HEALTH AND COMMUNITY SERVICES COMMITTEE

Members present:

Mr PJ Dowling MP (Chair)
Mrs JR Miller MP (Deputy Chair)
Mr SW Davies MP
Mr AS Dillaway MP
Mr JD Hathaway MP
Mrs DC Scott MP
Mr DE Shuttleworth MP
Mr MJ Trout MP

Staff present:

Ms S. Cawcutt (Research Director)
Ms L. Luong (Principal Research Officer)

BRIEFING—HEALTH LEG. (HEALTH PRAC. REG. NATIONAL LAW) A'MENT BILL AND HEALTH & HOSPITALS NETWORK & OR LEG. A'MENT BILL

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 24 MAY 2012

Brisbane

THURSDAY, 24 MAY 2012

Committee met at 1.58 pm

CARR, Ms Loretta, Acting Project Manager, Legislative Policy Unit, Queensland Health

CLEARY, Dr Michael, Deputy-Director General, Policy, Strategy and Resourcing, Queensland Health

SHEEHY, Mr Paul, Director, Special Legislative Projects, Queensland Health

WELCH, Ms Rachel, Director, Legislative Policy Unit, Queensland Health

CHAIR: Good afternoon. I declare open this public briefing with the officials of Queensland Health. On behalf of the committee I welcome you here. My name is Peter Dowling. I am the chair of this committee and the member for Redlands. The other members are Steve Davies, the member for Capalaba; Jo-Ann Miller, the member for Bundamba and deputy chair of the committee; Aaron Dillaway, the member for Bulimba; Desley Scott, the member for Woodridge; and Dale Shuttleworth, the member for Ferny Grove. On the phone we have John Hathaway, the member for Townsville, and Mr Michael Trout, the member for Barron River.

I remind you that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In this regard I remind members of the public that, under standing orders, the public may be admitted to or excluded from the hearing at the discretion of the committee.

The committee has resolved that the proceedings of the committee may be broadcast in line with the media broadcasting rules, which are available from the secretariat today. Hansard is also making a transcript of the proceedings, so I would ask you to identify yourself when you first speak and each subsequent time that you re-engage, and to speak clearly. It is the committee's intention to publish the transcript unless there is good reason not to do so.

The committee will make use of the information that is provided today when developing its report to the parliament on the two bills that are being examined. The committee will recommend whether the bills should be passed and may recommend amendments to the bills. I encourage everyone to turn off their mobile phones or pagers, or at least switch them to silent. This hearing is scheduled to end at 3 pm.

I now invite the officials from Queensland Health to provide a brief to the committee on the Health Legislation (Health Practitioner Regulation National Law) Amendment Bill. Then we will have time for committee members to ask questions if they feel so inclined. I remind all participants—not wanting to gag debate or discussion—that time is our enemy. We have one hour. If you can be succinct and brief that would be tremendous. Michael, would you like to brief us?

Dr Cleary: Thank you very much for the opportunity to meet with the committee. My name is Michael Cleary. By way of a very brief introduction around my background, I am a medical practitioner and I have worked in Queensland Health for 27 or 28 years. My current role is as the deputy director-general who oversights policy, strategy and resourcing within the Queensland Health. One of the areas that we oversight is the legislative policy that is managed through the department and covers all of those legislative arrangements that relate to the health legislation.

In terms of today, the bill that you made comment on is part of an ongoing process around registration for health professionals nationally. In 2009, parliament passed the Health Practitioner Regulation National Law Act 2009 to establish the National Registration and Accreditation Scheme for Health Professionals. In July 2010, 10 registered health professional groups transitioned to the national scheme, leaving four health professional groups to continue to be registered under Queensland registration systems.

The Health Practitioner Regulation National Law Act provides for a further four health professional groups to transition to the national scheme on 1 July this year. These four groups are the medical radiation practitioners, occupational therapists, Aboriginal and Torres Strait Islander practitioners and Chinese medicine practitioners. Two of these groups are currently registered within the Queensland health system. The bill, in effect, repeals the state registration arrangements for those two practitioner groups and will allow the smooth transition of those groups to the national registration scheme.

The bill also makes some other consequential amendments to the registration provisions. There will be two groups that continue to be registered in Queensland. Neither of those groups is registered in other states or territories. They are speech pathologists and dental technicians. Neither of those groups will be transitioning to a national registration scheme.

What I might do now, if it meets with the approval of the chair, is hand over to Loretta, who has been managing this project, to see if she has any further comments around the legislation.

CHAIR: Thank you, Loretta.

Ms Welch: Actually it will be me. I am the director of legislative policy. I will go into the rest of the detail of the bill and then Loretta can back up and answer any questions that you might have. As Michael said, the primary purpose of this bill is to repeal the Occupational Therapists Registration Act and the Medical Radiation Technologists Registration Act, as those two professions are transitioning on 1 July 2012. That transition is set in the Health Practitioner Regulation National Law Act, so this is not a bill that is transitioning them; it is just cancelling the requirement under state legislation for state registration in addition to national registration.

The majority of the amendments in the bill, then, are consequential amendments to Queensland acts to update definitions that currently refer to OTs and MRTs as state registered professions. There are a couple of extra little amendments that are consequential on the commencement of the national law. There were so many consequential amendments when the national law commenced that a few were missed. Again, these are just definitional issues to make sure that the national law is properly referenced.

There are two other sets of amendments that are related in this bill. The first is to the Health Practitioners (Professional Standards) Act. This is an act in Queensland that acts as a sort of bridge between the complaints and investigation-handling powers under both state and national registration schemes and the court system. Part of the complaints process is that when a board considers or investigates a complaint it can take action. One of those actions can be to take them through a proper disciplinary process that will end up in the Queensland Civil and Administrative Tribunal or the District Court. The professional standards act provides that linkage. It sets up the systems whereby complaints move across to the justice system.

The act is set into two parts: one that deals with state based registrants and one that deals with national based registrants. The first amendment is to move occupational therapists and MRT practitioners across to the national registration system. The second set of amendments are transitional amendments that will allow any complaints and investigations that are currently in place or will be in place on 1 July to continue to be dealt with under the state based schemes. That is just a natural justice approach, so that we do not change midstream the processes that apply. That is basically all the amendments related to the occupational therapists and the medical radiation technologists.

The last little amendment in this bill is a consequential amendment to the Mental Health Act. In 2010, when the national law commenced, we made consequential amendments to the definition in the Mental Health Act of 'psychiatrist', to make a psychiatrist in the Mental Health Act a specialist registrant under the national law. In doing that we inadvertently—it was not something that we foresaw at the time—excluded a group of registrants that up to that time had been psychiatrists under the Mental Health Act. They are what we call area-of-need registrants, or registrants registered to practise in an area of need. An area of need is a declared area, by the minister. It can be a geographical location and/or a speciality where it is difficult to recruit, where there is a lack of skills. For Queensland, psychiatry is an area of need.

Under the old registration system, area-of-need registrants in a speciality area were deemed to be specialist registrants. Under the national scheme, as part of the negotiations, that deeming was removed. So whilst they are permitted to be called 'psychiatrists' and they can practise in an area of psychiatry—they can do everything that a psychiatrist can do—technically they are not specialist psychiatrists registered under the national law. That meant that there was a discrepancy in the definition with the Mental Health Act that could have caused some problems in rural and remote areas. All we are doing is amending the definition in the Mental Health Act to capture area-of-need registered psychiatrists. It maintains the status quo from before 1 July 2010. In a nutshell, that is this little bill. Do you have any questions?

Mr SHUTTLEWORTH: Michael, you mentioned that speech pathologists and dental technicians were outside the national registration scheme and so are not under this banner. Is there any plan for them to be under that banner at some point or is there a requirement that they remain registered at the state level?

Dr Cleary: The arrangements for national registration were determined based on the risk profile of various speciality or professional groups. In the case of the two that I have mentioned, the assessment at a national level was that the profile of these groups was such that national registration may not be required. Queensland is currently the only state that registers these groups. They were registered in other states at an earlier period, but they are no longer registered in other states. At this point in time, Queensland will continue the registration of these two professional groups and these amendments will allow that to occur.

Ms Welch: I missed two little issues. One is that the mental health amendment is a retrospective amendment, which means that it deems area-of-need psychiatrists to be psychiatrists from 1 July 2010. It does not waive any negligence issues that may arise; it is simply to validate decisions that may have happened. The second is to alert you that the minister will be seeking to move a small amendment in committee. This bill amends a provision in the Health and Hospitals Network Act, which is being amended by the other bill we are talking about today. There is a naming discrepancy that arises when two bills amend the same things at the same time. There is no way around it: it has to be amended in committee. Whichever bill is debated second, the names are changed to reflect appropriately the amendment.

Mr HATHAWAY: Will the movement of these professional groups to the national system have any impact on the professional indemnity insurance of health practitioners?

Dr Cleary: The arrangements that are in place do not impact on the professional insurance arrangements for the health professionals. Under national law, however, all of the health professionals are required to hold insurance when they have moved under the new legislation. The reason for making that comment is that there were some groups for whom it was not a mandatory requirement but it is now regarded as a mandatory requirement that you have insurance under national law.

Mrs MILLER: Why does the retrospectivity go back to 2010? Why 2010?

Ms Welch: The date of 1 July 2010, which was the date of commencement of the national scheme, is when the anomaly arose. This is taking the retrospectivity back to the commencement of the national scheme, when the problem actually commenced. Prior to 1 July 2010 it was not an issue. Area-of-need psychiatrists were considered psychiatrists under the Mental Health Act and from 1 July 2010 they were not.

Mrs MILLER: How does this affect fundamental legislative principles?

Ms Welch: It is a breach of the fundamental legislative principles. However, the explanatory notes will go into a bit more detail about it. It is not affecting individual rights. If there is a negligence issue or an inappropriate decision issue, it does not change a patient's right to seek recourse in relation to that. All it merely does is validate appropriate decisions made by people who, if it had not been for that anomaly arising, would have made the right decisions under the Mental Health Act. It does not change their role or their position as a psychiatrist; it is just simply because the Mental Health Act has psychiatrists performing particular functions around involuntary patients and the definition of their role is a bit different to that of the normal understanding of a doctor.

Mrs MILLER: Are there any other sections that actually breach fundamental legislative principles?

Ms Welch: Not that we believe, no.

CHAIR: Did you have something further, Michael?

Dr Cleary: I just wish to comment and provide an example of how this works. In a hospital it may have been that there was a doctor who was registered. Under the previous registration scheme a specialist psychiatrist who met certain requirements of the state board could be called a deemed specialist. Under the Mental Health Act a deemed specialist was seen to be equivalent to a specialist who, for example, if they had trained and completed their training in Australia, had an Australian qualification. When we moved to national law, that arrangement was lost. Queensland was the only state that had that arrangement in place. As a consequence, psychiatrists who were practising in that field and had the title 'deemed specialist' lost that title and were really registered under a different provision. As you have heard, they are still able to practise, they have all the rights and all the responsibilities of a psychiatrist, it is just that they cannot hold themselves out to be a specialist under the new national law.

Once Queensland Health was made aware of that, when psychiatrists who were now registered under this different category were making decisions, we asked that they also refer their decision-making process through a doctor who was a specialist recognised as a specialist under the new legislation. So we put in place a work-around to make sure that we complied as far as was reasonably possible with the legislative requirements.

Mrs MILLER: So to capture these psychiatrists between 2010 and now, have they been working ultra vires?

Ms Welch: I do not have the answer to that. We would have to—

Mrs MILLER: Can you find out and let us know? Can you take that on notice?

Ms Welch: We can take that on notice and try to find out. We would have to audit all the psychiatrists.

Dr Cleary: The work-around that we put in place was that, where they made a decision, they had to refer that decision to a specialist who was, under the act, allowed to make that decision. That psychiatrist who may have been involved in formulating the decision then had the decision technically being made by the specialist psychiatrist registered under the act. It put an additional step in any processes around decision making and added a little bit of what you could call red tape to the process. But it meant that we complied with the requirements of the Mental Health Act.

Mrs MILLER: I would still like to know, please, whether any of these specialists were acting ultra vires and if you could get back to the committee.

CHAIR: Any further questions? There being none, we will move on to the second piece of legislation, the Health and Hospitals Network and Other Legislation Amendment Bill. Again, which one of your colleagues, Dr Cleary, will be leading us on this?

Dr Cleary: I might start off if that is okay. This bill amends the Health and Hospitals Network Act 2011 and is, as I see it, a very significant change in the way that health services will be provided in Queensland. The act establishes the boards which will oversight the management of the hospital and health services. It also makes some changes to the operation of the existing act. The key areas there are related to the ownership of land and buildings. This bill provides for the ownership of land and buildings to transition to the new hospital and health services under certain arrangements and also, subject to the proclamation of that particular section of the act, it also makes changes to employment arrangements.

Under the current legislation, the employment of staff, apart from health service executives, is through the director-general of Health. Under the provision in this bill, the employment will transition to the hospital and health service and at that time the CEO of the hospital and health service will take over the responsibilities and accountabilities for employees. Again, there will be certain requirements that the minister will put in place before that transition occurs and the arrangements will only be able to be progressed once that particular section of the legislation is proclaimed.

There are a number of other modifications to the legislation which you could say were of a less strategic nature. The first of those is the establishment of an executive committee of the board. That executive committee of the board will have a role in oversighting the strategic management of the hospital and health service. It is chaired by the chair of the board or the deputy chair of the board and will include the clinical members of the board. The CEO or the chief executive of the health service will be required to attend. The types of activities that board subcommittee will attend to will be those matters referred to it by the board but also matters that are of strategic importance. For example, it may be that the board wishes to have a closer role in assisting the organisation to manage waiting lists or programs around elective surgery. It may be that the board also wishes that group to participate in the management of events if some unexpected event occurs and requires the board to participate in the resolution of that event. Of course the legislation identifies that this group will have carriage of a very important function, which is oversighting the clinical engagement strategy, the community and consumer engagement strategy and the protocol that will be put in place between the health service and the local Medicare Local.

They are probably the key areas in terms of the changes that the bill is proposing. There is a number of other amendments and they include consequential amendments to the industrial relations legislation. That is because of the naming convention and some of the arrangements that will need to be put in place to allow appropriate governance by Queensland Health of award provisions, awards and enterprise bargaining agreements. I might again hand over to Paul Sheehy, who will talk us through some of the more detailed aspects of the bill.

Mr Sheehy: I will flesh out some of the points that Michael has made. Michael is focused on one of the key themes, which is about strengthening the decentralisation of healthcare delivery. There is also another element around implementing aspects of the National Health Reform Agreement, particularly around arrangements. Just so we are quite clear, a few name changes will be made. What was previously going to be called governing councils will now be hospital and health boards and the previous terminology of networks will now be hospital and health services. The legal entity will be a hospital and health service, such as the Metro North Hospital and Health Service, and that will be overseen by a hospital and health board.

As Michael Cleary indicated, there are a couple of prohibitions under the act as it currently stands that will be removed by this bill. One is the prohibition on owning land and buildings. That will be removed, but there will be some checks and balances put in the system. The approval of the minister and the Treasurer will be required to buy or sell land and also to grant a lease or take a lease of land and buildings. So that puts some checks and balances in the system. The land and buildings will not be transferred immediately. I probably should have said at the outset that the intention is that these amendments will come into force on 1 July when the substantive act itself will commence. So it is not intended that the land and buildings will transfer immediately on 1 July. A project will be put in place to ensure that the hospital and health services have the capability to fully manage their own land and buildings. Once that takes place, then the land and buildings of that relevant hospital and health service will be transferred by way of a transfer notice, which is a power under the existing act.

In relation to the employment of staff, I think Michael has covered that pretty well. Again, that will not commence on 1 July; that will happen when each hospital and health service is assessed and will actually then put a regulation in place that will empower that hospital and health service to employ staff. At that point in time all of the current employees who are at that stage departmental employees working in the service will become employees of the service on the same terms, conditions and entitlements. So, although the employer changes, everything else will remain the same when they move over to that employment arrangement.

The bill provides for the establishment of hospital and health ancillary boards. These are advisory boards. They can be established in relation to a particular hospital or a small geographic area. The purpose of these is to strengthen local input into the boards and the services. They will be set up with the approval of the minister. As well as advising the board, there is an objective there of strengthening local capability and capacity in decision making in terms of healthcare services. The bill will put that provision in place and then, subsequent to that, the minister can approve their establishment.

I think Michael Cleary dealt pretty comprehensively with executive committees in the bill so I will not go over those. As you would be aware, the National Health Reform Agreement was signed last year. Under that agreement, the state, the territories and the Commonwealth committed to putting in place legislation in key areas. The bill is essentially about strengthening transparency and accountability in funding so that the funding flows from the Commonwealth to the state are very clear, very open and publicly reported on. That will be done in a few ways. Firstly, there will be the appointment of what is called an administrator. Each state will have a state pool account. The full title is the administrator of the state pool account or the national pool, as it is called collectively. Although the position will be established by

each state and territory and the Commonwealth, the intention is that there will be one person—the same person—appointed to that position. That will be done through the Standing Council on Health. The health ministers will agree on that person and that person will then be appointed as the administrator.

The main role of the administrator is to release funds out of what is called a state pool account. So each state will have a state pool account. All Commonwealth money will go into that account and state activity based funding will go into that account. For transparency purposes, the administrator is the one who releases those funds. The release of the funds is done at the direction of the state minister. So the state minister would look at the relevant service agreements and activity levels, designate what funding needs to be released and then the administrator actions that. That is one of the main roles. The other main role is the public reporting. The administrator is required to do monthly reports and annual reports about the funding that comes into and goes out of the state pool account and also the activity and the other hospital and health services that are funded through that state pool account. Also in the annual report there will be an audited financial statement. In parallel with those arrangements, there is also another account, which is called the state managed fund. Predominantly that block funding—non-activity based funding—would pass through it. There is a diagram in the back of the explanatory notes which explains how the funds flow through the state pool account and the state managed fund.

In addition, there is a couple of other minor or lesser amendments. There is provision in the act that will enable the minister to suspend a board member on the grounds of alleged misconduct, which is a definition based on the Public Service Act, or if there is another prima facie ground for removal then the minister could take action if it is required urgently. There are also provisions which enable the minister to appoint an expert adviser—for example, a financial adviser—to a board. If a board, for example, is having difficulty in meeting its financial targets and the minister believed it would assist their performance, the minister could that person. The person is not a full board member. It is expected that the person would give advice during board meetings but would not be a voting board member.

Finally, there are amendments—again as Michael referred to—to the Industrial Relations Act. They are solely for the purpose of maintaining state-wide terms and conditions. So, once the employees become employees of hospital and health services, they will be on the same terms and conditions. That means that the director-general of Queensland Health will be the person who will be party to awards and will negotiate certified agreements for all health service employees and will also handle any industrial dispute that goes beyond the boundaries of a single hospital and health service. Those amendments are made for that purpose.

Just following on from Rachel's comment and just to alert you, there may be amendments in committee. We have introduced those amendments to the Industrial Relations Act for that purpose. As you would be aware, there was another bill that was introduced in the House that amends the Industrial Relations Act. Because of the complexities of those two provisions, we need to ensure that the issue that I just raised about ensuring that there is a state-wide approach to certified agreements et cetera also applies to those provisions that were introduced in the other bill. That is all I have. Thank you.

CHAIR: Thank you, Paul. Are there any questions?

Mrs MILLER: I have several. In relation to the ancillary boards, are they paid positions? Is the intention for these people on the ancillary boards to be paid?

Dr Cleary: In accordance with the legislation, the ancillary boards are set up to provide the opportunity for greater community involvement in parts of the health service. The legislation does not make provision for payment of members of the ancillary boards. But, in terms of the intent of that component of the legislation, it is really to draw in the involvement of the community in decision-making processes around local areas. The board that is the governing board is the board for the hospital and health service.

Mrs MILLER: Yes, I understand that. I just want to know whether or not the ancillary boards can or cannot be paid under this particular bill.

Dr Cleary: In terms of the legislation, there is no provision for the ancillary boards to be paid.

Mrs MILLER: Can they get reasonable expenses reimbursed?

Mr Sheehy: I can answer that question. There are provisions there to make regulations under the act.

Mrs MILLER: Yes, I know that.

Mr Sheehy: At this stage the legislation itself does not deal with that particular issue. That is something the minister might wish to consider in making that regulation.

Mrs MILLER: In relation to ancillary boards which the minister may establish, what if he comes up with a situation whereby the board itself does not necessarily want ancillary boards?

Dr Cleary: The legislation makes provision for the minister to consult with the hospital and health board and also with the community before he makes a decision. I think in terms of the process this is the minister's decision. The minister would take into account those two provisions in making that decision.

Mrs MILLER: In the case of a dispute, the minister would be the one resolving that dispute, I assume, under this legislation?

Mr Sheehy: It is ultimately the minister's decision. As Michael Cleary indicated, the minister could consult with those entities, but ultimately it is the minister's decision under the bill.

Mr DAVIES: I have a question about ancillary boards as well, if I may. I would like to flesh out a little bit how ancillary boards will work. My parents live in Kingaroy. There is a small hospital there. My mum is a nurse. She has been very unhappy. Would somewhere like Kingaroy form an ancillary board for that local district within the region? For example, if it is based in Toowoomba then the Toowoomba region. Is that how ancillary boards will work?

Mr Sheehy: Yes. The model is that, within a larger geographical area and the hospital and health services within that, yes, an individual hospital, if they were particularly interested, could approach the minister to have an ancillary board established for that hospital.

Mr DAVIES: So, Paul, the ancillary board would then make recommendations such as, 'We need a gynaecologist here.' They would make that recommendation and that recommendation would carry weight, would it?

Mr Sheehy: Yes, that is the purpose, to give advice to both the board and the service—the senior manager of the service directly—on areas that are relevant to their hospital. So, yes, it could be about the nature of services that are provided in that hospital.

Mrs MILLER: So basically what you are saying in relation to what Steve is saying is that in the district that I represent, which is Ipswich, you could have an Ipswich district board and then you could have a Boonah Hospital ancillary board and an Esk Hospital ancillary board. I thought it was the role of this government to cut out red tape or to cut out this type of thing. Now you are suggesting putting in layers and layers of boards. It seems to be a bit of a furphy if that is what you are talking about. How many hospitals do we have in Queensland—a hundred and something? So every hospital could in fact have their own ancillary board. That is right, isn't it?

Dr Cleary: Thank you for the question. In terms of the policy intent, I refer the committee to the minister's introductory speech where he makes comments such as—

Communities have consistently requested a greater say in the running of their hospital and health services. To meet this need, I propose to amend the act to enable the minister to establish ancillary boards. These ancillary boards will provide advice to hospital and health boards on the operations of specific hospitals or health services within their region.

So that is the policy intent as indicated by the minister. How that will be established is going to be something that will need further consideration. The regulations covering aspects of this provision will need to be drafted and, as Paul Sheehy has indicated, the decision-making power around the development of the ancillary boards rests with the minister. If I could just go on to reference another general comment that the minister made in his introductory speech—

The establishment of ancillary boards will also allow the progressive establishment of new, further devolved hospital and health service areas as capacity, capability and confidence grows in returning decision making and control of hospitals to local communities.

Again, I believe it was going to be a consultation process with the local communities and with the board that is charged with the management of these, some very large, enterprises.

Mrs MILLER: But it is the reality that potentially these ancillary boards can be set up in accordance with this legislation in every hospital.

CHAIR: That has been asked and answered, I think.

Mrs MILLER: Thank you. I will accept that as a yes. In relation to clause 22 and proposed new section 44A, where the minister may appoint advisers to boards, can you tell me what the policy intent is behind this and in what circumstances a minister may appoint advisers to the boards?

Dr Cleary: The establishment of the new structure and the establishment of the boards is something that has been considered in great detail by the department and by the minister. In terms of the way it has been established, there are what we might call safety net provisions that are being built into the legislation—safety net provisions that allow for the smooth transition from the current corporate model of managing hospitals and health services to the board model of managing hospital and health services.

Although we can foresee the majority of issues that may arise, there may be matters that arise from time to time where it is deemed appropriate by the minister to provide additional support to boards so they can meet their obligations in terms of the management of what can be quite large enterprises. As such, there is a provision in the legislation that would allow the minister to appoint a person to the board to assist the board in managing complex issues. I think it is, if you like, a protective mechanism to allow the minister to assist the boards in undertaking the new duties that they will undertake under this legislation.

Mrs MILLER: But also the minister could appoint a member of his own staff as an adviser to these boards, couldn't he?

Dr Cleary: In responding to the question, the issue here in my mind is around the capability and capacity of the boards. The boards are not representational but boards that have membership which includes legal, business, HR, as well as clinical members—which is very important—and community members. There may be areas where a board needs additional support. It might be that the board needs additional support to undertake its responsibilities around HR or other practices. They are the types of arrangements that I would foresee would be ones where the minister may consider that type of a provision being a useful provision to be able to use. Again, I would not be able to speak for the minister per se, except to foreshadow that there may be requirements for boards to seek additional support and this is a provision, as a safety net provision, to allow that.

This type of provision is also, as I understand it, in place in Victoria. The Victorian model for management of health services is one that we have taken a great deal of time to examine. We have looked at the arrangements that they initially put in place and the amendments to their initial arrangements, and we have taken their advice. This was one of the areas that they suggested would be an appropriate arrangement to put into play. Certainly it reflected on the experience in Victoria where there may be situations where before taking more serious action a minister may wish to provide support to the boards. So it was deemed to be a very positive approach and certainly Victoria has found it a very useful one.

Mrs MILLER: What about the other states? Do they have similar provisions in their legislation? Otherwise, it would be Australia-wide template legislation.

Dr Cleary: When the legislation was originally introduced we examined all of the other states and territories and the legislation that they had in place. There are differences between the states and territories in how they are proposing to operationalise the requirements of the National Health Reform Agreement. The smaller states have, to a degree, elected to run with one local hospital network. The Northern Territory, with two major hospitals, has, as an example. Other states and territories have different industrial relations provisions which have meant that they have had to put in place legislation that is aligned with their industrial relations provisions. Victoria was seen as one of the states that had taken this role the furthest. So we have taken a lot of the experience from Victoria and used that to refine the legislation that Queensland has introduced. So, yes, there are other states and territories that have arrangements to support their local boards. From our experience, Victoria is probably the most advanced state in terms of the thinking around its legislation.

CHAIR: Thank you. The member for Woodridge has a question.

Mrs SCOTT: I just wanted to address the management of land and buildings as it might affect my local hospital. I think, Michael, you are well aware of the restrictive nature of the footprint of the hospital and the expansion that is required there—

CHAIR: Is this at the Logan Hospital?

Mrs SCOTT: Yes, Logan Hospital. And the ongoing relationship—I think it has gone quiet at the moment—between the university, TAFE college and hospital and whether there has been further work on the strategic plan there. Would that be then carried on by the board—something as major as relocating the TAFE college to the university campus so that the TAFE college and the university are co-located and then the expansion of the hospital footprint?

CHAIR: Michael, are we wandering away from the legislation a bit by engaging in some of the hypotheticals around a specific hospital? I understand where you are coming from, but I fear we are moving a little away from the legislation.

Mrs SCOTT: I guess it is just a question of the extent of the hospital boards and whether or not that is going to remain the consideration for them.

CHAIR: In that broader sense, if you would not mind answering.

Dr Cleary: One of the arrangements that has been identified by Paul is the transitional arrangements around the ownership of land and buildings. In the near future after 1 July, until the provision is established and until appropriate processes and regulations underpinning the legislation are developed, the hospital and health services will continue to operate and manage the facilities under a licence agreement. They will, of course, have the ability to negotiate and make other arrangements with local providers as is appropriate. I would have thought that the new arrangements, with the delegation and decentralisation of management, will enhance the ability of communities to participate and in a meaningful way work through what types of arrangements would suit those communities locally. It is probably not the provisions around land and buildings that will be the important ones but the overarching change with the decentralisation and the empowerment of local communities through the hospital and health boards that will make the difference.

Mrs MILLER: In relation to division 3, clause 33 concerning chief executives, what happens if there ever eventuates a dispute between the board and a chief executive who is appointed under this particular legislation given—

Mr Sheehy: Apologies, could you refer to which clause?

Mrs MILLER: Division 3, clause 33. The health service board appoints a health service chief executive; we all agree on that?

Mr Sheehy: Yes.

Mrs MILLER: But the actual legislation is silent. What happens if there is a dispute between the board and the CEO on any matter?

Mr Sheehy: I think you would have to look at the specific issue. If it is, for example, an issue in a service agreement between the chief executive and the board, then the minister effectively arbitrates and makes the decision. In other circumstances, for example, if it is an issue around a health service directive, the director-general is required to consult with the hospital and health services, but at the end of the day the director-general makes the decision.

There are other areas where it is entirely up to the hospital and health service to make the decision. The legislation gives them the clear powers and functions to do things. So you would relate to the specific issue. For the director-general to become involved, there would have to be a specific provision in the act that enabled or empowered the director-general to get involved in a matter in a hospital and health service.

Mrs MILLER: So can the DG of the department request information et cetera from the chief executive? What I am asking here basically is: can there possibly be a dual reporting relationship from the chief executive up and out to the director-general, or is it solely the chief executive to the board and then the board to the director-general or the board to the minister? Are you able to give us that information in a flow chart? Could you take it on notice and get back to us?

Mr Sheehy: Sure. We could certainly explain that. Perhaps I was not 100 per cent clear. Certainly the hospital and health services as legal entities are separate and the chief executive reports to the board. So that is the clear line of accountability. The example I gave before probably was not on point for the question that you were asking, because I suppose I was referring to the relationship between the director-general and the entity—the hospital and health service—rather than the individual chief executive.

The chief executive of a hospital and health service reports to the board. There is no direct power or direction or direct relationship between the director-general of the department and the chief executive. They essentially work in separate entities but, as I say, the director-general, as the system manager, can do certain things in relation to the services as a whole—the service agreements, for example.

Mr HATHAWAY: My question is probably a follow-on from some earlier commentary in regard to the buildings, land management and the like, and specifically in regard to clauses 5 and 6 talking about major capital works. It might be beneficial to ask this in two parts. Can we get some commentary on the definition of 'major capital works' as opposed to 'minor' or 'medium' capital works which would be the responsibility of the board? Secondly, I assume—but I would appreciate some clarity on this—that the transition for the buildings and land management across to the local board would also be mindful of current work in progress—for example, that is in place and planned to be in place at a council hospital.

Dr Cleary: This is a very complicated area, and the more that we have examined the arrangements that need to be put in place for the transition of land and buildings, the more it is clear to me that this is going to require the establishment of a process within Queensland Health to examine a wide range of issues and resolve them before that transition is undertaken. There are many examples I can give, but due to time I will be brief.

In terms of the transition arrangements, it would be my view, although it is yet to be confirmed by our director-general, that we would establish a transition project to look at this policy direction, to work through what the mechanical requirements will be and how we can satisfy the policy direction while also meeting the relevant requirements. For example, Queensland Health may continue to manage some of the large building projects, because of their very nature. Townsville is a good example of this. You may have a building with which Queensland Health corporately is involved in a capital development because of its size and complexity on land owned by a hospital and health service and is wanting the builders to have access to buildings that are owned by the hospital and health service. I think we need to work through the contractual arrangements to see how that will work and to see how access for those types of projects will be provided. We need to undertake a very detailed body of work in this area to ensure that when we move forward the regulations, directives and policies that we have in place will not impinge the good working arrangements that are currently in place, nor add additional red tape to the process.

In terms of the definition of capital works, that is something that we are currently looking at in terms of the regulations. There will probably be in sequence and over time two different definitions. Under the current arrangements, as of 1 July the current provisions will apply where Queensland Health will continue corporately to own the land and buildings, and what will be defined as 'major capital works' will be defined in the regulations at that time. But, as this work that I mentioned before is undertaken and is drawn to a conclusion, then what will involve capital works I would see will change and the definitions will change.

One of the major reasons that we need to be mindful of the definition of capital works is that corporately we have a team that manages compliance requirements around capital projects, ensuring that we are meeting the required fire safety standards, for example. Although there may be a need for hospitals to seek endorsement for certain capital projects or approval, the majority of those smaller projects will be managed locally, as they are now. Many of our hospitals are already managing what I regard as fairly large projects. Cairns, for example, I think is managing internally a $6 million project to rescope their education services in one of the buildings that is being decommissioned as part of their capital project.

That was probably a very long answer. In summary, it is a very complex area. It is more complex than it would appear on the surface. We need to put in place an appropriate process to work up what all the issues are and seek policy direction where appropriate on what the best arrangements would be going forward. Certainly the goal is to ensure that the good working arrangements that are currently in place continue and that we do not burden people with additional administrative requirements.

Mr HATHAWAY: As a follow-on—and you used the Cairns Hospital as an example—is it a numerical $6 million value that determines whether you devolve the responsibility for a capital project to the hospital—in this case, Cairns? Is that the cut-off line that exists at the moment?

Dr Cleary: No, at the moment it depends on a range of issues. Obviously the value of the project is one. The larger the project, the more likely it is that it would be managed centrally. But another issue is whether the project is going to have an impact on existing buildings, whether it is a refit of an internal building et cetera. There are no specific guidelines that I can quote to you today, but we can certainly come back with some advice on the current arrangements and what the arrangements post 1 July would be.

CHAIR: It would also depend on the hospital's ability to manage the project, because some hospitals would be better equipped for large projects, whereas other hospitals would be out of their depth on a relatively minor project.

Dr Cleary: Yes, you are quite correct. Larger services like Metropolitan North and Metropolitan South services are very well equipped to manage capital projects, whereas perhaps the ability to manage capital projects in Longreach is lessened because of the capacity within the current district or the future health service.

Mr HATHAWAY: Thank you, Doctor. As you develop it post 1 July, I would like to be kept informed.

Mrs MILLER: I have a question—

CHAIR: I am mindful of the time.

Mrs MILLER: I know, there are only a couple of minutes. I have a question on industrial relations aspects. Today we have a situation where in Townsville, I understand, there are staff who have been told they have to take any excess leave before 30 June. Under this new scheme there is a board and there is a chief executive officer, but the director-general still has powers in relation to industrial relations agreements. If the board and the chief executive officer of that Townsville region direct staff to take so-called excess leave, what is the role of the director-general in relation to that given the enterprise bargaining agreements et cetera, given that this is happening in Townsville as we speak?

Dr Cleary: For our purposes today we would be best placed to respond to the policy issues that this raises.

Mrs MILLER: Yes, respond to the policy issues. I am happy for that.

Mr Sheehy: Those issues would be looked at by the director-general on a case-by-case basis. In terms of industrial disputes, the test in the act relates to whether a matter will impact beyond a particular hospital and health service. The underpinning principle is about having consistent state-wide terms and conditions. If an issue is a local issue then the director-general might say, 'No, you can handle that. That is a local issue.' If it is something that would have flow-on effects on the terms and conditions of health service employees elsewhere then the director-general could say, 'I will deal with that because that has flow-on implications for the terms and conditions across the state.'

CHAIR: Is it fair to say that those same circumstances occur in industries right across the country—where people accrue too much leave and periodically they are encouraged to take that leave rather than continue to accrue it?

Mrs MILLER: No, not in terms of the Public Service.

CHAIR: It is across the Public Service.

Mrs MILLER: No, it is not. I am a former public servant and I know what I am talking about here. I have one final question, please. Are the hospital boards and the ancillary boards subject to the Right to Information Act and regulations?

Mr Sheehy: Certainly the boards would be. I will get back to you and give you advice in relation to the ancillary boards.

Mrs MILLER: Thank you.

CHAIR: I am mindful that it is now three o'clock. Are there any final questions from any other member?

Mrs SCOTT: I have not gone through all of this so this question might be out of left field. I am interested in the major acquisitions in a hospital where the board sees clusters of things happening within their hospital regime and they see the need for something like an MRI machine that is hugely expensive and so on. What process is involved in acquiring very expensive new hospital equipment when they see the need?

Dr Cleary: This was considered and is taken into account in the current act in terms of providing a head of power. Queensland Health, with the health services, has looked at the ownership of major equipment. In terms of the arrangements that will be in place on 1 July, if we put land and buildings to one side then all of the equipment, from the minor equipment through to the major equipment, will be owned, operated and managed by the hospital and health services independently. There may be benefits going forward for some of the hospital and health services to work as a collective to see if they can obtain equipment at a lower price by purchasing in bulk and those types of arrangements, but the equipment will be owned, operated and managed by the hospital and health services. The support that we would provide after 1 July would be more around the efficiency gains through bulk purchasing and ensuring appropriate standards are set for the purchase of equipment which would be provided to the hospital and health services for their consideration.

CHAIR: Thank you. I have one final piece of housekeeping, and that is agreeing to a time for when we receive the responses to the questions on notice. I am thinking for the benefit of members that midday on Tuesday, the 29th would be best. Would that be acceptable to get those responses by then?

Dr Cleary: Yes.

CHAIR: That way it gives us a chance to get through them prior to our next meeting.

Ms Welch: Can I just clarify that we have all the questions on notice. I have three: first, how many area-of-need psychiatrists have been acting ultra vires; second, what is the criteria around the determination of who manages capital projects pre and post 1 July; and, third, are ancillary boards subject to the Right to Information Act?

CHAIR: I think with that middle question there was also the scope of works as to whether there is a defining line where it becomes the realm of Queensland Health as opposed to a hospital board. Is there some cut-off? Is that your recollection?

Mrs MILLER: Yes.

Mr Sheehy: Did you want further information about the relationship between the director-general and the chief executive?

Mrs MILLER: I would like a flow chart, please—just an organisational chart.

CHAIR: A chain of command.

Mrs MILLER: An organisational chart that has the legislative role there. The Public Service has dot lines as well and I am interested in your dot lines, too.

Ms Welch: So that is four questions?

Mrs MILLER: Yes.

CHAIR: Dr Cleary, I thank you and your team for the time you have spent with us this afternoon. It has been comprehensive and informative. Obviously, we have some tight time frames and we look forward to getting those responses to the questions on notice. Again, I thank the members of the public for their interest and I thank you for your attendance here today.

Committee adjourned at 3.04 pm