns with this bill. I do hope that members opposite will make representations on their behalf, although it would be rare for any government members to stand up for the rights of doctors, as they regard doctor bashing a sport and the more qualified the doctor the more they bash them.

Other concerns are raised by the Scrutiny of Legislation Committee in *Alert Digest No. 12 of 2008*, making the following statement in reference to the application of fundamental legislative principles—

The committee ... has identified concerns that elements of intergovernmental legislative schemes might undermine the institution of Parliament.

The honourable member for Caloundra alluded to this. The report continues—

The committee's concerns relate to the potential for the executive to formulate, manage and possibly alter such schemes to the exclusion of legislatures. The committee has also warned against a perception of a reduced need for legislative scrutiny of an intergovernmental agreement proposed for ratification.

Professor Gerard Carney's learned comments in *Constitutional Systems of the Australian States and Territories* are as follows—

A risk of many Commonwealth and State cooperative schemes is 'executive federalism' ...

This means that the executive branch actually manages and sets up these schemes to the exclusion of the legislatures. He goes on to state—

Some blurring of accountability is an inevitable disadvantage of cooperation ...

I note that part 4 of the bill establishes an Australian Health Practitioner Regulation Agency. A concern here is that the national agency and the national boards that would be set up may lack authority on the part of state governments to be able to distance themselves from the actions of the joint Commonwealth-state regulatory authority. The scrutiny committee makes a point that this concern is not addressed in the explanatory notes, although a lengthy statement is provided regarding consistency with the fundamental legislative principle that the legislation has sufficient regard to the institution of parliament. However, the explanatory notes do address a possible concern regarding executive pressure in line with Professor Carney's comments that, if we were to simply ratify the scheme without question—and that is what is very important about the debate that we are having today—then we may be overriding the institution of parliament.

The committee also referred to parliament the question of whether it has sufficient regard to this institution. As the bill is being debated the same week that the scrutiny committee made the recommendation, an answer has not been forthcoming and certainly casts further doubt on the government's good intent. I ask the minister to address this request by the Scrutiny of Legislation Committee in his reply.

I note the listed consultation process undertaken prior to the drafting of this bill in the explanatory notes. I ask the minister whether he would consider informing the House how many of these consultations were conducted here in Queensland. How many of them were there? Were there any at all? What was the general feedback? The costing that has been agreed by COAG is \$19.8 million, I understand, as a contribution by governments to transition to the national scheme by 1 July 2010.

Another question I have for the minister is whether he would give details of the amount that Queensland will be contributing, seeing that this figure has been listed. I also note that the scheme is intended to be self-funding in the long term. Perhaps the minister will outline how this will occur.

I refer to clause 8, which also raises some concerns and, in particular, clause 8(3) which, if made as subordinate legislation, would be subject to possible parliamentary disallowance under section 50 of the Statutory Instruments Act. The committee refers to parliament whether clause 8 has sufficient regard to the

institution of parliament. These are significant concerns by the committee. Together with a number of other points raised by this committee we ask the minister to give them full attention and clarification and make sure that they are all addressed thoroughly.

The AMA Queensland has concerns about the removal of parliamentary oversight of health professional standards right across Australia. It believes the process will be cumbersome, expensive, bureaucratic and, more importantly, in its professional opinion, will undermine the professional, democratic and parliamentary process in the name of national consistency. There is a good argument here for national consistency. It certainly in many ways streamlines a process, but it also sweeps up everybody under the one ruling. The AMA says that doctors support national consistency as far as registration is concerned. They cannot, however, agree to a system that puts patients at risk by removing parliamentary and medical scrutiny from the mix. They say that the bill allows decisions to be made on the basis of expediency, such as staff shortage, rather than sound medical judgement.

Additionally, they believe that this bill will allow quick-fix solutions that would harm patients. They believe that the public interest would be better served by a bill that only deals with registration and not accreditation—for example, introducing national registration arrangements through a simple recognition process across existing state medical boards that would ensure doctors are qualified and safe, and can work anywhere in Australia. It would simply allow a national register to be maintained without spending millions on a totally new bureaucracy.

The AMA would also like to see separate government arrangements for registration and accreditation because it would be good regulatory practice to separate the setting and verification of standards from the application and maintenance of standards. They believe this advice has been ignored in this bill. Any system, they say, must protect patients by ensuring that accreditation of education and training programs for health professionals is undertaken by independent expert bodies to strict international standards without interference. Many times in this House the opposition has raised the issue of top-heavy bureaucracy running at the expense of front-line services or those who actually provide hands-on services.

The Australian Doctors Fund—the ADF—sent me a comprehensive document with an executive summary and its analysis, on behalf of its members, of the work of Professor Stephen Duckett, a former senior public servant, whose premise is that Australian healthcare delivery can be largely attributed to a lack of central planning by the government. The ADF questions whether there is evidence to support his claim. A lack of cost-benefit analysis and consideration to do so for such widespread proposals also astounds it.

The COAG model would see the introduction of intermediaries between the doctor and the patients, such as allied healthcare professionals. Such policies would introduce into Australia what is being called by the ADF a two-tiered health system where the direct access to a doctor is substituted by the use of lesser trained gatekeepers called patient assessors.

The ADF believes this would particularly affect those with a limited ability to pay. If this proves to be the case then this Labor government will be denying those with the least resources—the poorest in our society—any direct doctor contact. The ADF has concerns that these proposals would weaken the ability of the Australian medical profession to deliver quality care due to blurred distinctions between doctors and other professions and remove valuable training opportunities at a time when record numbers of doctors are set to graduate from university. On page 2 of the summary it says that there is no compelling case for this to proceed. It says that in excess of 400,000 health professionals may eventually need to be accommodated. The scale of the task is enormous.

The ADF notes a number of other issues in Professor Duckett's work, including a rapidly increasing demand for medical and allied healthcare services. Medicare transactions now run at 300 million per year and are increasing at eight per cent per annum according to this paper. It could be anticipated then, with the recent federal government changes to the Medicare threshold, that demands on the system will increase by an estimated 10 per cent. As we already have struggling hospitals—and I am sure no member would disagree with that—with bed and staff shortages, it is certainly a matter of concern for governments in the future as to how they will cope with these added patients. Simply expanding the number of healthcare services and providers who can see a patient by centralising the system is not the answer.

The ADF cannot find any evidence that the proposals will lead to an alleviation of the rural medical workforce imbalance either. The ADF believes that proposals to integrate positions, assistants and others in quasimedical roles into the health workforce will reduce training opportunities for existing and future medical practitioners as training places are already at a premium.

The ADF recommends the Australian medical profession not be included in the current COAG-IGA plan, legislation or regulation and that the functions of state medical boards and the Australian Medical Council be maintained in their current state. I do understand this varies slightly from the AMA's request here.

It also asks that a web based program allowing for simultaneous use in all states be introduced and recognised in current state based legislation incorporating existing mutual recognition principles. It acknowledges that borders create unnecessary boundaries for doctors. I can attest to that as I live on the border. We have incredible problems with accessing health services on the border. It creates registration issues across the borders. This is the case for anyone who actually wishes to practise outside their home state. This would apply also to a specialist who wants to come here and perform operations that are not available. To be able to have a seamless border for registration certainly makes sense.

Another of the ADF's recommendations is that current state based medical registers be integrated into the national register. That would mean that the compendium of medical registries be upgraded. It also says that the council of state medical board presidents should continue to function as a national coordinating committee.

It would also like an independent cost-benefit analysis of all of these COAG-IGA proposals in respect of national registration and accreditation. It concludes by saying that there is no compelling case or public demand for changing the way doctors have been traditionally educated, trained and recognised. The national interest requires public confidence in the medical profession. Any attempt to demedicalise the Australian medical workforce would generate public anxiety and uncertainty at a time when Australians want security and predictability.

The Australian Peak Nursing and Midwifery Forum has also sent some correspondence. I do believe that my colleague the honourable member for Caloundra argued their case very thoroughly. I would like to mention the ANMC, the Australian Nursing and Midwifery Council, which is seeking an amendment to the legislation to provide the national nurses and midwife board with the power to establish an office in each participating jurisdiction. It makes comment on section 138 of the IGA where it speaks about arrangements for the accreditation of courses where there is no existing accreditation body. It also seeks reference in the legislation to codes and standards.

Concerns about retrospective amendment to legislation, it says, will take considerable time. In the interim, if the legislation is flawed the system ends up failing the very community it seeks to serve. This is critical it says. If insufficient time is allowed for legislative drafting and consultation with stakeholders on the development of the scheme we will have let the community down—their words, not mine.

One GP wrote me the following—

Despite some shortcomings the current Australian delivery of health care is better than most countries.

Thank goodness for that—

Most patients can see the doctor of their choice in a timely fashion.

Most management decisions can be made by that doctor.

Decisions to implement 'team care' is made by that doctor.

That doctor assumes legal responsibility and therefore liability for each and every decision made.

The State Medical Boards assume responsibility as to the standards of medical care.

Accreditation, upskilling, demonstration of competence and the requirement to document ongoing medical education is now correctly required of every medical practitioner.

So why substantially change a system like this? The GP continues—

Why take responsibility from ... State Medical Boards and hand it to a massive, cumbersome and almost certainly less efficient Federal bodies?

Why put a less trained intermediary to decide who gets to see a doctor?

They may not have the equivalent training. The GP continues—

What would the public say when told they can no longer see the doctor of their choice?

This GP asks that registration be made national, that we leave accreditation as it is and we let trained doctors be the gatekeepers of our health system.

In closing, it is a concern that this Labor government is blindly wanting to fall into line with COAG without listening to the professionals in the field. But then that is fairly typical of the members of this Labor government. They do not really like doctors. They pretend to like nurses. They do not take on board the professional input that could see the schemes be more successful. Those opposite continually place more importance on bureaucracy than front-line trained, qualified professionals who have dedicated years to study their chosen fields. Patient welfare should be a priority but if we pass this legislation they will come a very poor second. I cannot commend the bill in its current form.