

## Queensland Health and Hospitals Network Bill 2011

---

### General Practice Queensland feedback - 1 August 2011

**Background:** Queensland Health wrote to General Practice Queensland (GPQ) on 16 June 2011 seeking the Queensland Divisions Network's views on the draft Health and Hospitals Network Bill 2011. The primary purpose of the legislation is to enable the establishment of Local Health and Hospital Networks (LHHNs) in Queensland.

**Consultation process:** On 22 June, 2011, GPQ circulated to the Queensland Divisions' Board Chairs and CEOs the letter from Queensland Health, the draft Bill, and the Explanatory Notes. GPQ also undertook consultation at the Queensland Divisions Forum in Cairns on Friday, July 29, 2011.

The following points are provided to Queensland Health as feedback from the Queensland Divisions Network.

#### General comments:

The Queensland Divisions Network acknowledges that:

1. the Bill implements Qld's commitments under the COAG Inter-Governmental Agreement (20 April 2010) and the Heads of Agreement on National Health Reform (13 February 2011).
2. the states are the 'system managers' for the public health system.
3. the transfer to the new organisational arrangements will be very complex. We note that the transfer notice provisions of the Bill have been included to transition thousands of contracts and agreements.

#### Terminology and language:

In relation to terminology, we note that there is no definition of consumer or community engagement, and no definition of 'effective' engagement. It would be useful to include these to reduce ambiguity.

The language throughout the Guiding Principles (Clause 13) is tentative and rather weak (e.g., 'there should be engagement'.) Principle (g) suggests engagement with clinicians in planning, developing and delivering public sector health services. It does not include Medicare Locals, consumers or community organisations as part of this planning process. Principle (g) should be broadened to include health professionals/clinicians from outside the network to ensure that clinicians in primary care have a voice, and that Queensland Health has an appropriately informed understanding of the primary care perspective.

In relation to Clause 19 - Functions of Networks:

In (i) and (j) we suggest replacing 'to cooperate' with 'to effectively engage with', and include Medicare Locals specifically in functions (i) and (j). In function (n), replace 'to consult' with 'to effectively engage with' consumers and carers.

### **Areas in the Bill where further detail and/or clarification is required:**

It is not clear what discretion Queensland Health will have to provide health services other than hospitals through the Local Health and Hospital Networks. If Queensland Health continues to run primary health care services through its community health organisations, there needs to be clarity about how these organisations will be reformed, and how will they collaborate with Medicare Locals on population health planning and coordinated service delivery? Paragraph 60 of the February 2011 COAG Heads of Agreement - where the parties agree to work together on system-wide policy and planning and State-wide planning for GP and primary health care services - is also relevant here, and the details of how this will be done in Queensland will be critical to the success of LHHNS and Medicare Locals.

Moreover, the details of how this system-wide policy and planning and State-wide planning for GP and primary health care services links with the draft Bill's provisions on LHHN performance reporting, QH health service directives, and quality assurance must be articulated clearly and distinctly.

The draft Bill appears to be enabling legislation, with details lacking in areas that are important to Medicare Locals, for example, engagement strategies and protocols with PHC organisations (see Part 2 of the Draft Bill, pp. 26-38 particularly). (The comments above in relation to terminology are also relevant here.)

For example, we note that the Bill requires each LHHN to develop and publish a clinician engagement strategy and a consumer and community engagement strategy, with these strategies are to be reviewed every three years.

In relation to the Consumer and Community Engagement Strategy, we note that:

- This should not be developed in isolation from the consumer/engagement strategies of Medicare Locals. The strategies should be similar but with a different focus.
- Medicare Local representatives should be included in the consultation.
- There are no outlined engagement strategies for hard-to-reach groups.
- There is an assumption that community organisations will have the capacity to engage with LHHNs and Medicare Locals – this may not necessarily be the case without appropriate resourcing and/or training.

We also note that LHHNs are required to develop a protocol with Medicare Locals to facilitate cooperation in the planning and delivery of health services, and that these protocols are to be reviewed every three years. Our specific comments here are:

- The word 'protocol' may not be the best term to use here – possibly 'binding agreement' or something to specify obligations more distinctly.
- In Clause 42, in the first paragraph, remove the term 'best endeavours to agree on a protocol' and replace it with 'develop a binding agreement'.
- Similar terms should be used in Clause 43 and there should be explicit mention of evaluating the partnership between LHHNs/Medicare Locals formally.

As it stands, it is not clear whether these details will be negotiated bilaterally and locally between the relevant LHHN and the Medicare Local. How will equity considerations be incorporated in the engagement strategies and protocols, and consistent implementation achieved?

In relation to Part 4, Division 1, Performance and Auditing, we note that:

- There are no partnership performance measures detailed between LHHNs/Medicare Locals – it will be important to include performance measures related to engaging, partnering and collaborating with primary care and Medicare Locals.
- There should be provision for consumer/patient representatives to be involved in the auditing process.
- In relation to Clause 64 sub clause (4) “After considering the report the chief executive may issue a direction to a network”. The word ‘may’ is too tentative and open to interpretation. This should be strengthened.
- Reports should be made publicly available.
- The role of quality improvement frameworks (at different jurisdictional levels) could be articulated more clearly.

Prepared by General Practice Queensland  
for and behalf of the Queensland Divisions Network.