Parliamentary Committees

Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022

Report No. 21, 57th Parliament
Health and Environment Committee
July 2022

Health and Environment Committee

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Acknowledgements

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All web address references are current at the time of publishing.

Contents

Abbreviations

AAP	Australian Association of Psychologists
ACEM	Australasian College of Emergency Medicine
ACN	Australian College of Nursing
ACRRM	Australian College of Rural and Remote Medicine
ADAQ	Australian Dental Association Queensland
ADF	Australian Doctors' Federation
Advertising Guidelines	AHPRA's *Guidelines for advertising a regulated health service*
AHPRA	Australian Health Practitioner Regulation Agency
ALA	Australian Lawyers Alliance
AMA	Australian Medical Association
AMAQ	Australian Medical Association Queensland
ASO	Australian Society of Ophthalmologists
ASORC	Australian Society of Rehabilitation Counsellors
ASPS	Australian Society of Plastic Surgeons
Bill	Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022
Committee	Health and Environment Committee
FLPs	Fundamental legislative principles
HO Act	*Health Ombudsman Act 2013*
HRA	*Human Rights Act 2019*
ICA	Insurance Council of Australia
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
Independent Review	Independent review of the regulation of health practitioners in cosmetic surgery
IPO	Interim prohibition order
LSA	*Legislative Standards Act 1992*

National Board(s)	National health practitioner boards
National Law	*Health Practitioner Regulation National Law Act 2009*
National Scheme	National Registration and Accreditation Scheme for the Health Professions
NHPO	National Health Practitioner Ombudsman
NMBA	Nursing and Midwifery Board of Australia
NSW	New South Wales
OHO	Office of the Health Ombudsman
QDN	Queenslanders with Disability Network
QLS	Queensland Law Society
QNMU	Queensland Nurses and Midwives' Union
RACGP	Royal Australian College of General Practitioners
RACS	Royal Australian College of Surgeons
Strategy Group	Aboriginal and Torres Strait Islander Health Strategy Group
UNDRIP	United Nations Declaration on the Rights of Indigenous People
UWU	United Workers Union

Chair's foreword

On behalf of the Health and Environment Committee, I present this report on the committee's examination of the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill).

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament. The committee also examined the Bill for compatibility with human rights in accordance with the *Human Rights Act 2019*.

This report summarises the committee's examination of the Bill, including the views expressed in submissions and by witnesses at the committee's public hearing.

The committee has recommended that the Bill be passed. The committee has also recommended that the Minister for Health and Ambulance Services delays the commencement of provisions to remove the current prohibition on the use of testimonials in advertising for health services until the completion of the Independent review of the regulation of health practitioners in cosmetic surgery. This will enable AHPRA and the National Boards to consider the outcomes of the review and develop association guidelines and educational material on the appropriate use of testimonials in health service advertising.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill. I also thank our Parliamentary Service staff and Queensland Health.

I commend this report to the House.

Mr Aaron Harper MP

Chair

Recommendations

The committee recommends the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 be passed.

The committee recommends that the Minister for Health and Ambulance Services provides an undertaking, during the second reading debate, to not commence the provisions repealing the prohibition on testimonials in health service advertising until:

- the completion of the *Independent review of the regulation of health practitioners in cosmetic surgery*, and
- the accompanying guidelines and educational material have been published.

1 Introduction

1.1 Role of the committee

The Health and Environment Committee (committee) is a portfolio committee of the Legislative Assembly, established on 26 November 2020 under the *Parliament of Queensland Act 2001* and the Standing Rules and Orders of the Legislative Assembly.[1]

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Environment, Great Barrier Reef, Science and Youth Affairs.

The functions of a portfolio committee include the examination of bills and subordinate legislation in its portfolio area to consider:

- the policy to be given effect by the legislation
- the application of fundamental legislative principles
- matters arising under the Human Rights Act 2019
- for subordinate legislation – its lawfulness.[2]

The Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (Bill) was introduced into the Legislative Assembly and referred to the committee on 11 May 2022. The committee was required to report to the Legislative Assembly by 1 July 2022.

1.2 Inquiry process

During its examination of the Bill, the committee:

- invited written submissions on the Bill from the public, identified stakeholders and email subscribers, and received 40 submissions
- held a public briefing on 23 May 2022, which was attended by officials from Queensland Health (see Appendix B for a list of officials)
- received written advice from Queensland Health in response to matters raised in submissions
- held a public hearing on 8 June 2022 (see Appendix C for a list of witnesses).

The submissions, correspondence from Queensland Health and transcripts of the public briefing and hearing are available on the committee's webpage.

1.3 Policy objectives of the Bill

The objectives of the Bill are to amend the Health Practitioner Regulation National Law (National Law), as agreed by Australian Health Ministers on 18 February 2022, to:

- strengthen public safety and confidence in the provision of health services
- improve the governance of the National Registration and Accreditation Scheme for health professions (National Scheme)
- enhance the effectiveness and efficiency of the National Scheme.[3]

1 *Parliament of Queensland Act 2001*, s 88 and Standing Order 194.

2 *Parliament of Queensland Act 2001*, s 93; and *Human Rights Act 2019* (HRA), ss 39, 40, 41 and 57.

3 Explanatory notes, pp 1 and 4.

Key reforms in the Bill include:

- refocusing the objectives and guiding principles of the National Law to make public safety and confidence paramount considerations, and to recognise the National Scheme's role in ensuring the development of a culturally safe and respectful health workforce for Aboriginal and Torres Strait Islander Peoples
- introducing a power for national regulators to issue interim prohibition orders to prohibit or restrict unregistered practitioners from providing health services or using protected titles, similar to the power already given to the Health Ombudsman in Queensland
- introducing a power for the Health Ombudsman and national regulators to issue public statements about persons whose conduct poses a serious risk to public health and safety
- removing barriers to information sharing to protect the public and enable more efficient and appropriate resolution of notifications (complaints)
- improving processes by which National Boards make registration decisions and manage health, conduct and performance issues.[4]

The Bill also makes minor and technical amendments to the National Law to correct typographical errors, make terminology clearer or more consistent, update references and contemporise some provisions.[5]

To accommodate Queensland's co-regulatory arrangements for registered health practitioners, the Bill also amends the *Health Ombudsman Act 2013* (HO Act) and makes minor modifications to how certain amendments to the National Law will operate in Queensland.[6]

If the Bill is passed, the amendments would automatically apply in all states and territories that are part of the National Scheme, except Western Australia, which must pass corresponding legislation, and South Australia, which must make regulations to apply the changes.[7]

1.4 Consultation on the Bill

The explanatory notes state that the reforms in the Bill were developed with extensive community consultation, including:

- targeted consultation in April and May 2017 – three national forums were held and 36 submissions were received
- a consultation paper published in July 2018 (100 organisations and individuals provided feedback), followed by 8 consultation forums across Australia (attended by approximately 300 people)
- targeted consultation on a draft Bill between 26 February 2021 and 27 April 2021 (50 written submissions received), and 2 national webinar sessions held on 7 and 8 April 2021 to explain the proposed amendments and respond to stakeholders questions.[8]

4 Statement of compatibility, p 1.

5 Explanatory notes, p 18.

6 Statement of compatibility, p 1.

7 National Health Practitioner Ombudsman, Legislation, www.nhpo.gov.au/legislation.

8 Explanatory notes, pp 26-27.

Queensland Health advised that:

> Stakeholder submissions largely indicated support for the draft Bill. Some stakeholders suggested changes to the drafting to improve its operation or to address specific issues or concerns. A small number of stakeholders opposed the inclusion of one or more of the reforms in the Bill. Some issues regarding implementation of specific reforms were identified by stakeholders, as well as potential unintended effects. The Bill was updated, where appropriate, to reflect some of the feedback received. [9]

1.5 Should the Bill be passed?

Standing Order 132(1) requires the committee to determine whether or not to recommend that the Bill be passed.

After examining the Bill, including its policy objectives, and the evidence and information provided by Queensland Health, submitters and witnesses, the committee recommends that the Bill be passed.

Recommendation 1

The committee recommends the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 be passed.

[9] Explanatory notes, p 27.

2 Background to the Bill

2.1 National Scheme

The Council of Australian Governments agreed, in 2008, to establish the National Scheme for health practitioners in Australia.[10]

On 1 July 2010, the National Scheme came into effect, with the enactment of the Health Practitioner Regulation National Law (National Law) in all states and territories except Western Australia, which joined the National Scheme on 18 October 2010. Each state and territory has its own variant of the National Law.

The National Law regulates 16 health professions:

- Aboriginal and Torres Strait Islander health practice
- Chinese medicine
- Chiropractic
- Dental
- Medical
- Medical radiation practice
- Nursing
- Midwifery
- Occupational Therapy
- Optometry
- Osteopathy
- Paramedicine
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology[11]

The National Law establishes 15 National Boards to regulate the registration and accreditation of the 16 health professions, and the Australian Health Practitioner Regulation Agency (AHPRA) provides support to the National Boards in discharging their functions.[12]

There are approximately 825,000 health practitioners in Australia, with approximately 168,000 practising in Queensland.[13]

The National Law also establishes:

- a framework for approving registration standards, codes and guidelines
- accreditation authorities and functions to support education and training
- title protections for the registered health professions
- a complaints process for managing health, conduct and performance matters
- investigation powers.[14]

In all states and territories, except New South Wales (NSW) and Queensland, the National Boards are responsible for the management of complaints and notifications against registered health practitioners and students of the registered profession.[15] This may involve the investigation, hearing

[10] Council of Australian Governments, *Intergovernmental Agreement for a National Registration and Accreditation Scheme for Health Professions, 2008*.

[11] Australian Health Practitioner Regulation Agency and National Boards, What we do, https://www.ahpra.gov.au/About-Ahpra/What-We-Do.aspx.

[12] Explanatory notes, p 2.

[13] Queensland Health, public briefing transcript, Brisbane, 23 May 2022, p 2 and 5.

[14] Explanatory notes, p 2.

[15] National Law, s 35.

and review of competence, conduct or impairment matters. However, the most serious cases which could result in suspension or cancellation of a practitioner's registration, are dealt with by tribunals and external panels.

The National Boards may establish state and territory boards to exercise their functions in a jurisdiction, e.g. the Queensland Board of the Medical Board of Australia and the Queensland Board of the Nursing and Midwifery Board of Australia.[16]

The National Boards, and their state and territory boards and committees, consist of practitioner members and community members appointed by the Ministerial Council.[17]

Queensland Health advised that 'The purpose of the national scheme is to ensure that only health practitioners who are suitably trained and qualified to practise in an ethical and competent manner are registered to practise'.[18]

2.2 Co-regulatory jurisdictions

In Queensland and NSW, complaints handling and disciplinary functions operate under co-regulatory arrangements, as recognised by the National Law.

NSW joined the National Scheme in relation to the centralised accreditation of training and courses and the health practitioner regulation provisions; however it opted to retain its existing health complaints system.[19]

Queensland initially joined the National Scheme in its entirety; however, it established its own health complaints system in July 2014, with the establishment of the Office of the Health Ombudsman (OHO) under the HO Act. Similar to NSW, health practitioners in Queensland continue to be registered under the National Scheme.

Under Queensland's co-regulatory model, two entities - the OHO and AHPRA – deal with notifications (complaints) about a registered health practitioner's health, conduct or performance. The HO Act provides that the OHO has primary responsibility for managing complaints about registered health practitioners and unregistered health practitioners (e.g. speech pathologists, massage therapists and naturopaths).[20] Queensland Health advised that:

> Under our co-regulatory arrangements, the Office of the Health Ombudsman is the first point of contact for all health complaints with regard to registered and unregistered health practitioners as well as complaints in relation to the delivery of health services in this state. The Health Ombudsman may refer appropriate matters to national boards or Ahpra to deal with and … the Health Ombudsman also has responsibility for oversighting unregistered health practitioners in Queensland.[21]

The OHO must consult with AHPRA to decide which regulator is best placed to respond to the issues raised. In appropriate circumstances, the OHO may refer matters to AHPRA. AHPRA then works with, and on behalf of, the National Board for the relevant profession to resolve the matter under the processes set out in the National Law.

16 National Law, s 36.

17 National Law, s 33.

18 Public briefing transcript, Brisbane, 23 May 2022, p 2.

19 Claudette S. Satchell et al, 'Approaches to management of complaints and notifications about health practitioners in Australia', *Australian Health Review*, 2016, 40, p 313.

20 Explanatory notes, p 2.

21 Public briefing transcript, Brisbane, 23 May 2022, p 2.

Generally, AHPRA deals with matters involving a practitioner's health and with less serious conduct and performance issues, while the OHO retains responsibility for investigating and prosecuting the most serious allegations of misconduct.[22]

2.3 Reviews of the National Scheme

The explanatory notes state that the amendments in the Bill arise from the following reviews of the National Scheme:

- Independent *Review of the National Registration and Accreditation Scheme for health professions* – completed in 2014, and covered issues including governance, accountability, management of complaints and notifications, and public protection mechanisms[23]
- *Review of Governance of the National Registration and Accreditation Scheme* (Governance Review) – completed in November 2017, and made 14 recommendations about the overall governance of the National Scheme, role and functions of National Scheme entities, the National Scheme's interactions with states and territories and the appointment of state, territory and regional Boards
- *Independent Review of Accreditation Systems within the National Registration and* Accreditation *Scheme for health professions* (Accreditation Systems Review) – completed in 2018, and made 32 recommendations to strengthen the education of the health workforce.[24]

[22] Explanatory notes, p 2.

[23] Independent Review of the National Registration and Accreditation Scheme for health professions, Independent Reviewer Mr Kim Snowball commissioned by the Australian Health Ministers' Advisory Council, December 2014.

[24] Explanatory notes, p 4.

3 Examination of the Bill

3.1 Public safety and confidence in the provision of health services

3.1.1 Guiding principles and objectives

3.1.1.1 Introduction of new paramount principle

The Bill inserts a new paramount principle into the National Law to provide that protection of the public and public confidence in the safety of services provided by registered health practitioners and students are paramount considerations.[25]

Consequently, the Bill omits the existing modification provision to the National Law applying in Queensland, which provides that the health and safety of the public is already the paramount principle in Queensland.[26]

The other existing guiding principles of the National Law are retained. These include that:

- the National Scheme is to operate in a transparent, accountable, efficient, effective and fair way
- the fees required to be paid under the National Scheme are to be reasonable having regard to the efficient and effective operation of the scheme
- restrictions on the practice of a health profession are to be imposed under the National Scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.[27]

Queensland Health stated that 'Under this amendment, Ahpra, national boards and all other entities under the national law will be required to prioritise public safety and confidence in their actions and when they are making decisions'.[28]

Submitters' views

A number of submitters, including Queensland Nurses and Midwives' Union (QNMU), Queenslanders with Disability Network (QDN) and Queensland Law Society (QLS), supported the strengthened focus on public safety and confidence in health services.[29] QDN considered that the amendment would:

> … bring the National Law and National Scheme into alignment with guiding principles and regulatory decision-making across all entities and across all decisions about accreditation and registration standards, registration decisions and decisions to take health, conduct or performance action against a practitioner.[30]

The Australian Dental Association Queensland (ADAQ), while supporting the inclusion of public confidence in health services as a guiding principle, did not support its inclusion as a paramount principle. ADAQ considered that including public confidence as a paramount principle could impact on health practitioners' rights, including their right to practice.[31]

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25 Bill, cl 33 to 35, amend sections 3 and 4 of, and inserts new section 3A into, the National Law.

26 Bill, cl 131, omits sections 13 and 14 of the *Health Practitioner Regulation National Law Act 2009* (Qld).

27 National Law, section 3(3); Bill, cl 34 inserts new section 3A into the National Law.

28 Public briefing transcript, Brisbane, 23 May 2022, p 2.

29 See, for example, submissions 12, 18, and 28.

30 Submission 18, p 4.

31 Submission 3, p 2.

The Royal Australian College of General Practitioners (RACGP) considered that the Bill does not achieve an appropriate balance, noting that health practitioners also need to have confidence in the National Law. RACGP stated:

> Practitioners already lack confidence in the current system, particularly as it relates to complaints. It is perceived to focus more on the prosecution of practitioners than the protection of patient safety through remediation of the issues that lead to the complaint. Undergoing an investigation for a complaint can be an extremely stressful and time-consuming process, that can have significant reputational and professional consequences, regardless of whether the practitioner in question is at fault.[32]

RACGP considered that a lack of practitioner confidence in the National Law may lead to more defensive medicine, which risks misdiagnosis, over-treatment of benign conditions and under-treatment of serious conditions due to fear of vexatious complaints or prosecutions.[33]

Similarly, the Insurance Council of Australia (ICA) raised concerns that the proposed public confidence principle could lead to unfair outcomes for doctors and medical practitioners, undermining confidence in the legislation.[34]

The Australian Medical Association (AMA) agreed that the protection of the public is a critical role of the National Scheme, but considered that the proposed amendments were unnecessary, as the current arrangements already deliver this goal.[35]

AMA considered that the public confidence principle would not help the operation of the National Scheme, as it is not clear what the principle means in practice and its introduction further complicates an already complex scheme.[36]

MIGA and ICA agreed that the term 'public confidence' lacks clear definition and scope and raised concerns about how courts and tribunals would interpret the term.[37]

MIGA suggested that the 'integrity of a health profession' would be a more appropriate paramount consideration. MIGA considered 'This would allow a more nuanced, balanced approach that assesses matters by reference to professional standards and ethics'.[38]

AHPRA considered that the proposed amendment would:

> … provide greater clarity and put beyond doubt that all entities exercising powers under the National Scheme – including but not limited to Ahpra, the National Boards, courts and tribunals – must place public protection and public confidence as paramount considerations in administering the scheme, making regulatory decisions, or otherwise exercising functions under the National Law.[39]

Department's response

Queensland Health noted AHPRA's advice that the paramount principle will provide a strong foundation to its existing regulatory approach and mirrors Health Ministers' *Policy Direction 2019-01 – Paramountcy of public protection when administering the National Scheme*. Queensland Health also noted that AHPRA and the National Boards will further engage with their regulatory partners and

32 Submission 7, p 3.

33 Submission 7, p 3.

34 Public hearing transcript, Brisbane, 8 June 2022, p 91.

35 Submission 13, p 5.

36 Submission 13, p 5.

37 Submissions 16 and 27.

38 Submission 27, p 4.

39 Submission 21, p 2.

external stakeholders to ensure that the Bill's paramount guiding principle is reflected in all relevant policies and procedures.[40]

Queensland Health advised that the proposed amendment was not a major change in Queensland. In 2013, when Queensland became a co-regulatory jurisdiction under the National Law, it modified the principles to make health and safety of the public paramount. Queensland Health stated:

> This paramount principle has guided regulatory decisions since that time and is regularly cited in tribunal decisions, with no evidence of confusion or conflict with the other guiding principles of the National Law. A similar paramount guiding principle also applies under the *Health Ombudsman Act 2013*.[41]

In relation to submitters' concerns about the lack of clarity in the definitions proposed, Queensland Health advised that 'public confidence' and similar concepts such as 'public interest' are included in the guiding principles or objectives of several other laws in Australia, and there is established precedent of interpretation by tribunals. Queensland Health stated that the concept of 'public confidence' is also already included in the National Law, as an example of when a National Board may take immediate action against a practitioner (see section 156 of the National Law).[42]

Queensland Health advised that the Bill would create a specific obligation to place public safety and public confidence foremost in all decisions and actions of AHPRA, the National Boards and other entities exercising functions under the National Law. Queensland Health considered that this will also provide decision-makers with clear grounds to explain their decisions.[43]

Queensland Health stated that the other existing guiding principles include that the National Scheme is to operate in a transparent, accountable, efficient, effective and fair way and that restrictions on the practice of a health profession are to be imposed only if it is necessary to ensure health services are provided safely and are of an appropriate quality.[44]

3.1.1.2 Introduction of new principle and objective on cultural safety

The Bill inserts a new objective and guiding principle into the National Law to acknowledge the National Scheme's role in building the capacity of the Australian health workforce to provide culturally safe health services to Aboriginal and Torres Strait Islander Peoples and the elimination of racism in the provision of health services.[45]

The explanatory notes state:

> The new objective and guiding principle will set clear expectations for National Scheme entities to foster cultural safety for Aboriginal and Torres Strait Islander Peoples accessing health services and to consider how regulatory decisions may impact the health and wellbeing of Aboriginal and Torres Strait Islander Peoples and their confidence in the safety of health services.[46]

Queensland Health advised:

> With the new guiding principle and objective, it provides direct levers to influence cultural safety, including through minimum levels of practice that registered health practitioners must meet and setting standards for educational courses that lead to registration. In this way the national scheme can contribute to real change on the path to achieving health equity for First Nations people.[47]

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40 Queensland Health, correspondence, 10 June 2022, pp 4-5; submission 21, pp 2-3.

41 Queensland Health, correspondence, 10 June 2022, p 4.

42 Queensland Health, correspondence, 10 June 2022, p 4.

43 Queensland Health, correspondence, 10 June 2022, p 5.

44 Queensland Health, correspondence, 10 June 2022, p 5.

45 Bill, cl 36 and 37, amend sections 3 and 3A of the National Law.

46 Explanatory notes, p 5.

47 Public briefing transcript, Brisbane, 23 May 2022, p 2.

Submitters' views

A significant number of submitters, including the Australasian College for Emergency Medicine (ACEM), Speech Pathology Australia and QNMU, supported the proposed amendment.[48]

CRANAplus considered that the development of a culturally safe and respectful health workforce would contribute to the elimination of racism in the provision of health services and is essential in supporting a diverse workforce that aligns with the communities in which services are delivered.[49]

The Australian College of Nursing (ACN) questioned whether there was a timeframe for all entities to ensure that health professions are trained and culturally responsive.[50] ACEM, while supportive of the amendment, suggested that a definition of the tem *culturally safe* should be included in the Bill. [51]

Mr Ray Bange OAM considered that the principle and objective should be broadened to foster cultural safety for other groups.[52]

AHPRA welcomed the proposed amendment, advising that:

> … it is consistent with the National Scheme's *Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* and *Statement of Intent*, to ensure a culturally safe health workforce supported by nationally consistent standards, codes and guidelines across all professions in the National Scheme; and greater access for Aboriginal and Torres Strait Islander Peoples to culturally safe services of health professions regulated under the National Scheme.[53]

AHPRA stated that the National Scheme is well placed to help ensure a health system that is culturally safe and free from racism for Aboriginal and Torres Strait Islander Peoples and recognises that Indigenous Australians have a shorter life expectancy than non-Indigenous Australians and are at least twice as likely to rate their health as fair or poor.[54]

Department's response

Queensland Health noted submitters' support for the new guiding principle and objective, stating that as with the new paramount guiding principle, communication will be essential to the successful implementation of this reform. Queensland Health noted that if the amendment is passed, AHPRA and National Boards will work with the Aboriginal and Torres Strait Islander Health Strategy Group (Strategy Group) on implementation as well as communication.[55]

Queensland Health stated that the amendments aim to directly address cultural safety for Aboriginal and Torres Strait Islander Peoples due to the unique challenges and importance of addressing discrimination and fostering cultural safety in this context. Queensland Health considered that this is appropriate in light of government priorities to promote better health outcomes and health equity for Aboriginal and Torres Strait Islander Peoples. [56]

48 See, for example, submissions 4, 5, 12, 13, 17, 18, 32, 34, 35 and 36.

49 Submission 36, p 3.

50 Submission 34, p 2.

51 Submission 4, p 2.

52 Submission 32, p 2.

53 Submission 21, p 3.

54 Submission 21, p 3.

55 Queensland Health, correspondence, 10 June 2022, p 5; submission 21, p 3.

56 Queensland Health, correspondence, 10 June 2022, pp 5-6.

Queensland Health advised that the new objective and guiding principle were developed in close consultation with the then National Aboriginal and Torres Strait Islander Health Standing Committee and Strategy Group.[57]

In relation to the suggestion to include a definition of the term *cultural safety*, Queensland Health stated it is appropriate for its meaning to be reflected in policies, procedures and other instruments outside of legislation. Queensland Health considered that allowing the meaning of *cultural safety* to be adaptable to changing circumstances will support the objective of the amendment.

Queensland Health advised that the Strategy Group has consulted on, and finalised, a baseline definition of *cultural safety* for use in the National Scheme and developed principles to inform the definition.[58]

3.1.2 Health practitioner registration process

The Bill amends the National Law to:

- provide that a National Board may, following a show cause process, withdraw a practitioner's registration, if the Board reasonably believes the registration was improperly obtained because the practitioner, or someone else, gave the Board false or misleading information[59] – the Board's decision would be subject to appeal to a responsible tribunal[60]
- clarify that health practitioners who have had their registration suspended, and whose registration would otherwise have expired during their period of suspension, must apply to renew their registration within one month of their suspension ending.[61]

3.1.2.1 Submitters' views

AMA, Australia Association of Psychologists (AAP) and CRANAplus supported the proposed amendment.[62]

AMA noted the serious risks that improperly qualified practitioners pose to the health of the community. AMA considered that the inclusion of a show cause process 'provides a balance between streamlining proceedings and ensuring that individuals have some avenue for 'appeal''.[63]

AAP considered that the requirement for suspended practitioners to submit renewal documents within one month of their suspension ending would '… ensure recency of practice, professional development, and criminal history are addressed in a time manner and registration reinstated if appropriate'.[64]

57 Queensland Health, correspondence, 10 June 2022, p 6.

58 Queensland Health, correspondence, 10 June 2022, p 6.

59 Bill, cl 70, inserts new ss 85A to 85E into the National Law.

60 Bill, cl 74, amends section 199 of the National Law.

61 Bill, cl 80 inserts new sections 112A to 112D into the National Law.

62 Submissions 13, 15 and 36.

63 Submission 13, p 14.

64 Submission 15, p 4.

The Australian College of Rural and Remote Medicine (ACRRM) opposed the amendments. They considered that it is an example of the guiding principle of public confidence in the safety of health services undermining fair and proper principles of natural justice. ACCRM stated:

> This amendment may potentially lead to registered health practitioners' having their registration wrongly removed, being denied a fair hearing by the responsible tribunal prior to removal of registration, and then having to appeal that decision to the responsible tribunal.[65]

3.1.2.2 Department's response

Queensland Health stated that the amendments are necessary to ensure only suitably trained and appropriately qualified practitioners are registered. Queensland Health advised:

> Currently, a National Board is unable to re-consider a decision to approve a practitioner's registration, even if it becomes aware that the information it based its decision on was false or misleading. Instead, it must take other disciplinary action, such as suspending the practitioner and initiating proceedings before a tribunal. Queensland Health advised that the proceedings may last many months, during which time the status of the practitioner's registration remains uncertain and the practitioner is afforded the same procedural rights as practitioners who obtained their registrations properly.[66]

Queensland Health stated that the amendments will enable National Boards to deal with these situations more effectively, and to do so in a manner that protects the integrity of the registration process. Queensland Health highlighted the following safeguards in the Bill:

> To ensure procedural fairness, the power will be subject to a show cause process. A National Board must give a practitioner written notice of a proposal to withdraw their registration, setting out the reasons for the proposal and inviting the practitioner to make a written or verbal submission to the Board about the proposal. After considering the practitioner's submissions, the Board must give the practitioner written notice of its decision as soon as practicable, but no later than 30 days after making the decision. If the decision is to withdraw the practitioner's registration, the notice must state the reasons for the decision, that the practitioner may appeal the decision, and how and when the appeal may be made. A practitioner may appeal a National Board's decision to a responsible tribunal.[67]

3.1.3 Regulatory responses to risks

The Bill makes a number of amendments aimed at increasing and strengthening the regulatory responses available to AHPRA, National Boards and the Health Ombudsman.[68]

3.1.3.1 Interim prohibition orders and prohibition orders

The Bill inserts a new power into the National Law to enable AHPRA and a National Board to issue, following a show cause process, an interim prohibition order (IPO) to unregistered practitioners, including practitioners whose registration has lapsed or been suspended.[69] An IPO may be issued, without a show cause process, if AHPRA or a National Board reasonably believes it is necessary to protect public health or safety.[70]

An IPO may prohibit, or restrict, a person from providing a specified health service or all health services or prohibit a person from using protected titles.[71] The Bill makes provision in relation to the duration of IPOs (generally expiring 60 days after issue) and the revocation, variation and extension of IPOs.[72]

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65 Submission 35, p 4.

66 Queensland Health, correspondence, 10 June 2022, p 9.

67 Queensland Health, correspondence, 10 June 2022, p 9.

68 Explanatory notes, p 6.

69 Bill, cl 94 inserts new sections 159C and 159D into the National Law.

70 Bill, cl 94, inserts new section 159E into the National Law.

71 Bill, cl 94, inserts new section 159B into the National Law.

72 Bill, cl 94, inserts new sections 159F to 159M into the National Law.

The Bill provides that a contravention of an IPO is an offence with a maximum penalty of $60,000, 3 years' imprisonment, or both.[73] A decision to issue or extend an IPO will be subject to appeal to a responsible tribunal.[74]

Queensland Health advised that if AHPRA or a National Board issues an IPO to an unregistered practitioner practising in Queensland, it must notify the OHO and may refer the notification to the OHO, while the IPO is in place.[75]

In addition, the Bill provides that AHPRA must publish information about an IPO on its website (e.g. the practitioner's name, day the IPO starts and the action prohibited or restricted). This requirement does not apply if AHPRA reasonably believes there is no public interest in publishing the information or the publication of the information would present a serious risk to the health and safety of the practitioner or a member of their family or a close associate. [76]

The Bill also amends the National Law to allow a prohibition order issued by a tribunal to place restrictions on a practitioner's provision of health services.[77] The explanatory notes state 'This complements the existing power of the tribunal to make an order that completely prohibits a practitioner from providing all or specified health services or using a protected title'.[78]

Submitters' views

AAP, QDN, CRANAplus, Australian Medical Professionals' Society and Nurses' Professional Association and Australian Society of Rehabilitation Counsellors (ASORC) supported the proposed power for AHPRA and National Boards to issue IPOs to unregistered practitioners.[79] AAP considered the proposal '… will ensure that the public can have confidence that their provider is appropriately qualified and registered'.[80]

However, a number of submitters, including ACRRM, QNMU and Royal Australian College of Surgeons (RACS), raised concerns.[81]

ACRRM considered that IPOs are unnecessary given the National Boards' existing powers to take immediate action, stating that it had concerns that 'the addition of interim orders may result in further bureaucracy, delays in reaching a conclusion and as such extend the period of uncertainty for the health practitioner involved'.[82]

QNMU questioned the need to expand the role of AHPRA and the National Boards to issue IPOs to unregistered practitioners given that the OHO already has the discretion to deal with registered and unregistered health practitioner complaints.[83]

73 Bill, cl 94, inserts new section 159O into the National Law.

74 Bill, cl 95 amends section 199 of the National Law.

75 Public hearing transcript, Brisbane, 23 May 2022, p 3.

76 Bill, cl 94, inserts new section 159N into the National Law.

77 Bill, cl 99, amends section 196 of the National Law.

78 Explanatory notes, p 6.

79 Submissions 15, 18, 23, 36 and 39.

80 Submission 15, p 4.

81 Submissions 12, 35 and 40.

82 Submission 35, p 4.

83 Submission 12, attachment, p 13.

While broadly supporting the amendment, AMA and National Health Practitioner Ombudsman (NHPO) raised concerns about the provisions which enable notice of an IPO to be provided verbally to a practitioner, as part of any show cause process.[84]

The NHPO noted that other health complaints legislation requires notices to be made in writing, with the practitioner permitted to elect to provide a response verbally or in writing. The NHPO considered that permitting verbal notice could unnecessarily undermine the show cause process because:

- it may prove difficult to accurately convey the details of a proposed IPO verbally
- practitioners may find it more difficult to provide a comprehensive response to the proposed IPO when written notice has not been provided.[85]

AMA recommended that AHPRA and the National Boards should also be able to issue IPOs to registered health practitioners who are operating outside of their registered health profession.[86]

QLS supported the amendment to allow a prohibition order issued by a tribunal to place restrictions on a practitioner's provision of health services. It noted, however, that there is no corresponding amendment to the mirror provision at section 107(4) of the HO Act.[87]

ACRRM raised concerns about the inclusion of three years' imprisonment as a penalty for a contravention of an IPO.[88]

AHPRA advised that the new power was designed to complement other National Law powers to protect the public, stating that the power to issue an IPO would enable them to prevent a person offering health services in an unregistered capacity (e.g. if the person had surrendered their registration to avoid restrictions).

AHPRA advised that it has a criminal prosecution function for dealing with unregistered persons who hold themselves out as being registered, misuse a protected title or perform a restricted practice. AHPRA advised that it could use the proposed power to issue an IPO to prevent such a person from continuing to engage in the conduct while the investigation and prosecution was ongoing. AHPRA provided the following example:

> Ahpra may consider issuing an IPO if it is investigating a person conducting dental practice without being registered as a dentist. Such a person can present a significant risk to the public and an IPO should be an effective public order in preventing that person continuing to engage in that activity.[89]

AHPRA stated that it '… expects to use this new power judiciously and only when necessary to respond to a serious risk and protect public health or safety' and will review relevant operational policies and procedures to support decision-making.[90]

The Health Ombudsman supported the proposed amendments, stating that it was confident that it could implement a process to ensure the OHO and AHPRA work together effectively. The Health Ombudsman also supported the increased maximum penalties for contravening an IPO or prohibition order, considering that the increased penalties appropriately reflect the seriousness of the offence.[91]

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84 Submissions 13 and 39.

85 Submission 39, pp 1-2.

86 Submission 13, p 15.

87 Submission 28, p 2.

88 Submission 35, p 5.

89 Submission 21, p 4.

90 Submission 21, p 4.

91 Submission 33, pp 2-3.

Department's response

Queensland Health advised that the ability to issue IPOs will allow AHPRA or a National Board, to take swift action to control a serious risk while other action is being finalised or a matter is handed over to another regulator, such as the OHO, who is better placed to undertake more comprehensive regulatory action.[92]

In relation to concerns about providing a show cause notice verbally, Queensland Health stated the requirements align with those for taking immediate action against a registered health practitioner, in that the notice to the person and any submissions from the person can be written or verbal.[93]

Queensland Health advised that although it is expected that the notice from the regulator will usually be in writing, there may be circumstances where a verbal notice would be more appropriate.[94]

Queensland Health stated that the ability to issue an IPO will only apply to unregistered persons, as there are existing immediate actions available if a registered practitioner operates outside of their registered health profession. These actions include suspending or imposing a condition on the practitioner's registration. Queensland Health considered that 'this is a more appropriate regulatory action to take when dealing with a registered health practitioner'.[95]

Queensland Health stated that the amendments would complement the existing powers of the Health Ombudsman to issue IPOs in Queensland. Queensland Health noted AHPRA's commitment to exercise this power judiciously and collaborate with the OHO to ensure that the agency best placed to issue the IPO does so, and to reduce the risk of unnecessary duplication.[96]

Queensland Health advised that it:

> … is expected the majority of interim prohibition orders in Queensland will continue to be issued by or in collaboration with the Health Ombudsman. Ahpra and the Health Ombudsman have a well-established working relationship. The joint consideration process will further assist coordination about which entity is best placed to issue an interim prohibition order.[97]

3.1.3.2 Public statements

The Bill amends the National Law and HO Act to provide that AHPRA, National Boards or the Health Ombudsman may issue public statements about a person in the following circumstances:

- the regulator reasonably believes the person has contravened a relevant provision (e.g. use of a protected title or unprofessional conduct or professional misconduct)
- the person is the subject of investigations or disciplinary proceedings, and
- the person's conduct poses a serious risk to public health and safety.[98]

92 Queensland Health, correspondence, 10 June 2022, p 15.

93 Queensland Health, correspondence, 10 June 2022, p 15.

94 Queensland Health, correspondence, 10 June 2022, p 15.

95 Queensland Health, correspondence, 10 June 2022, p 15.

96 Queensland Health, correspondence, 10 June 2022, p 15.

97 Queensland Health, correspondence, 10 June 2022, p 15.

98 Bill, cl 100 inserts new sections 159P to 159T into the National Law and cl 20 inserts new sections 90AA to 90AD into the HO Act.

A decision to issue a public statement would be subject to a show cause process[99] and subject to appeal to a responsible tribunal.[100]

The Bill provides that no liability is incurred by AHPRA, a National Board or the Health Ombudsman, in making a public statement in good faith.[101]

In addition, the Bill provides that AHPRA, a National Board or the Health Ombudsman must revoke a public statement if they are satisfied that the grounds on which the statement was made no longer exist or did not exist at the time the statement was issued.[102]

The Bill also makes provision for the timeframes for the show cause process and issuing a notice of a final decision as to whether to issue a public statement.[103]

Submitters' views

QDN, CRANAplus and ASORC supported the introduction of the power to issue public statements about persons whose conduct poses a serious risk to public health and safety.[104]

CRANAplus considered that it was critical to allow regulators to warn the public about the risks posed by a person under investigation or disciplinary proceedings to 'protect remote and isolated workforces and vulnerable communities'.[105]

The Health Ombudsman supported the proposed amendment, stating that given the OHO frequently receives complaints about very serious conduct, it is prudent for the Health Ombudsman to have the power to warn the public about practitioners who pose a serious risk to persons. The Health Ombudsman noted that health commissioners in South Australia, NSW and Victoria already have the power to issue a public statement.[106]

Submitters, such as ADAQ, Speech Pathology Australia, Australian Doctors' Federation (ADF), AMA, AMAQ and AAP, raised significant concerns about the proposed amendments[107] with some submissions referring to them as a power for AHPRA and the OHO to 'name and shame' practitioners.[108]

Submitters considered that the issuing of a public statement could cause significant harm to health practitioners, including: permanent reputational damage; loss of income and employment; and mental health issues.[109] For example, ADAQ stated:

> … not only could this lead to unfounded and irreparable reputational damage to the individual, but it could also have harmful effects on practitioners' mental health. Given how fast information can disseminate on-line and how on-line information remains indefinitely on the internet and is not bound

99 Bill, cl 100 inserts new section 159R into the National Law; Bill, cl 20 inserts new section 90AB into the HO Act.

100 Bill, cl 101 and 102 amend section 199 and 200 of the National Law; cl 24 and 25 amend sections 94 and 97 of the HO Act.

101 Bill, cl 100 inserts new section 159Q into the National Law.

102 Bill, cl 100 inserts new section 159T into the National Law.

103 Bill, cl 100 inserts new section 159R into the National Law; Bill, cl 20 inserts new section 90AB into the HO Act.

104 Submissions 18, 36 and 38.

105 Submission 36, p 3.

106 Submission 33, p 3.

107 Submissions 1, 3, 5, 8, 9, 13, 15, 17, 23, 25 and 31.

108 Submissions 3, 8 and 9.

109 Submissions 25 and 40.

> by location, naming and shaming health practitioners has the capacity to follow an individual everywhere and forever.
>
> Whilst it is acknowledged that naming and shaming can sometimes lead to positive behaviour change and alert the community to perceived risks, its effects are unpredictable and irreversible. Naming and shaming practitioners could also have the impact of causing negative consequences, such as depression and anxiety and in extreme cases, even lead to suicide.[110]

ADF considered that the publicly naming of a practitioner is a judgement of guilt that cannot be reversed by any subsequent finding of innocence.[111] Similarly, AMA stated the issuing of a public statement would imply guilt and is likely to ruin a practitioner's reputation. AMAQ and QLS raised concerns that the amendment contravened the principles of the presumption of innocence and natural justice.[112]

AMA considered that a public warning is a severe and non-retractable step and should be undertaken only after a health practitioner has been shown to have breached a code of conduct or convicted of a relevant offence.[113]

Submitters, including Speech Pathology Australia, considered that the publication of any complaint should not be allowed before a complete and thorough investigation is conducted and a determination of the facts and evidence before a tribunal.[114]

AMA and Doctors' Health in Queensland considered that no evidence had been produced to demonstrate that a significant problem exists to warrant this level of regulation.[115] Doctors' Health in Queensland considered that the proposed amendments conflict with reports published by the Australian Commission on Safety and Quality in Healthcare, which contended that:

> …the biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm.[116]

A number of submitters noted that AHPRA, National Boards and OHO already have regulatory powers to prevent an individual from practising, where the regulator is of the view that they present a risk to the public.[117] ADAQ considered that;

> … the current process of suspending a practitioner where there is a risk to the public is the most appropriate remedy as by suspension, the health and safety of the public is maintained and the public is protected.' [118]

AMA and AMAQ noted that following this process, at the conclusion of a tribunal process, a National Board may issue a media statement, which is entirely appropriate.[119]

110 Submission 3, p 2.

111 Submission 9, p 4.

112 Submissions 17 and 28.

113 Submission 13, p 8.

114 Submissions 1 and 5.

115 Submissions 13 and 25.

116 Submission 25, p 3.

117 Submissions 8 and 2.

118 Submission 3, p 3.

119 Submissions 13 and 17; public hearing transcript, Brisbane, 8 June 2022, p 22.

RACGP called for further clarification of the threshold to be reached prior to making a public statement, and Avant Mutual considered that there should be a high threshold for action. [120] Avant Mutual stated:

> It is important that a public statement is proportionate to the risk and the power is only exercised when the risk to the public outweighs the risk of harm to the practitioner. It should only be used when there is no other means of averting this risk.[121]

RACP considered that the safeguards in the Bill, e.g. show cause, appeals processes and requirements to revoke a statement, would not prevent the unforeseen damage that could occur from issuing a public statement about a practitioner who was later found not to be at fault.[122]

AMAQ considered that the requirement for a public statement to be revoked if the grounds no longer existed, or never existed, are wholly insufficient to remedy the harm caused by an inaccurate public statement. AMAQ stated that 'The unfounded accusations would remain available, permanently, in the public domain, and a revocation by the regulator cannot effectively and practically correct the public record'.[123]

AMA and RACS noted that, in reality, media organisations that publish the initial statement will not be under any obligation to publish any correction or revocation.[124]

Avant Mutual also raised concerns about a situation where grounds for making the public statement did not exist at the time the statement was made. While noting that the decision is appealable, Avant Mutual considered that this was not sufficient to protect against the significant reputational damage likely to be caused by a public statement, if the power is not exercised cautiously.[125]

Some submitters considered that the safeguards for practitioners should be strengthened, including:

- a requirement for a clinical expert or committee to advise on the potential risks to the public
- a minimum time for practitioners to respond to a show cause notice
- a longer time between a decision to make a public statement and the making of that statement (to allow for tribunal review)
- a requirement for the regulator to issue a public apology, if it determines that a public statement should not have been issued
- timescales for revoking the original statement
- recourse for practitioners to apply for defamation actions, damages and legal costs if a claim is later determined to be unfounded.[126]

QLS recommended that further consideration be given to the impact of these provisions, balancing the need to ensure public safety with the rights of individual practitioners and the significant and irreversible damage that may be caused to this person.[127]

AHPRA disagreed that the proposed amendment was a power to 'name and shame' practitioners, stating that the threshold for issuing a public statement is set appropriately high. AHPRA stated that

120 Submissions 7 and 31.

121 Submission 31, p 8.

122 Submission 7, p 4.

123 Submission 17, p 1.

124 Submissions 13 and 40.

125 Submission 31, p 8.

126 Submissions 7, 13, 17 and 31.

127 Submission 28, p 4.

it could see 'a narrow but important role for those powers', stating that 'In a small number of circumstances it would help us to protect the public if we could public explain risk and warn patients'.[128] AHPRA provided the following example of a circumstance where it may issue a public statement:

> Ahpra may be investigating a notification about a registered health practitioner, and it comes to light that infection control procedures have not been followed appropriately which poses a serious risk that patients have been exposed to an infectious disease. In addition to working with public health officers, Ahpra could issue a public statement to warn the public of the potential health risk and continue to bring disciplinary proceedings against the practitioner.[129]

The Health Ombudsman also undertook to use the power judiciously, stating the power would be used in the '… types of circumstances where the explanation of the nature of risk was assessed as necessary to address the public health and safety'. The Health Ombudsman noted that the Victorian Health Complaints Commissioner uses the power to issue public statements judiciously, issuing approximately 10 public statements over recent years.[130]

Department's response

Queensland Health stated that allowing the Health Ombudsman, AHPRA and the National Boards to issue a public statement will enhance public protection and increase public trust in health services by increasing visibility of actions taken against practitioners and unregistered individuals.

Queensland Health highlighted that, under the amendments, a public statement can only be made about persons:

- who are the subject of an assessment, investigation or disciplinary proceeding, or
- whom the regulator reasonably believes have committed certain offences under the National Law, such as unlawfully using a protected title or performing a restricted practice, engaging in prohibited advertising, or directing or inciting professional misconduct.

Also, the regulator must reasonably believe both that:

- the person poses a serious risk to others because of their conduct, performance, or health, and
- it is necessary to issue a public statement to protect public health or safety.

Queensland Health stated:

> This is a high threshold, which limits the circumstances for issuing a public statement to those that are inherently serious and have potentially serious public health consequences. Given these strict criteria for issuing a public statement, it is expected that this power would only be used sparingly in cases where the public clearly has a right to be warned of immediate and serious risks to public health or safety.
>
> For example, the ability to issue an early warning to the public may have been useful during the investigation of a drug-addicted anaesthetist who was sentenced to prison in 2013 for infecting over 50 patients with hepatitis C. The anaesthetist had injected himself with the opiate fentanyl before using the same needles to administer the drug to his patients. The ability to make a public statement in circumstances such as these may lead to the identification of additional victims, allowing them to seek medical assistance.[131]

Queensland Health advised that the Bill also includes other safeguards for those who may be the subject of a public statement. For example, prior to making a public statement, the regulator must undertake a show cause process, allowing the practitioner to make written or verbal submissions

[128] Public hearing transcript, Brisbane, 8 June 2022, p 35.

[129] Submission 21, p 4.

[130] Public hearing transcript, Brisbane, 8 June 2022, p 36.

[131] Queensland Health, correspondence, 10 June 2022, p 16.

about the proposed statement. The regulator must also consider the submissions before making a decision.[132]

In addition, Queensland Health advised that the regulator must wait at least one business day before publishing the statement, during which time a practitioner may seek an injunction from a court or tribunal. Queensland Health stated 'This provides an additional check against the possibility of a public statement being issued based on erroneous information or without the threshold conditions being met'.[133]

Queensland Health noted that although some submitters argued that the minimum one-day waiting period is not sufficient, it is not the intent of the provision to allow practitioners to routinely seek injunctions, as this would frustrate the ability of regulators to issue timely warnings to the public.[134]

Queensland Health stated that where there is a gross mistake of fact or abuse of discretion such that the regulator proposes to act without sufficient cause, the practitioner's prepared response for the show cause process would likely serve as the basis for an urgent application to a court or tribunal. Queensland Health considered that the show cause period plus the extra one business day should provide sufficient time to make this application.[135]

Queensland Health contended that providing additional time or extending the additional procedural protections to practitioners would frustrate the fundamental purpose of the public statement power by preventing regulators from acting quickly in urgent circumstances that pose a serious risk to public safety. Further, Queensland Health noted that the statutory timeframe is only a minimum and the regulator could provide additional time if the circumstances are not urgent and the delay in issuing the statement would not compromise public safety.[136]

Queensland Health highlighted other safeguards in the Bill for practitioners, namely:

- The regulator must revoke a public statement if it is satisfied the grounds for the statement no longer exist or did not exist at the time the statement was made. In such cases, the statement must be revoked publicly in the same or a similar way to how it was made.
- A decision to make a public statement can also be appealed to the responsible tribunal.[137]

Queensland Health stated that AHPRA has committed to making necessary system changes to support the issuing of public statements and their revocation as needed. AHPRA will also develop operational processes and procedures as part of its implementation activities to ensure the judicious exercise of this power and appropriate procedural fairness for those who are the subject of a public statement.[138]

Committee comment

The committee notes the significant concerns raised by submitters about the impact that issuing a public statement may have on a practitioner, including reputational damage, potential loss of income and employment and the impact on practitioners' mental health and wellbeing.

The committee also acknowledges the impact that these powers may have on practitioners' rights to procedural fairness and natural justice, given that public statements may be issued prior to the completion of an investigation or any determination of a matter by a tribunal.

132 Queensland Health, correspondence, 10 June 2022, p 16.

133 Queensland Health, correspondence, 10 June 2022, p 16.

134 Queensland Health, correspondence, 10 June 2022, p 16.

135 Queensland Health, correspondence, 10 June 2022, p 16.

136 Queensland Health, correspondence, 10 June 2022, p 16.

137 Queensland Health, correspondence, 10 June 2022, p 17.

138 Queensland Health, correspondence, 10 June 2022, p 17.

However, on balance, the committee considers that the powers are appropriate and will assist AHPRA, National Boards and the Health Ombudsman in protecting and promoting the health and safety of the public. In reaching this view, the committee noted that the threshold for using the power is high.

The committee also noted the undertakings provided by both AHPRA and the Health Ombudsman to use the power to issue public statements judiciously, in the small number of circumstances where issuing such a statement is necessary to protect the public from people who pose a serious risk to health and safety.

3.1.3.3 Disciplinary action against unregistered health practitioners

The Bill amends the National Law to empower National Boards to take disciplinary action against a person who continues to practice or use a protected title after their registration has lapsed.[139] The Bill also clarifies when disciplinary actions may be undertaken against a registered health practitioner for behaviour that occurred whilst they were not registered.[140]

The explanatory notes state:

> The amendments will ensure that National Boards can respond to a practitioner's failure to renew their registration on time in a manner that is proportionate to the severity of the practitioner's conduct and that takes into account other relevant considerations, including competing enforcement priorities and the need to provide effective deterrents to protect the public and promote confidence in the National Scheme.[141]

The explanatory notes clarify that:

> The amendments are not intended to preclude or discourage the National Agency from investigating and prosecuting offences or the National Boards from imposing conditions on a practitioner's registration in appropriate cases. The National Agency and the National Boards will retain these powers and will be able to apply them in addition to, or instead of, any disciplinary action taken by a Board in relation to the same conduct.[142]

Submitters' views

Submitters, such as AAP and AMA, supported the proposed amendments. AAP supported providing National Boards with the discretion to deal with a practitioner who has inadvertently practised while unregistered, noting that it would allow a proportionate response to brief or inadvertent lapses of registration.[143] AMA considered that individuals who hold themselves out to be a practitioner without proper registration should not avoid disciplinary action by letting their registration lapse.[144]

AHPRA stated that the proposed amendment would help ensure that the National Boards can respond to a practitioner's failure to renew their registration on time in a way that is proportionate to the severity of a practitioner's conduct. Under the proposals, Boards would be able to take into account other relevant considerations, including competing enforcement priorities and the need to provide effective deterrents to protect the public and promote confidence in the National Scheme.[145]

RACGP opposed the amendments, stating that the National Boards already have powers to prosecute more serious instances of practicing without registration, and where less serious instances occur,

139 Bill, cl 87 to 89 amend sections 117 to 119 of the National Law.

140 Bill, cl 90 amends sections 138 and 139 of, and inserts new sections 139A and 139B into, the National Law.

141 Explanatory notes, p 7.

142 Explanatory notes, p 7.

143 Submission 15, p 6.

144 Submission 13, p 14.

145 Submission 21, p 5.

there are provisions to apply conditions where necessary when renewing a practitioner's registration. RACGP considered:

> There is potential for this amendment to be unacceptably overused, whereby there would be the ability to apply unnecessary conditions to practitioners whose registration has lapsed at no fault of their own.[146]

QNMU argued that disciplinary action should only take place if there is evidence of intent, rather than an honest mistake including, for example, if an illness may have led to an unintended lapse in registration.[147]

Avant Mutual considered that the proposed power to take action against a person who is registered in relation to behaviour that occurred before registration is too broad, unfair and inappropriate.[148]

Department's response

Queensland Health advised that the amendments serve two main purposes:

- removing any doubt that proceedings may be taken against a practitioner for serious misconduct that occurred before a practitioner was registered, e.g. a practitioner may be charged with sexual assault or another serious offence based on acts they committed before they were granted registration in their profession
- providing that a practitioner who continues to practice or use a protected title while their registration has lapsed is engaging in unprofessional conduct and may be the subject of disciplinary proceedings under the National Law.[149]

Queensland Health stated that a practitioner should not continue to practise or use a protected title after their registration has lapsed. Queensland Health considered that allowing these matters to be dealt with through disciplinary proceedings provides an alternative to the current powers, which are limited to prosecuting the practitioner for an offence (such as holding out) or waiting to impose conditions on the practitioner's registration if they apply to renew their registration.[150]

Queensland Health stated that the current powers are inadequate. Prosecuting a practitioner is unnecessarily punitive in cases where a lapse in registration is brief and inadvertent. Waiting to impose a condition when the practitioner applies to renew their registration undermines the integrity of the registration process and could put the public at risk if immediate conditions are warranted.[151]

Queensland Health advised that, in many cases, a more appropriate response would be to take disciplinary action against the practitioner under the National Law, as permitted by the Bill.[152]

Queensland Health considered that the amendments will ensure that National Boards can respond to a practitioner's failure to renew their registration on time in a manner that is proportionate to the severity of the practitioner's conduct and that takes into account other relevant considerations, including competing enforcement priorities and the need to provide effective deterrents to protect the public and promote confidence in the National Scheme.[153]

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146 Submission 7, p 3.

147 Submission 12, attachment, p 12.

148 Submission 31, p 5.

149 Queensland Health, correspondence, 10 June 2022, p 13.

150 Queensland Health, correspondence, 10 June 2022, p 13.

151 Queensland Health, correspondence, 10 June 2022, p 13.

152 Queensland Health, correspondence, 10 June 2022, p 13.

153 Queensland Health, correspondence, 10 June 2022, p 14.

3.1.3.4 Increasing maximum penalties for offences

The Bill would increase the maximum penalties for the following offences under the National Law:

- advertising offences – maximum penalty increased for an individual from $5,000 to $60,000 and for a body corporate from $10,000 to $120,000[154]
- directing and inciting offences – maximum penalty increased for an individual from $30,000 to $60,000 and for a body corporate from $60,000 to $120,000.[155]

The explanatory notes state that 'These changes bring the penalties into line with the penalties for other serious offences under the National Law and underscore the focus on deterring unscrupulous practice'.[156]

The Bill also amends the HO Act to increase the existing maximum penalties for contravening an IPO or prohibition order – an increase from 200 penalty units to 450 penalty units or three years' imprisonment.[157] The Bill also provides that the offence of contravening an IPO or prohibition order are designated as indicatable offences that are misdemeanours.[158]

The explanatory notes state:

> The increase in penalties reflects the seriousness of these offences, which apply to persons who wilfully ignore a lawful order and continue to practise in a way that could seriously harm the public. The amendments also ensure that the same conduct is not subject to different penalties depending on which regulator issues an order.[159]

In relation to the increased penalties for advertising offences, Queensland Health stated that:

> Ministers considered the policy recommendation that they should be increased because deceptive advertising practices can have devastating impacts on people. For example, misleading claims about the benefit of particular treatments or the risks of certain treatments could influence a person's decision as to whether they might undertake a particular treatment approach or it might influence them to decide to go ahead with a risky or unnecessary procedure. This brings penalties in line with those for other serious offences under the national law such as misusing a protected title, which was increased to the same level through a previous amendment bill. That was deemed to recognise the serious risks with regard to advertising and the potential impact and outcomes for individual consumers.[160]

With regard to directing and inciting offences, Queensland Health stated:

> … it is a concern that a health practitioner may be directed or encouraged to undertake a practice that amounts to unprofessional conduct or professional misconduct. That also increases the penalty. This recognises that for many health practitioners there is an increased corporatisation of health services and the potential for non-practitioner directors and managers of a health service to try and influence the health practitioners they employ to practise in a way that might compromise client care or clinical independence. It might be promoting a certain technical item that may not necessarily be needed by that individual but is promoted or where the owner may have a pecuniary interest. It was considered necessary to increase those penalties to retain an effective deterrent against those practices and also to bring the penalties into line with other penalties for serious offences under the national law.[161]

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154 Bill, cl 85 amends section 133 of the National Law.

155 Bill, cl 86 amends section 136 of the National Law.

156 Explanatory notes, p 8.

157 Bill, cl 18 and 21 amend sections 78 and 90P of the HO Act.

158 Bill, cl 28 amends section 271 of the HO Act.

159 Explanatory notes, p 8.

160 Public briefing transcript, Brisbane, 23 May 2022, pp 7-8.

161 Public briefing transcript, Brisbane, 23 May 2022, pp 7-8.

Queensland Health also advised that the proposed maximum penalties are commensurate with penalties in other legislation, such as Australian Consumer Law and the *Food Act 2006* (Qld).[162]

Submitters' views

Submitters, including QNMU, AAP and Australian Lawyers Alliance (ALA), supported the proposed increases to maximum penalties. They considered that a significant increase in penalties for advertising offences will make it more difficult for practitioners to view these penalties as a cost of doing business and may lead to greater compliance with advertising regulations and guidelines.[163]

3.1.4 Information sharing to protect the public

3.1.4.1 Reporting of schedule medicine offences

The Bill amends the National Law to provide that a health practitioner or student must notify the relevant National Board if they are charged or convicted with any offences related to regulated medicines or poisons.[164]

Submitters' views

Submitters, such as QDN and CRANAplus, supported the proposed amendments.[165] CRANAplus considered the amendments to be of critical importance for remote and isolated practice, which are at increased risk with respect to the potential harms associated with these offences. CRANAplus noted that the expanded reporting requirements will work in tandem with amendments allowing employers to be notified of certain risks, which enable employers to make informed decisions that protect public safety.[166]

Several submitters, including QNMU, AMA, AMAQ and Avant Mutual did not support, or raised concerns about, the proposed amendments.[167]

Avant Mutual and QNMU considered that the threshold to report all scheduled medicine offences was too low and would require practitioners to report relatively minor offences or unintended errors. QNMU recommended that a scheduled medicine offence should only be reported where there is evidence of repeated offences or misappropriation of medicines.[168] QNMU stated:

> There are many contributing factors to health practitioners mistakenly committing what could be a scheduled medicine offence. Some of those contributing factors are: unsafe staffing workloads, skill mix, lack of in-service education, poor governance, and poor policies and procedures. The QNMU strongly recommends clarity in the legislation between reporting offences where there is evidence of wilful intent as distinct from unintended errors or mistake.[169]

AMA noted that practitioners would be required to notify when charged with an offence that they may subsequently be found not to have committed. AMA recommended narrowing the requirements, so that practitioners are not required to notify charges for offences that do not attract imprisonment and only notify of scheduled medicine offences with a minimum specified fine that relate to the provision of a health service (unless that behaviour was also punishable by imprisonment).[170]

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162 Public briefing transcript, Brisbane, 23 May 2022, p 8.

163 Submissions 6, 12, 15, 24 and 33.

164 Bill, cl 81 amends section 130 of the National Law.

165 Submissions 18 and 36.

166 Submission 36, p 3.

167 Submissions 12, 13, 17 and 31.

168 Submission 12, p 11.

169 Public hearing transcript, Brisbane, 8 June 2022, p 15.

170 Submission 13, p 6.

AMA was also concerned that allowing jurisdictions to exclude certain offences from being a scheduled medicine offence could result in wide variation across jurisdictions and the inadvertent capture of minor offences.[171]

Department's response

Queensland Health advised that currently the National Law only requires the reporting of convictions for offences that are punishable by imprisonment. There is no requirement to report charges for offences for which the maximum term of imprisonment is less than 12 months.

The explanatory notes state:

> Many offences related to regulated medicines and poisons (scheduled medicines) are punishable by payment of a fine rather than imprisonment and are therefore not reportable under the existing legislation. As a result, National Boards may not be notified of a practitioner's or student's scheduled medicine offence history, even though it may be relevant to the person's suitability to hold registration.[172]

Queensland Health provided the following example:

> … under section 35 of the *Medicines and Poisons Act 2019* (Qld), the unauthorised supply of medicines or poisons is an offence punishable by up to 500 penalty units ($68,500). Although this is a serious offence, currently there is no obligation to report it because it is not punishable by imprisonment. Under the amended reporting requirements, a practitioner who is charged or convicted of this offence (or other offences under the Medicines and Poisons Act) would be required to report the charge or conviction to the National Board.[173]

Queensland Health noted the proposed amendment was recommended by the OHO in its 2016 *Investigation report: undoing knots constraining medicine regulation in Queensland*, which discusses the risks drug impaired practitioners may present to themselves and the public.[174]

Queensland Health considered that early reporting of these offences will allow National Boards to respond quickly to risks posed to the public by practitioners or students who misuse scheduled medicines, for example by imposing conditions restricting access to scheduled medicines. If the Health Ombudsman or National Board considers the health and safety of the public to be at risk, it may take interim action against the practitioner's registration while awaiting a final determination of the possible offence.[175]

Queensland Health highlighted that the notification of a charge or conviction does not mean that the regulator will necessarily take action against a practitioner or student. Instead, the regulator will consider whether the possible offence may have a bearing on the practitioner's suitability to practise their profession safely and ethically. The regulator may:

- request additional information from the practitioner about the matter
- resolve no further action be taken
- refer the matter for further investigation or assessment.[176]

In relation to the provisions allowing jurisdictions to exclude offences from being a scheduled medicine offence for the notification requirement, Queensland Health stated that they are necessary due to the significant differences in the types of offences that exist under each state and territory's

171 Submission 13, p 6.

172 Explanatory notes, p 8.

173 Queensland Health, correspondence, 10 June 2022, p 10.

174 Queensland Health, correspondence, 10 June 2022, p 10.

175 Queensland Health, correspondence, 10 June 2022, p 10.

176 Queensland Health, correspondence, 10 June 2022, p 10.

respective medicines and poisons laws. Queensland Health stated that allowing individual jurisdictions to restrict the scope of reportable scheduled medicine offences would enable the new reporting requirements to be no broader than necessary to protect the public.[177]

3.1.4.2 Disclosure of information to protect the public

Currently, under the National Law, a National Board may require a health practitioner to provide information about their current employment and practice arrangements. If a National Board decides to take health, conduct or performance action against a practitioner, it can notify a practitioner's employer or people with whom they share premises, so action can be taken to protect patients and the community.

The Bill amends the National Law to extend these information sharing powers to permit a National Board to request information about a practitioner's former practice arrangements (e.g. employer). A National Board would be able to notify these people, if action is taken against a practitioner.[178] The explanatory notes advise:

> The power to notify affected persons is discretionary and available only if the Board reasonably believes the practitioner's conduct posed a risk of harm at the time of the prior employment, practice arrangement, or sharing of premises.
>
> This amendment will capture those circumstances in which practitioners have caused harm to patients through successive workplaces. It will improve information sharing between employers and regulators and allow for identification of previously unknown risks to the public.[179]

The Bill also permits, and in some cases requires, a National Board to disclose serious risks posed by a practitioner prior to taking any disciplinary action.[180]

The Bill amends the National Law to provide that a National Board must give written notice to a practitioner's current employer and other relevant entities with whom the practitioner has current practice arrangements, if it reasonably believes that:

- a registered health practitioner's health, conduct or performance poses a serious risk to persons
- it is necessary to give a notice to protect public health or safety.

A National Board may also give written notice relating to the risk posed to other health practitioners who share premises and the cost of premises with the practitioner.[181]

The explanatory notes state the provisions:

> … will improve protections for the public in those small number of cases where a regulator has formed a reasonable belief that a practitioner poses a serious risk to the public but has yet to take action, including where the regulator is waiting for further information to finalise a complex matter involving multiple health, performance or conduct concerns. Notifying these persons that a practitioner is under investigation for a relevant serious matter will allow them to take action to protect the public, such as by enabling a practitioner's employer to implement training or supervision requirements.[182]

The Bill makes similar provisions to provide that AHPRA or a National Board may disclose information about an unregistered person who is being investigated or prosecuted under the National Law. The Bill enables AHPRA or a National Board, in these circumstances, to share information with a person's current employer, other entities that have practice arrangements with the person, and registered

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177 Queensland Health, correspondence, 10 June 2022, p 10.

178 Bill, cl 82, 83 and 84 amend sections 5, 132 and 206 of the National Law.

179 Explanatory notes, p 9.

180 Explanatory notes, p 9.

181 Bill, cl 110 inserts new section 220A into the National Law.

182 Explanatory notes, p 9.

health practitioners with whom the person shares premises or the cost of premises. The provision does not permit the sharing of patient information with a registered health practitioner or another entity.[183]

The explanatory notes advise that:

> The power is discretionary and can only be exercised if the regulator reasonably believes that the person poses a serious risk and that it is necessary to give the notice to protect public health or safety. Enabling regulators to disclose that an unregistered person is under investigation or prosecution for an offence will allow employers and other persons to take necessary actions to protect the public, such as restricting the health services that an unregistered practitioner may provide.[184]

In addition, the Bill amends the HO Act to provide the Health Ombudsman with the power to notify previous employers and persons who share, or have shared, premises with a practitioner about particular serious matters or tribunal decisions relating to the practitioner.[185]

Submitters' views

Definition of practice arrangement

Submitters, including AMA, AMAQ, Australian Medical Professionals Society and Nursing Professional Association of Australia and Avant Mutual, raised concerns about the proposed expanded definition of a *practice arrangement* and the requirement for practitioners to report previous practice arrangements to a National Board.[186]

Avant Mutual considered the requirement for a practitioner to submit previous practice information, including volunteer or honorary positions, is too broad, onerous, unfair and could cause significant reputational damage to practitioners. They also considered that the amendment potentially impinges on a practitioner's right to privacy. Avant Mutual also noted that the amendment would give National Boards broad discretion to notify former employers and associates about risks and regulatory actions, with no qualification as to the time or subject of the action.[187]

AMA contended that the amendments do not clearly specify who is included within the meaning of a *practice arrangement* and *practice information*. AMA questioned whether the definition includes arrangements between a self-employed medical specialist with a right of practice in a private hospital, and stated that the definitions arguably include current and former patients.[188]

Safeguards for practitioners

Several submitters, including RACGP, AMA, AMAQ, AAP, QLS and Avant Mutual, expressed concerns about the amendments giving increased powers to regulators to disclose information to certain people, including previous employers and associates. These concerns were based on the reputational harm that could result from such disclosures.[189]

These submitters contended that the amendments do not have sufficient safeguards for practitioners, such as a show cause or notification process before disclosures are made. RACGP considered the lack of a show cause process could unintendedly harm practitioners who are not at fault.[190]

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183 Bill, cl 111 inserts new section 220B into the National Law.

184 Explanatory notes, p 10.

185 Bill cl 17, 29 and 30 amend sections 71, 279 and 280 of the HO Act.

186 Submissions 13, 17, 23 and 31.

187 Submission 31, p 6.

188 Submission 13, p 7.

189 Submissions 7, 12, 13, 15, 17, 23, 28, 31 and 35.

190 Submission 7, p 4.

QNMU considered that the threshold for disclosing information should be higher to ensure natural justice for practitioners (e.g. that a matter has been referred to the immediate action committee and the committee has decided there is a serious risk to public safety).[191] QNMU, AAP, and others, argued that disclosures should only be made after action has been taken against a practitioner, that is, not during the investigation process.[192]

AMA and RACS raised concerns the amendments may require a National Board to give notice to entities in circumstances where there is no risk.[193] AMA provided the following example:

> … if a serious (but potentially vexatious) complaint was made that a surgeon has a tremor and the Medical Board considered that it was necessary to notify one third party (eg, the public hospital where the surgeon works), section 220A would be triggered and the Medical Board would be required to notify any other third party that falls within paragraph (b). These could include arrangements which do not carry this risk. For example, the surgeon may be recorded as the first aid officer for their daughter's netball team.[194]

RACGP was concerned about the liability and risk that may fall on employers who receive information from a regulator about a practitioner employee. RACGP recommended that regulators provide timely and detailed information to employers to mitigate those risks.[195]

Disclosure of information about unregistered persons

Submitters, including QDN and CRANAplus, supported the amendments to allow regulators to disclose information to certain people about serious risks posed by unregistered persons. CRANAplus stated the amendments are critical and will protect remote and isolated workforces and vulnerable communities, who are particularly at risk.[196]

Department's response

Definition of practice arrangement

Queensland Health stated that the proposed amendments to cover previous employment and practice arrangements are:

> … necessary to support other amendments in the Bill that authorise the disclosure of information to former employers and associates to prevent risks of harm to patients and the public. Allowing the disclosure of this information will remove a significant barrier to sharing information about practitioners who cause harm to patients through successive workplaces. It will also ensure that employers and other relevant persons can be alerted to serious risks as soon as possible and take steps to mitigate harm to the public.[197]

Queensland Health advised that the National Boards would not have an unfettered ability to notify former employers and associates of any regulatory actions taken against a registered health practitioner. Under the proposed amendments, disclosure would only be permitted if there is a link between the regulatory action taken and the practitioner's previous practice. This includes the requirement that the practitioner's health, conduct or performance posed a risk to persons or public safety at the time of the former practice arrangement.[198]

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191 Submission 12, p 5.

192 Submissions 12, 15 and 31.

193 Submissions 13 and 40.

194 Submission 13, p 9.

195 Submission 7, p 5.

196 Submissions 18 and 36.

197 Queensland Health, correspondence, 10 June 2022, p 10.

198 Queensland Health, correspondence, 10 June 2022, p 10.

Queensland Health stated that the definition of *practice arrangement* is intentionally broad, as it is intended to capture a wide variety of persons and entities who employ, engage or enable registered health practitioners to provide health services to the public, and who may need to be notified in the event that the practitioner is subject to regulatory action. This includes entities such as private hospitals that do not employ registered health practitioners, but grant admitting privileges or make facilities available to practitioners for the provision of patient care.[199]

Queensland Health contended that the language and context of the definition makes clear that it does not extend to arrangements between a practitioner and a patient. The definition relates primarily to contracts of employment, contracts for services and other agreements involving the provision of health services for or on behalf of an entity. While the definition also refers to other types of agreements and arrangements, Queensland Health stated that these words must be interpreted with reference to the more specific terminology of the provision.[200]

Safeguards for practitioners

Queensland Health highlighted that information may only be disclosed if the National Board reasonably believes that the practitioner poses a serious risk to others and it is necessary to give notice to protect public health or safety.

Queensland Health advised that these amendments are less significant for Queensland than for other jurisdictions because in most cases the Health Ombudsman must already notify employers and associates when a practitioner is being investigated in connection with a serious matter.

Queensland Health acknowledged that the Bill does not require a notice to be provided to the relevant practitioner, nor does it require a show cause process prior to a Board making a relevant disclosure under these amendments. It considered that such requirements would prevent the timely sharing of information to those in a direct position to protect the public. Queensland Health stated that such an approach could also compromise an ongoing investigation.

Queensland Health considered that the extended disclosure powers are subject to appropriate safeguards, stating:

> Importantly, a notification can only be made to the current employer and associates of a practitioner, and only if the regulator reasonably believes the practitioner's conduct poses a serious risk of harm. Further, a Board does not need to give notice if it is not in the public interest to do so. For example, a notification would not be required if the public interest is outweighed by the practitioner's right to privacy, or if disclosing information would impact an investigation into the practitioner or place other people in danger. In cases where a practitioner's employment or other arrangements do not pose a risk to others, the practitioner's right to privacy would outweigh the interest in disclosing information to those entities.[201]

Queensland Health also advised that AHPRA would, if the Bill passes, develop information and educational materials to assist employers and other associates to manage these disclosures.[202]

3.1.4.3 Mandatory notification by employers

The Bill inserts the following example to the current provision in the National Law which requires employers to notify AHPRA of notifiable conduct by a practitioner-employee:

> An employer takes action against a registered health practitioner by withdrawing or restricting the practitioner's clinical privileges at a hospital because the employer reasonably believes the public is at risk of harm by the practitioner practising the profession in a way that constitutes a significant departure

199 Queensland Health, correspondence, 10 June 2022, p 10.

200 Queensland Health, correspondence, 10 June 2022, pp 10-11.

201 Queensland Health, correspondence, 10 June 2022, pp 19-20.

202 Queensland Health, correspondence, 10 June 2022, p 20.

> from accepted professional standards—see paragraph (d) of the definition of notifiable conduct in section 140. The employer must notify the National Agency of the notifiable conduct.[203]

The explanatory notes state:

> The inserted notation complements broader efforts to educate employers and raise awareness about their mandatory notification obligations. The notation will alert employers to the fact that they may have a duty to report certain employer actions to the National Agency. This will encourage them to review guidance and other resources about employer notification requirements published by the agency and the National Boards.[204]

Submitters' views

While not opposing the amendments, QNMU argued that employers should only be required to notify AHPRA, if there has been a finding of misconduct and that treating practitioners should have an exemption from notifications about health impairment.[205] AAP and AMA did not oppose the amendment, but recommended that further education or guidance for employers be provided.[206]

Department's response

Queensland Health noted that QNMU's proposal was outside the scope of the Bill, and advised that AHPRA has a range of resources available on its website to make mandatory notifications easier to understand, including videos, case studies and frequently asked questions.[207]

3.1.4.4 Alternative name used by practitioners

The Bill amends the National Law to provide that registered practitioners may practice under an alternative name and have that alternative name published on the public register alongside their legal name.[208] The Bill also enables the public to search the public register for alternative names of practitioners.

The explanatory notes state:

> This amendment will provide flexibility for practitioners who practise under an alternative name for legitimate reasons, such as adopting an anglicised name. It will also increase safety for the public by allowing people to verify a practitioner's registration under their alternative name and see any relevant conditions or other restrictions on their registration.[209]

The Bill provides that a National Board may refuse to record a nominated name in the public register or on the certificate of registration for several reasons, including if it is obscene or offensive, resembles a protected or specialist title, or is contrary to the public interest.[210]

Submitters' views

Speech Pathology Australia supported the proposed amendments, including the use of both a married and professional name and names associated with a language or cultural background.[211]

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203 Bill, cl 91 amends section 142 of the National Law.

204 Explanatory notes, p 10.

205 Submission 12, attachment, p 12.

206 Submissions 13 and 15.

207 Queensland Health, correspondence, 10 June 2022, p 14.

208 Bill, cl 114 inserts new sections 131A and 131B into the National Law.

209 Explanatory notes, pp 10-11.

210 Bill, cl 112 and 115 amend section 124 and 225 of the National Law.

211 Submission 5, p 2.

3.1.4.5 Removing prohibition of testimonials

The Bill removes that current prohibition, under the National Law, on practitioners using testimonials, or purported testimonials, in advertisements about regulated health services.[212]

While the term *testimonial* is not defined in the National Law, AHPRA's *Guidelines for advertising a regulated health service* (Advertising Guidelines) advises:

> AHPRA and the National Boards have adopted its [a testimonial] ordinary meaning of a positive statement about a person or thing. In the context of the National Law, testimonials are recommendations or positive statements about the clinical aspects of a regulated health service used in advertising.[213]

The Advertising Guidelines provide that not all reviews or positive comments made about a regulated health service are considered testimonials. For example, comments about customer service or communication style that do not include a reference to clinical aspects are not considered testimonials for the purposes of the National Law.

A clinical aspect exists if one of the following is expressed:

- symptom – the specific symptom or the reason for seeking treatment
- diagnosis or treatment – the specific diagnosis or treatment provided by the practitioner
- outcome – the specific outcome or the skills or experience of the practitioner either directly or via comparison.[214]

The Advertising Guidelines state that the prohibition on using testimonials (or purported testimonials) to advertise regulated health services does not affect:

- patients sharing information, expressing their views online or posting reviews on review platforms
- how members of the public can interact with review sites or discussion forums
- individuals or businesses that do not advertise a regulated health service.

The prohibition on the use of testimonials only exists when:

- an advertiser makes use of testimonials (as defined above) to advertise a regulated health service
- a person or a business advertises in a way that makes use of the reviews/testimonials to promote the service.[215]

Under the proposed amendments, a person will still be prohibited from advertising a health service, including by using testimonials, in a way that:

- is false, misleading or deceptive or is likely to be misleading or deceptive
- offers a gift, discount or other inducement to attract a person to use the service or business, unless the advertisement also states the terms and conditions of the offer
- creates an unreasonable expectation of beneficial treatment

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212 Bill, cl 85 amends section 133 of the National Law.

213 AHPRA, *Guidelines for advertising a regulated health service*, p 15.

214 AHPRA, *Guidelines for advertising a regulated health service*, p 15.

215 AHPRA, *Guidelines for advertising a regulated health service*, p 15.

- directly or indirectly encourages the indiscriminate or unnecessary use of regulated health services.[216]

Submitters' views

Eucalyptus expressed strong support for the proposal to remove the prohibition on testimonials for the following reasons:

- the current regulatory position is unclear and difficult to both observe and enforce
- the benefits of achieving regulatory uniformity with other forms of advertising, e.g. the regulation of testimonials under the National Law and the regulation of testimonials of therapeutic goods under the *Therapeutic Goods (Therapeutic Goods Advertising Code) Instrument 2021* (Cth)
- consumers expectations and the benefits of testimonials
- the importance of focusing on ensuring that testimonials are not misleading.[217]

At the public hearing, Eucalyptus highlighted two misconceptions about prohibition on testimonials that:

- all forms of testimonial advertising of health services is currently prohibited
- the proposed amendment will allow all types of testimonial advertising - there will still be numerous protections limiting the content of advertising of health services.[218]

Other submitters raised significant concerns about the proposal to allow testimonials in health service advertising, stating it would open the door to false and misleading advertising that could undermine public safety. In summary, submitters raised the following issues in relation to testimonials:

- the subjective nature of testimonials
- the lack of robust evidence and potential to mislead, particularly vulnerable people
- the increased risk of false expectations about services and outcomes, resulting in financial cost to patients, as well as adversely impacting on their health and wellbeing.[219]

Submitters also considered that removing the prohibition on testimonials would further tip the power imbalance between medical practitioners and prospective patients, reducing patient safety.[220]

Such submitters asserted that testimonials are inherently open to abuse, easily faked and difficult to regulate, especially on social media.[221] The Australian Society of Plastic Surgeons (ASPS) advised that:

> This prohibition [on testimonials] was intended to preserve the fiduciary duty of the profession to put the interests of the public good above our own self-interest, whilst the removal of this prohibition encourages a market force approach, allowing the pursuit of self-interest.[222]

216 National Law, s 133.

217 Submission 11, pp 2-5.

218 Public hearing transcript, Brisbane, 8 June 2022, p 11.

219 Submissions 2, 5, 6, 13, 14, 15, 16, 17, 24, 26, 27, 29, 30 and 34.

220 ALA, public hearing transcript, Brisbane, 8 June 2022, p 5.

221 Submission 13, p 8.

222 Public hearing transcript, Brisbane, 8 June 2022, p 7.

Similarly, AMA stated:

> Testimonials are broadly acknowledged throughout our industry as being, even when they are true, quite misleading in terms of how they are presented and whether the individual testimonial applies to the patient who is reading the testimonial and, of course, there is a potential for fake testimonials, which would be extremely difficult to regulate.[223]

Speech Pathology Australia, and others, highlighted that health services are different to products, with greater potential risk, therefore it is in the interests of public safety that advertising rules should also be different, with health practitioners held to the highest standard.[224] At the public hearing, Dr Faux stated:

> Buying health is not like buying a TV. When we buy health, we do not buy the characteristics of what we purchase. There is very little to recommend a colonoscopy. What we instead buy is the promise of an outcome, which is usually some improvement in our health. The problem is that we do not know whether we need what is being sold to us or whether it will provide the outcome we want. We do not have equal information or bargaining power. Throughout the academic literature which I reviewed in my doctoral studies, this is called information asymmetry. It is an irrevocable truth and one of the key reasons the health market does not behave like other consumer markets and therefore cannot be compared to them.[225]

ASPS highlighted the difficulties that the public has in assessing surgical and medical competence, and stated that this 'makes them rely on other characteristics that they can assess as a proxy for competence, such as presentation of rooms or politeness of staff' and results in patients inaccurately 'equating the quality of the advertising with the quality of the service'.[226]

AAP raised concerns about the potential coercion of patients to make positive reviews and the power differential between practitioner and client, with clients unlikely to voice treatment concerns.[227]

AMAQ highlighted the issue of low health literacy compounding the negative impact of testimonials, stating:

> Throughout the community there are pockets of low health literacy and there are a large number of Australians who are vulnerable to manipulative messages. We believe that the patient testimonials are exactly that sort of manipulative statement. They are very powerful because they explain an individual's experience of a health service, but they are likely to be interpreted by people in ways that may not apply to their individual circumstances.[228]

AMA expressed concerns about the ability of AHPRA and the National Boards to adequately regulate testimonials if the prohibition is removed, noting there is likely to be a significant increase in testimonials and regulators will only be able to act if they can demonstrate the testimonials are false or misleading.[229]

ASPS stated that the removal of the prohibition would mean AHPRA had to adopt a more nuanced approach requiring the following assessment:

> … if a doctor has a testimonial on their website, is it a false one, is it a sourced one, is it a resourced one, is it a paid one—as in, paid to the third-party provider—is it representative, has it been filtered? There

223 Public hearing transcript, Brisbane, 8 June 2022, p 21.

224 Submission 5, p 3.

225 Public hearing transcript, Brisbane, 8 June 2022, p 1.

226 Public hearing transcript, Brisbane, 8 June 2022, p 7 and 8.

227 Submission 15, p 7.

228 Public hearing transcript, Brisbane, 8 June 2022, p 25.

229 Submission 13, p 8.

> are all sorts of difficulties that Ahpra would face ascertaining whether that meets their overall standards. At the present time it is a blanket: no, you cannot do it.[230]

Similarly, Professor Deva considered that there was no way to police whether, or not, the use of testimonials in medical advertising is compliant with AHPRA standards and stated:

> Failure to enforce these standards will only embolden the use of testimonials as a marketing and advertising tool rather than one that provides factual information to patients seeking a particular treatment or services of a practitioner.[231]

Professor Deva and ALA considered that AHPRA would need additional resources to regulate the use of testimonials and take a proactive approach.[232] Professor Deva stated:

> Ahpra needs to be given resources—or if it is the ACCC—to be able to look through what is out there and then ultimately to also be given teeth such that people who knowingly breach the principles of advertising in health care and the use of surrogate or real testimonials are held to account. I think that is really part of the solution. There is no point putting guidelines in if they are flaunted every single day because it actually weakens the capacity to bring change into the sector.[233]

ALA recommended that practitioners should be required, as part of the registration process, to provide details to AHPRA of every website or social media page they use as part of their practice and to provide a declaration that they have complied with advertising regulations.[234]

Some submitters, including Operation Redress, ALA, ASPS, Australasian Society of Aesthetic Plastic Surgeons, Dr Faux and Professor Deva, noted the particular risks associated with the use of testimonials in advertisements for cosmetic surgery. Such submitters referred to the *Four Corners* program 'Cosmetic Cowboys' broadcasted in 2021 in relation to the cosmetics industry which revealed, among other issues, the risks association with practice building on testimonials. Dr Faux stated:

> On *Four Corners* I described the cosmetic industry as like the Wild West but without the sheriffs. I am very concerned that lifting the testimonial ban will make this worse. It will be like the Wild West but without sheriffs or deputies, both having handed over their badges to the cowboys. There will be effectively no rules and no police, just anarchy.[235]

Dr Faux stated that all advertising for cosmetic services will likely breach the advertising requirements, as they are for procedures that are not medically necessary and therefore 'encourage unnecessary use of regulated health services.'[236] The ALA and Operation Redress argued that young people and children may be specifically targeted in advertising cosmetic surgery.[237]

Professor Deva raised concerns that the removal of the prohibition on testimonials may also push other areas of medicine into a more commercial model of practice, stating:

> We are starting to see in some aspects of orthopaedic surgery, weight loss surgery and bariatric surgery where commercial models of advertising and marketing are luring patients in with various schemes and

230 Public hearing transcript, Brisbane, 8 June 2022, p 8.

231 Submission 2, p 3.

232 Public hearing transcript, Brisbane, 8 June 2022, pp 4-5.

233 Public hearing transcript, Brisbane, 8 June 2022, p 4.

234 Public hearing transcript, Brisbane, 8 June 2022, p 6.

235 Public hearing transcript, Brisbane, 8 June 2022, p 2.

236 Submission 6, p 4.

237 Submissions 24 and 26.

> claims that are not based on any reality but are based purely on commercial gain. That it will impact on more patients being put in harm's way.[238]

Dr Faux also raised concerns that the removal of the prohibition would worsen the current overlap between the Australian Competition and Consumer Commission and AHPRA, with patients falling 'between the cracks' with neither regulator taking responsibility when breaches occur.[239]

Submitters recognised that AHPRA and the Medical Board of Australia have commissioned an *Independent review of the regulation of health practitioners in cosmetic surgery* (Independent Review), which includes a review of current advertising restrictions.[240] They also noted that Australia's Health Ministers have recently undertaken a national consultation into title protection for the title 'surgeon.'[241]

AHPRA advised that the Independent Review was considering what further guidance specific to cosmetic surgery may be required to better protect the public. AHPRA advised, however, that 'The testimonial amendment will not prevent Ahpra and the Medical Board acting on the recommendations of the independent review'.[242] AHPRA advised that it expected to publish the outcomes of the review, including its full findings, recommendations and submissions received (where appropriate), in September 2022.[243]

While appreciating the intention of the amendment, ICA expressed concerns about the obligations of health practitioners to ensure the accuracy and balance of testimonials on sites under their control.[244] ICA recommended that AHPRA issue a declaration that 'no penalties [will be] imposed on health practitioners over the first 12 months and that the regulator would provide guidance on compliance over this period'.[245]

A number of submitters, including the ALA, MIGA and Avant Mutual, recommended that the removal of the prohibition on testimonials be delayed until the completion of the Independent Review and AHPRA has developed guidance on ensuring testimonials meet advertising requirements and undertaken an awareness campaign.[246] MIGA highlighted the importance of guidelines, stating:

> … practitioners will need to be educated on their ongoing obligations in relation to this aspect. In spite of the attempts and efforts that have been made by all key stakeholders and Ahpra themselves to educate practitioners in this area, we still find ourselves in difficulty.[247]

AHPRA considered that the amendment is consistent with its current focus on testimonials involving more risk, i.e. those that are false, misleading or deceptive or likely to be.[248] AHPRA highlighted that the maximum available penalty for breaches of advertising restrictions are increased to reflect the

238 Public hearing transcript, Brisbane, 8 June 2022, p 3.

239 Submission 6, p 3.

240 *Independent review of the regulation of health practitioners in cosmetic surgery – consultation paper,* March 2022, Commissioned by AHPRA and the Medical Board of Australia.

241 Submissions 2, 6, 14, 24, 26 and 30.

242 Public hearing transcript, Brisbane, 8 June 2022, p 35.

243 Public hearing transcript, Brisbane, 8 June 2022, p 37.

244 Submission 16, p 3.

245 Public hearing transcript, Brisbane, 8 June 2022, p 29.

246 Submissions 24, 27 and 31; Dr Faux, public hearing transcript, Brisbane, 8 June 2022, p 2.

247 Public hearing transcript, Brisbane, 8 June 2022, p 30.

248 Submission 21, pp 6-7.

potential harm false or misleading advertising can have for consumers and align with other breaches of the National Law such as the deliberate misuse of a restricted professional title. [249]

AHPRA considered that the removal the prohibition on testimonials also reflects a fundamental shift since 2010 in technology and advertising and how consumers access information about regulated health services and registered health practitioners. AHPRA stated:

> Consumers expect to have access to reviews and testimonials when purchasing any services, including health services, and to be able to share their views about the services they receive and the people they receive them from. This is happening in all walks of life, is at the heart of social media communication and is partly what has given rise to the emergence of social media influencers. It seems to us that on this issue the train has left the station. It would be better for us to focus our regulatory effort where there is greater risk of harm to the public and where expectations of regulatory focus can be realistically met.[250]

AHPRA also stated:

> We think that the benefit of the change and focusing on those risk aspects mean that regulation does keep up with current society in respect of the general public, and that includes consumers of health services relying on various materials these days, including testimonials.[251]

In addition, AHPRA advised that the proposed amendment:

> … also brings us more into line with the general law and approach in respect of the regulation of testimonials. Take, for example, the approach of the ACCC. It does not impose blanket bans on testimonials but does regulate the use of testimonials in appropriate circumstances, including in certain health related fields such as in relation to platforms that might provide reviews of medical practitioners. All in all, we think that it is an opportunity for us to really focus our resources not on a blanket ban in respect of testimonials but in respect of those that present the greatest risk to the public.[252]

AHPRA noted that the proposed amendment would take effect on a date to be fixed by proclamation, giving AHPRA time to work with the National Boards to review their Advertising Guidelines and communicate with stakeholders about the change and what it means.[253]

Department's response

Queensland Health noted that the removal of the prohibition on testimonials in health service advertising would not mean that the use of testimonials in health service advertising was unregulated. Queensland Health advised:

> Like all other forms of health service advertising, testimonials will be prohibited where they are false, misleading or deceptive; offer a gift, discount or inducement without stating the terms and conditions; create an unreasonable expectation of beneficial treatment; or encourage the unnecessary use of health services. The Bill also increases the maximum penalty for breaching advertising restrictions from $5,000 for an individual and $10,000 for a body corporate to $60,000 for an individual and $120,000 for a body corporate.[254]

Queensland Health stated that the advertising and social media landscape has significantly changed in the decade since the National Law commenced, stating:

> Testimonials and reviews are common online, and new forms of advertising, particularly on social media, have blurred the lines between information and advertising. Patients and consumers have a growing expectation that they will be able to express their views – both positive and negative – about health

[249] Submission 21, pp 6-7.

[250] Public hearing transcript, Brisbane, 8 June 2022, p 35.

[251] Public hearing transcript, Brisbane, 8 June 2022, p 37.

[252] Public hearing transcript, Brisbane, 8 June 2022, p 37.

[253] Submission 21, pp 6-7.

[254] Queensland Health, correspondence, 10 June 2022, p 11.

> services, including on sites such as a practice Facebook page. While the current law prevents positive reviews, it also stops patients from sharing negative experiences in advertising. The patient and consumer voice is effectively silenced.[255]

Queensland Health advised that the National Law's prohibition of testimonials also creates challenges for practitioners and regulators, stating:

> Practitioners have reported confusion about their obligations and what constitutes a testimonial. Both practitioners and regulators report difficulty in distinguishing testimonials about clinical care from testimonials about non-clinical care. Adding to this confusion, the blanket prohibition of testimonials about health services is inconsistent with Commonwealth legislation regulating testimonials about therapeutic goods and the use of testimonials in online platforms.[256]

Queensland Health advised that:

> In practice, regulatory action focuses largely on those testimonials that will make false or misleading claims and pose a high level of risk to the public. In progressing these amendments it creates a balance between consumer expectations and current practice whilst still having fairly strong protections for the public.[257]

In addition, Queensland Health stated that regulating advertising is a resource intensive activity for the National Boards and AHPRA. Queensland Health noted that the wording of the National Law does not differentiate between testimonials that involve a risk of harm, and those which do not. Currently a significant number of advertising complaints come from other practitioners and often relate to technical breaches with low or no risk to patient safety. These complaints take time and resources to investigate and respond to. Queensland Health considered that the same resources would otherwise be focussed on higher risk matters.[258]

Queensland Health considered that allowing testimonials in health service advertising will bring advertising restrictions in the National Law into step with current advertising practices and consumer expectations. It will ensure regulators focus on the most harmful forms of advertising—those that are or may be false, misleading or deceptive and therefore pose a higher level of risk to the public. Additionally, it will promote consistency with Commonwealth laws that also regulate aspects of health service advertising, which will make it easier for persons to understand and comply with advertising requirements under the National Law.[259]

Finally, Queensland Health acknowledged that the advertising of cosmetic surgery and related services poses specific risks and challenges. Queensland Health noted that these risks and challenges are being examined through multiple independent and national reviews.[260]

In addition, states and territories are consulting on a proposal to restrict the title 'surgeon' under the National Law and on other opportunities to help patients and consumers make informed choices about undergoing cosmetic surgical procedures. Queensland Health advised that the proposed amendment removing the ban on testimonials would not prevent regulators and Australian Health Ministers acting on the recommendations and findings of these reviews.

Queensland Health stated that, if the Bill passed, AHPRA and the National Boards would revise the Advertising Guidelines to ensure the changes are fully reflected and will consider the need for further specific guidance about the use of testimonials in advertising, especially where there are specific risks

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255 Queensland Health, correspondence, 10 June 2022, p 11.

256 Queensland Health, correspondence, 10 June 2022, p 11.

257 Public briefing transcript, Brisbane, 23 May 2022, p 8.

258 Queensland Health, correspondence, 10 June 2022, p 11.

259 Queensland Health, correspondence, 10 June 2022, p 11.

260 Queensland Health, correspondence, 10 June 2022, p 11.

of harm, such as in the cosmetic surgery context and/or in social media. They will also consider the need for further guidance about good practice in using testimonials in advertising. Queensland Health stated:

> Ahpra will communicate with stakeholders about the change. Ahpra has an Advertising hub which contains the laws and other guidance about how to advertise; resources to help advertisers understand their obligations and to check their advertising is correct; and information for the public including about how to make a complaint and how Ahpra manages complaints about advertising.[261]

In relation to implementation, Queensland Health advised that the amendments that repeal the prohibition on testimonials in health service advertising are to be commenced by proclamation, allowing for the phased implementation of the amendments.[262]

Committee comment

The committee acknowledges the concerns raised by submitters about the potential impact of the removal of the prohibition on testimonials in advertising health services, especially in relation to advertising cosmetic surgery and procedures.

The committee notes that the removal of the prohibition would not mean that the use of testimonials in health service advertising is unregulated. Testimonials that are false, misleading or deceptive in a way that creates an unreasonable expectation of beneficial treatment or in a way that encourages the indiscriminate or unnecessary use of health services will still be prohibited.

Given the potential impact of the proposed amendments, and the stated benefits of a phased introduction, the committee agrees with submitters that it would be prudent to await the completion of the Independent Review and to ensure that AHPRA was in a position to publish accompanying guidelines and educational material before removing the prohibition.

Accordingly, the committee recommends that the Minister for Health and Ambulance Services provides an undertaking not to commence the provisions repealing the prohibition on testimonials until the completion of the Independent Review and AHPRA has published the accompanying guidelines and educational material.

Recommendation 2

The committee recommends that the Minister for Health and Ambulance Services provides an undertaking, during the second reading debate, to not commence the provisions repealing the prohibition on testimonials in health service advertising until:

- the completion of the Independent review of the regulation of health practitioners in cosmetic surgery, and
- the accompanying guidelines and educational material have been published.

[261] Queensland Health, correspondence, 10 June 2022, p 12.

[262] Queensland Health, correspondence, 10 June 2022, p 12.

3.1.4.6 Exclusion of information from public register

The Bill amends the National Law to provide National Boards with the discretion to remove information about a registered health practitioner from the public register, if the publication of that information presents a serious risk to the health or safety of the practitioner or a member of their family or an associate of the practitioner.

The term an *associate of the practitioner* includes a friend, neighbour or colleague of the practitioner. A family member includes a person related by blood, marriage or adoption, a person in a de facto relationship with the practitioner and a person connected to the practitioner through Aboriginal and Torres Strait Islander kinship ties. [263]

Submitters' views

Submitters, including QNMU, AAP and AMA, supported the proposed amendments. Avant Mutual noted that the amendments gives a National Board discretion to record information which it previously excluded, if it reasonably believes that the circumstances justifying the exclusion have changed. Avant Mutual suggested that practitioners should be given notice and an opportunity to be heard before a National Board records previously excluded information.[264]

Department's response

Queensland Health did not consider that it is necessary to require National Boards to consult a practitioner before recording information that was previously excluded from a National Register or Specialists Register, on the basis that it would present a serious risk to the health or safety of the practitioner, their family or their associates.

Queensland Health advised that, under new section 226(2A) of the National Law, a National Board's decision to record previously excluded information must be based on a reasonable belief that the circumstances that justified the exclusion have changed.

In forming this reasonable belief, the Board would need to consider whether there is an ongoing risk to the practitioner or their family or associates, including communicating with the practitioner as necessary to obtain relevant information about the practitioner's current circumstances.[265]

3.2 Governance of National Scheme

3.2.1 Ministerial Council

The Bill amends the National Law to remove reference to the Council of the Australian Government, which has been dissolved. The Bill defines the Ministerial Council as a body, however described, that consists of the Minister of each participating jurisdiction, and the Commonwealth, who is responsible, or principally responsible, for matters relating to health.[266]

In addition, the Bill provides that the Ministerial Council may delegate its power to approve registration standards for health practitioners to any entity it considers appropriate to exercise the power.[267]

[263] Bill, cl 116 amends section 226 of the National Law.

[264] Submission 31, p 9.

[265] Queensland Health, correspondence, 10 June 2022, p 20.

[266] Bill, cl 53 amends section 5 of the National Law.

[267] Bill, cl 54 amends section 12 of the National Law.

3.2.1.1 Submitters' views

A number of submitters raised concerns about the proposal for the Ministerial Council to delegate its power to approve registration standards.[268]

ACRRM considered that the power to approve registration standards should sit with the Ministerial Council and not with a delegated agency, as 'this would appropriately ensure decision-making rests with elected representatives of government'.[269]

ACN considered that the power to approve standards should only be delegated with the express approval of the relevant professional body.[270] ADF and Australian Society of Ophthalmologists (ASO) raised concerns about the impact on medical professions and medical standards. Both submitters considered that the proposed amendments had the potential to replace the independent role of the Australian Medical Council in relation to the accreditation and assessment of medicine in Australia.[271]

AAP considered that the delegation of the power to approve registration standards needs to be kept outside of AHPRA, and decisions need to be made by an impartial third party, following active consultation.[272] Avant Mutual raised similar concerns about a National Board approving registration standards that they had drafted, calling for the Ministerial Council to continue to have oversight over these decisions.[273]

Avant Mutual noted that the Bill contained no guidance about which entities the Ministerial Council may delegate to, nor the basis upon which the Council may consider delegation appropriate. Avant Mutual, therefore, suggested that more detail should be included about the scope of the power to delegate and the entities to whom it would be appropriate to delegate the power.[274]

3.2.1.2 Department's response

Queensland Health advised that registration standards for health practitioners are drafted by National Boards and submitted to the Ministerial Council for approval. Currently even minor updates and other amendments with no significant policy implications must be approved by Ministers. The explanatory notes state:

> To streamline the process for approving registration standards and reduce delays, particularly for minor or non-controversial standards, the Governance Review recommended that the Ministerial Council be able to delegate its power to approve standards. On 31 October 2019, Health Ministers agreed to this recommendation.[275]

Queensland Health stated that the proposed amendments allow the Ministerial Council to delegate its powers to approve registration standards to an entity it considers appropriate to exercise those powers. For example, the Ministerial Council may consider delegating certain powers to the Agency Management Committee (being re-named by the Bill to the Agency Board) acting on the advice of AHPRA and jurisdictions, or to the Health Chief Executives Forum.

Under section 29 of the National Law, a formal instrument of delegation would be made if Ministers choose to delegate these powers. Importantly, the Ministerial Council wouldretain its obligation to

[268] Submissions 9, 12, 15, 31, 34 and 35.

[269] Submission 35, p 3.

[270] Submission 34, p 3.

[271] Submissions 9 and 37.

[272] Submission 15, p 7.

[273] Submission 31, p 4.

[274] Submission 31, p 4.

[275] Explanatory notes, p 12.

ensure that the function is properly exercised. As an additional accountability measure, section 29 of the National Law also prohibits sub-delegation of the power.

Proposals to delegate the Ministerial Council's power to approve registration standards would also be informed by consultation with stakeholders and advice from State and Territory health departments.[276]

3.2.2 Functions of the National Agency

The Bill amends the National Law to update the functions of AHPRA to recognise its broad advisory functions. Under the proposed amendments, AHPRA would have the function of providing advice to the Ministerial Council on all matters relating to the National Scheme, not just those matters relating to the scheme's administration.

The Bill also provides that AHPRA may do anything necessary or convenient for the effective and efficient operation of the National Scheme, within the scope of the National Law.[277]

3.2.2.1 Submitters' views

Avant Mutual, ACRRM, ASO and ADF were concerned that the amendment gave the AHPRA broad, discretionary powers.[278]

Avant Mutual raised the importance of AHPRA, when giving advice to the Ministerial Council, to consult with the relevant National Boards and to obtain professional input.[279] ACRRM considered that the provision should clearly express the nature of the power and, where appropriate, provide guidance as to how the entity should exercise the power.[280]

Similarly, ASO was concerned that this 'broad discretionary and largely unchecked power' may result in systematic abuse.[281] ADF asserted that the amended functions essentially gave AHPRA a 'blank cheque'.[282]

3.2.2.2 Department's response

Queensland Health advised that the proposed amendment was recommended in the Governance Review, in recognition of AHPRA'S co-ordinating role in administering the National Scheme. Queensland Health stated:

> AHPRA performs a wide range of functions and is held accountable for meeting ministerial expectations of the National Boards and other entities. It manages this through its co-operative arrangements with the National Boards. Queensland Health stated that providing the ability to do all things 'necessary or convenient' will support AHPRA to perform its statutory functions. [283]

Queensland Health advised that it is not intended that the new function extends the scope of AHPRA's powers. Instead, it is intended to recognise that AHPRA may do anything incidental or ancillary to fulfil the specific powers and functions conferred on it. Queensland Health provided the following example:

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276 Queensland Health, correspondence, 10 June 2022, p 7.

277 Bill, cl 52 amends section 25 of the National Law.

278 Submissions 9, 31, 34, 35, 37

279 Submission 31, p 4.

280 Submission 35, p 3.

281 Submission 37, p 2.

282 Submission 9, p 2.

283 Queensland Health, correspondence, 10 June 2022, p 7.

> … as part of the AHPRA's response to the COVID-19 pandemic, it worked with and on behalf of the National Boards to enable the establishment of a pandemic sub-register and enabled communications with practitioners in response to the requests of jurisdictions.[284]

In addition, Queensland Health stated that allowing entities to do 'anything else necessary or convenient' to be done in performing its functions is common in legislation. For example, similar provisions are included in:

- section 66 of the Biosecurity Act 2014
- section 20 of the Education (Queensland Curriculum and Assessment Authority) Act 2014
- section 210 of the *Guardianship and Administration Act 2000.*

Queensland Health advised that the amendment also mirrors the language of a similar function given to National Boards, which is appropriate given AHPRA's role in administering the National Scheme.[285]

3.2.3 Renaming the Agency Management Committee

The Bill changes the name of the Agency Management Committee to Agency Board.[286] The explanatory notes state 'This title better reflects the body's role and functions, including governance for the National Scheme'.[287]

The Bill includes transitional provisions to ensure that the renaming of the Agency Management Committee does not affect the validity of persons appointed to the committee prior to the name change.[288]

3.2.4 Dissolving the Australian Health Workforce Advisory Council

The Bill amends the National Law to dissolve the Australian Health Workforce Council.[289]

The Australian Health Workforce Advisory Council was formed to provide independent advice to the Ministerial Council on certain matters. The Ministerial Council only sought advice from the Council on one occasion, with the advice provided in October 2011. The Council has been in abeyance since August 2012.[290]

3.2.4.1 Submitters' views

AMA and AMAQ supported the proposed dissolution of the Australian Health Workforce Advisory Council.[291]

ACN raised concerns about the proposed dissolution of the Australian Health Workforce Advisory Council, expressing a preference for an independent voice and advice to the Ministerial Council. ACN also opposed the broadening of the advisory role of AHPRA, and recommended that advice provided by AHPRA to the Ministerial Council, other than on administrative matters, should be provided with the express agreement of the relevant National Board.[292]

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284 Queensland Health, correspondence, 10 June 2022, p 7.

285 Queensland Health, correspondence, 10 June 2022, p 7.

286 Bill, cl 42 to 51 amend sections 5, 17, 29, 30, 33, 236 and schedule 2 to the National Law.

287 Explanatory notes, p 13.

288 Bill, cl 49 inserts new section 324 into the National Law.

289 Bill, cl 38 to 41 amends sections 5 and 236 and schedule 1 of the National Law; Bill, cl 132 omits section 17 of the *Health Practitioner Regulation National Law Act 2009* (Qld).

290 Explanatory notes, p 13.

291 Submissions 13 and 17.

292 Submission 34, p 3.

3.2.4.2 Department's response

Queensland Health advised that, in practice, the Ministerial Council receives advice on most matters relating to the National Scheme from AHPRA and the Health Chief Executives Forum and its subcommittees. Queensland Health stated:

> The *Review of Governance of the National Registration and Accreditation Scheme* concluded that the Australian Health Workforce Advisory Council is not necessary for the effective governance of the National Scheme and recommended removal of the provisions establishing it.[293]

3.3 Effectiveness and efficiency of the National Scheme

3.3.1 Timeframes for commencing registration

The Bill amends the National Law to allow for the commencement of specialist, provisional, limited and non-practising registrations to be post-dated up to 90 days after a registration decision is made.[294]

3.3.1.1 Submitters' views

Submitters, such as AMA, AMAQ and QDN supported the proposed amendments.[295]

ACRRM opposed the proposed amendments, stating that it could see no justification for a period of 90 days being applied in cases where a National Board did not specify a date. ACRRM considered that either a date should be specified in all cases or the 90 day period should be reduced, for example, to 30 days.[296]

3.3.1.2 Department's response

Queensland Health stated that the amendment would address administrative challenges and make the registration process more efficient. Queensland Health advised:

> When the National Law commenced, section 56(2) provided that a person's general registration took effect from the date of the National Board's registration decision. That provision was found to cause a number of administrative challenges, particularly for processing applications by persons moving from student to general registration, interns moving to general registration, and internationally qualified practitioners trying to meet the requirements of National Boards, employers and immigration authorities.[297]

To resolve these challenges, section 56(2) of the National Law was amended in 2017 to allow National Boards to post-date general registration.

Queensland Health advised that since the amendment of section 56(2), similar administrative challenges have been identified in relation to decisions to grant specialist registration, provisional registration, limited registration and periods of non-practising registration. Queensland Health stated that the amendments will enable National Boards to delay the effect of those registration decisions for up to 90 days.[298]

3.3.2 Increasing the use of undertakings from practitioners

Under the National Law, a National Board may impose a condition on a practitioner's registration, but cannot currently accept an undertaking from a practitioner as part of the registration process.[299]

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293 Queensland Health, correspondence, 10 June 2022, p 6.

294 Bill, cl 55 to 59 amend sections 56, 61, 64, 72 and 76 of the National Law.

295 Submissions 13, 17 and 18.

296 Submission 35, p 3,

297 Queensland Health, correspondence, 10 June 2022, p 8.

298 Queensland Health, correspondence, 10 June 2022, p 8.

299 National Law, s 83.

A condition on the registration of a practitioner aims to restrict their practice in some way to protect the public. Examples of conditions include:

- completing further specified education or training
- undertaking a specified period of supervised practice
- managing a practitioner's practice in a certain way.

There may also be conditions related to a practitioner's health (such as psychiatric care or drug screening).[300]

An undertaking means a practitioner agrees to do, or to not do something in relation to their practice of the profession. Current undertakings which restrict a practitioner's practice of the profession are published on the register of practitioners. An undertaking is voluntary, whereas a condition is imposed on a practitioner's registration.[301]

The Bill amends the National Law to permit a National Board to accept an undertaking from a practitioner applying for registration, endorsement of registration and renewal registration.[302]

The explanatory notes state:

> Due to the requirement to observe natural justice, placing a condition on a practitioner's registration when they register or renew their registration can be time consuming and resource intensive. Allowing National Boards to accept undertakings from practitioners, where appropriate, will free up resources for managing other priorities. The amendment will also increase the use of undertakings as they will no longer be solely a disciplinary measure. Practitioners may be more willing to provide an undertaking than have a condition imposed on their registration because this will avoid delays in registration and increase their involvement in the process.[303]

In addition, the Bill amends the HO Act to allow the OHO to accept undertakings from practitioners as an immediate registration action to mitigate risks to the public.[304]

The amendments also permit a National Board to refuse to renew a practitioner's registration if the practitioner has contravened an undertaken they have given during their previous period of registration.[305]

3.3.2.1 Submitters' views

There was general support amongst submitters for the proposal, including from CRANAplus, Avant Mutual and ACRRM.[306]

CRANAplus stated that the availability of undertakings as an alternative to placing conditions on a practitioner's registration may achieve more timely outcomes while still protecting the public.[307]

Avant Mutual noted that, under the amendments, a National Board can refuse to renew a practitioner's registration for failing to comply with an undertaking. Avant Mutual considered that refusing to renew for a failure to comply with an undertaking is tantamount to deregistration, and

300 AHPRA, Glossary, https://www.ahpra.gov.au/Support/Glossary.aspx#C.

301 AHPRA, Glossary, https://www.ahpra.gov.au/Support/Glossary.aspx#C.

302 Bill, cl 60 to 65 amend sections 52, 57, 62 and 65 of, and insert new sections 83A and 103A into, the National Law.

303 Explanatory notes, pp 13-14.

304 Bill, cl 4 to 16 amend sections 14, 37, 57, 59, 60, 61, 62, 63, 65 of, and inserts new sections 58A, 58B, 65A to 65F into, the HO Act.

305 Bill, cl 66 amends section 112 of the National Law.

306 Submissions 31, 35 and 36.

307 Submission 36, p 4.

submitted that this power needs to be exercised in a way that is proportionate to the nature of the breach. Avant Mutual suggested that this should be explained in the relevant section for clarity and to ensure adherence to the principle of proportionality.[308]

The Health Ombudsman supported the proposal to permit the acceptance of undertakings as a form of immediate registration action. The Health Ombudsman considered that the amendments would:

- enhance the efficiency of Queensland's co-regulatory system and make the HO Act more consistent with the National Law
- enable the OHO to more quickly and effectively take immediate registration action to protect health and safety.[309]

AHPRA also supported the proposed amendments, stating that they would improve timeliness, reduce pressure on Board resources and improve oversight of practitioners. AHPRA considered that practitioners may also benefit from being able to voluntarily agree to undertake corrective actions, rather than being subject to a process where a National Board imposes a condition on their registration.[310]

3.3.2.2 Department's response

In response to Avant Mutual's concerns, Queensland Health advised that the National Boards must have regard to the guiding principles and objectives of the National Scheme in exercising its functions. The guiding principles include that the National Scheme is to operate in a transparent and fair way and that restrictions on the practice of a health profession are to be imposed under the scheme only if necessary to ensure the health services are provided safely and are of an appropriate quality.[311]

3.3.3 Changing or removing conditions on endorsements of registration

An endorsement of registration recognises that a person has an extended scope of practice in a particular area because they have an additional qualification that is approved by the National Board, eg Nurse Practitioners.[312]

The Bill clarifies that the process for a National Board to change or remove a condition on an endorsement of registration is the same as for changing or removing a condition on a practitioner's registration.[313]

3.3.4 National Boards to require records at the preliminary assessment

The Bill amends the National Law to provide that a National Board may require a person to provide specified information, within a specified reasonable time, during the preliminary assessment of a notification.[314] This power is already available to the Health Ombudsman in Queensland.

A person must comply with a request for information unless they have a reasonable excuse, e.g. the information may incriminate the individual – maximum penalty for failing to comply is $5,000 (an individual) and $10,000 (a body corporate).[315]

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308 Submission 31, p 4.

309 Submission 33, p 2.

310 Submission 21, p 5.

311 Queensland Health, correspondence, 10 June 2022, p 8.

312 AHPRA, Glossary, https://www.ahpra.gov.au/Support/Glossary.aspx#C.

313 Bill, cl 67 and 68 amend sections 126 and 127 of the National Law.

314 Bill, cl 92, inserts new sections 149A and 149B into the National Law.

315 Bill, cl 92, inserts new sections 149A and 149B into the National Law.

The explanatory notes state:

> When conducting a preliminary assessment of a notification, a National Board can request information from practitioners. However, confidentiality restrictions mean that some clinical records can only be provided if the notification was made by a patient and the patient consents to the disclosure of the records. As there is no ability for National Boards to compel disclosure of documents at the preliminary assessment stage, practitioners cannot provide Boards with confidential information that may be relevant and enable efficient resolution of the notification. Instead, Boards may be required to commence an investigation to obtain the information necessary to determine whether regulatory action is needed.
>
> The Bill gives regulators the power to require practitioners to provide information or documents, including patient and practitioner records, to support a preliminary assessment of a notification.[316]

The explanatory notes state that the amendments '… will increase the efficiency of the preliminary assessment process and support timely resolution of matters, which is likely to improve the experience of both practitioners and notifiers'. [317]

3.3.4.1 Submitters' views

Avant Mutual supported the proposed amendment. ACRRM, however, considered that the terms *specified reasonable time* and *specified reasonable way* should be replaced with clearly defined terms to ensure that all practitioners are subject to the same time limits and specifications.[318]

AMA and AMAQ recommended a minimum one-month timeframe for practitioners to produce documents on the request of a National Board.[319]

QNMU raised concerns about the proposals, based on a practitioner's right to privacy during an investigation.[320]

3.3.4.2 Department's response

Queensland Health advised that the requirement for practitioners to produce requested documents within a specified reasonable time is consistent with other similar provisions in the National Law, stating:

> This flexibility enables consideration of the particular circumstances of the matter, including the complexity of the request and the practitioner's ease of access to the information or documents.[321]

In relation to QNMU's concerns about a practitioner's privacy, Queensland Health noted that a National Board can currently request information from practitioners to inform their preliminary assessment and compel disclosure at later stages of an investigation. Queensland Health stated:

> The amendments do not affect the types of documents or other information the National Boards can access; they simply bring forward the point in time at which National Boards can require the information to be produced. This will increase the efficiency of the preliminary assessment process and support timely resolution of matters, which is likely to improve the experience of both practitioners and notifiers.[322]

Queensland Health considered that the amendments would be particularly useful in situations where confidentiality restrictions currently restrict access to clinical records. Queensland Health stated:

316 Explanatory notes, p 14.

317 Explanatory notes, p 14.

318 Submission 35, p 4.

319 Submissions 13 and 17.

320 Submission 12, attachment, p 14.

321 Queensland Health, correspondence, 10 June 2022, p 14.

322 Queensland Health, correspondence, 10 June 2022, p 14.

> … allowing National Boards to compel disclosure of documents at the preliminary assessment stage, will enable practitioners to provide confidential information that may be relevant and enable efficient resolution of the notification.[323]

Queensland Health advised that the amendments would not require practitioners to provide requested information if it might incriminate them. Queensland Health also noted that these changes already apply in Queensland under the HO Act.[324]

3.3.5 Show cause process

Currently, under the National Law, once a National Board proposes to take *relevant action* (e.g. suspend a practitioner's registration or impose conditions) and initiates a show cause process, it must either take the proposed action, take no further action or take a different relevant action under division 10 of the National Law. The explanatory notes state:

> This could preclude the National Board from taking action under a different division, such as investigating a matter under division 8 or initiating a health or performance assessment under division 9. This may be appropriate where, for example, new information comes to light in the show cause process that warrants further investigation or assessment.[325]

The Bill amends the National Law to permit a National Board to take appropriate action against a registered health practitioner under the health, conduct and performance provisions in part 8 of the National Law, even if the Board initially proposed to take a different regulatory action under division 10 of part 8.[326]

The Bill also provides that when taking a relevant action under division 10 of part 8, National Boards will no longer be exempt from the show cause process requirements of section 179 when they have already investigated the relevant matter or completed a health or performance assessment of the registered health practitioner or student. The explanatory notes stated that 'In practice, National Boards always afford practitioners opportunity to show cause, so this amendment brings the National Law into line with current practice'.[327]

3.3.5.1 Submitters' views

Australian Medical Professionals Society and Nursing Professional Association of Australia raised concerns about the time afforded to practitioners to respond to show cause notices and the ability of regulators to take immediate action without a show cause process.[328]

NHPO raised concerned that allowing a National Board to take a different form of regulatory action from that initially proposed in a show cause notice, potentially one that has a greater impact, was not consistent with the principles of procedural fairness. The NHPO suggested that an alternative arrangement could be to allow a National Board to waive a show cause process with the agreement of the relevant practitioner.[329]

3.3.6 National Board to refer matters to other entities at preliminary assessment

The Bill amends the National Law to permit a National Board to refer matters to another entity after a preliminary assessment of the notification, if it decides the subject matter may be dealt with by that entity.

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323 Queensland Health, correspondence, 10 June 2022, p 14.

324 Queensland Health, correspondence, 10 June 2022, p 14.

325 Explanatory notes, p 15.

326 Bill, cl 105 and 106 amend sections 179 and 180 of the National Law.

327 Explanatory notes, p 15.

328 Submission 23, p 5.

329 Submission 39, p 3.

If the National Board refers a notification, or part of a notification, to another entity, it must give the entity a copy of the notification, or if the notification was not made in writing, a copy of the Board's record of the details of the notification, and any other relevant information.

The National Board may ask the other entity to provide information about how the notification was resolved.[330]

3.3.6.1 Submitters' views

RACGP opposed the amendments, maintaining that referrals should only be permitted to medical colleges for remedial purposes or the relevant court or tribunal.[331]

QNMU suggested that regulators should only be able to refer matters after preliminary assessment to a practitioner's employer, if the employer is the complainant, but not to other entities.[332]

While broadly supportive of the proposed amendments, United Workers Union (UWU) raised concerns about the prospect of regulators referring matters to entities without appropriate expertise. UWU also raised concerns about referring matters to employers who may be concurrently dealing with the same subject matter through an internal disciplinary process, causing a conflict of interest. Accordingly, UWU recommended that 'employers' be specifically excluded from the entities to which a referral can be made.[333]

Avant Mutual and RACGP considered that allowing a National Board to continue to deal with a matter that has been referred to another entity could lead to duplication, multiple investigations by different entities, reduced efficiency and potentially conflicting outcomes for practitioners.[334]

Separately, Avant Mutual suggested that National Boards should be able to take no further action in relation to a notification, if the notifier has not first raised the matter with the practitioner about whom the notification is made. In doing so, Avant Mutual noted that the HO Act allows the Health Ombudsman to take no further action in these circumstances.[335]

3.3.6.2 Department's response

Queensland Health noted that upon receipt of a notification, National Boards must conduct a preliminary assessment to determine if:

- the notification relates to a health practitioner or student registered in the health profession for which the Board was established
- a ground for the notification exists
- the notification could also be made to a health complaints entity.

Queensland Health stated that during the preliminary assessment of a notification, National Boards can refer a notification to another Board, if the notification relates to a person registered in the health profession for which the other Board was established. National Boards can also refer a notification to a jurisdiction's health complaints entity if the notification would provide a ground for such a referral.

Queensland Health advised that, except in the limited circumstances noted above, National Boards are currently unable to refer a notification to another entity or for another purpose at the preliminary assessment stage, and instead must wait until after a further investigation.

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330 Bill, cl 103 inserts new section 150A into the National Law.

331 Submission 7, pp 4-5.

332 Submission 12, attachment, p 11.

333 Submission 20, p 8.

334 Submissions 7 and 31.

335 Submission 31, p 9.

Queensland Health stated:

> At times, it is clear to a Board at the preliminary assessment stage that another entity is better placed to manage the issues raised by the notification. In these circumstances, the Bill will allow a National Board to refer the matter, or a part of the matter, to the other entity for further regulatory action. This is intended to speed up the notification process and reduce the number of matters that unnecessarily proceed to a formal assessment or investigation under the National Law. This will reduce the time from notification to final regulatory action, benefitting both the notifier and practitioner. It will also allow National Boards to focus their resourcing on the matters most appropriate for them to manage.[336]

While the amendments do not limit the types of entities to which the National Boards may refer matters, Queensland Health noted that such referrals may only be made to entities that have the power to deal with the subject-matter of the notification.

Queensland Health provided the following example of where it would be appropriate for a National Board to refer certain aspects of a notification to another entity, while retaining other aspects:

> … a notification may allege that a practitioner has engaged in a scheduled medicine offence and that the practitioner has a substance abuse problem. In these circumstances, a National Board could refer the alleged scheduled medicine offence to the relevant State-based regulator while also conducting its own assessment of the practitioner's health, conduct and performance. In this way, the amendments promote better coordination among regulators, which will improve efficiency and promote more effective regulatory outcomes.[337]

In relation to Avant Mutual's recommendation, Queensland Health advised that it is not appropriate to insert a ground for a National Board to take no further action where a notifier has not raised their concerns with the practitioner who is the subject of the notification. Queensland Health stated that the comparison drawn to the HO Act is not applicable because that Act deals with a broader range of health service complaints, including complaints about unregistered health practitioners, and contains mechanisms for resolving complaints through voluntary conciliation.[338]

3.3.7 Discretion for regulators not to refer matters to a responsible tribunal

Under the National Law, a National Board must refer all professional misconduct cases to a responsible tribunal. The Boards do not have any discretion to take another action or to decide to take any further steps in respect of the matter.

The explanatory notes acknowledge that:

> In most cases, it will be appropriate to refer the matter to a tribunal. Referral to a tribunal acknowledges the seriousness of professional misconduct and allows for the imposition of the most severe penalties under the National Law. However, tribunal proceedings are time consuming and expensive for all parties.[339]

The Bill amends the National Law to give a National Board limited discretion to decide not to refer professional misconduct cases to the responsible tribunal, if the Board decides there is no public interest in the matter being referred to the tribunal.[340]

336 Queensland Health, correspondence, 10 June 2022, pp 17-18.

337 Queensland Health, correspondence, 10 June 2022, p 18.

338 Queensland Health, correspondence, 10 June 2022, p 18.

339 Explanatory notes, p 16.

340 Bill, cl 107 to 109 amend sections 178 and 193 of, and inserts new section 193A into, the National Law.

In reaching this decision, a National Board must have regard to:

- the need to protect the health and safety of the public
- the seriousness of the alleged conduct, including whether the registered health practitioner may have engaged in wilful misconduct
- whether the practitioner is the subject of more than one notification or has previously been the subject of a notification
- whether the practitioner is still registered and, if not registered, may again seek registration in the future
- any other benefit the public may receive by having the matter referred to a responsible tribunal, including the benefit of a public decision in relation to the matter
- any other matter the Board considers relevant to the decision.

If the National Board decides not to refer a matter to the responsible tribunal, AHPRA must publish information about that decision in its annual report.[341]

3.3.7.1 Submitters' views

Submitters, such as AMA, ICA, UWU, MIGA and QLS supported the proposed amendment.[342] QLS provided examples of where matters have been referred to QCAT in circumstances where there is no public interest (e.g. the practitioner is no longer registered or has retired).[343] MIGA considered the amendment was an improvement, noting 'It will assist with workload issues, time and cost and allow consideration of a situation where the professional is not actually an ongoing risk to the public'.[344]

ICA and MIGA raised concerns, however, that the threshold of *no public interest* in a referral may be too low and difficult to satisfy.[345] ICA suggested that the development of guidelines dealing with the exercise of this discretion should be produced, in consultation with insurers, to provide clarity and enable appropriate and effective use of the discretion.[346] While MIGA recommended that the requirement that there be no *public interest* be replaced with there is *insufficient public interest* in the referral of a matter.[347]

ACRRM argued that the amendments are contrary to natural justice and human rights because practitioners may be prevented from having their case determined by a responsible tribunal.[348]

UWU raised a similar concern, recommending that decisions not to refer a matter to a tribunal should be made with the consent of the practitioner or, alternatively, that the practitioner be able to seek external review of the decision.[349]

3.3.7.2 Department's response

Queensland Health considered that the public interest test and factors achieve a balance between ensuring that the most serious professional misconduct matters continue to be heard by a tribunal, and ensuring that resources are not used to pursue matters where there is no risk to the public and

341 Bill, cl 109 inserts new section 193A into the National Law.

342 Submissions 13, 16, 18, 20, 27, 28 and 31.

343 Submission 28, p 3.

344 Public hearing transcript, Brisbane, 8 June 2022, p 30.

345 Submissions 16 and 27.

346 Submission 16, p 4; public hearing transcript, Brisbane, 8 June 2022, p 30.

347 Submission 27, p 2.

348 Submission 35, p 4.

349 Submission 20, p 8.

no public interest in having the matter heard by a tribunal.[350] Queensland Health provided the following example:

> A National Board may decide not to pursue proceedings against a practitioner who has retired from practising for health reasons and is very unlikely to apply for registration in the future.[351]

Currently, a National Board is required to initiate tribunal proceedings whenever a registered health practitioner may have engaged in professional misconduct or may have obtained their registration through improper means. Queensland Health clarified that the amendments would provide National Boards with discretion not to initiate proceedings if there is no public interest in doing so.

Queensland Health advised that the amendments would not prevent a National Board from taking other regulatory action. Such regulatory action would remain appellable or subject to other appropriate procedural protections under the National Law. In addition, the discretion not to refer certain matters to a responsible tribunal would not affect a practitioner's rights to appeal regulatory decisions to a responsible tribunal.[352]

3.3.8 Removal of endorsements of registrations for midwife practitioners

The Bill removes endorsements of registrations for midwife practitioners.[353]

The explanatory notes advised that, in 2010, when the National Scheme commenced, one practitioner was registered as a midwife practitioner under the *Nurses Act 1991* (NSW). This practitioner's registration was transitioned to the national register with an endorsement as a midwife practitioner.

Since this time, the Nursing and Midwifery Board of Australia (NMBA) has not approved any further midwife practitioner endorsements. The NMBA does not have a registration standard for endorsement as a midwife practitioner and there are no approved programs of study that qualify a midwife to practice as a midwife practitioner.

As there is no evidence that there is a workforce requirement for such an endorsement, the Bill will repeal the section of the National Law that allows the NMBA to endorse registrations of midwife practitioners. A new savings provision will ensure that the sole registered midwife practitioner will remain able to practice under that protected title.[354]

3.3.8.1 Submitters' views

ACN agreed with the proposed removal of the endorsement, subject to providing safeguards for midwife practitioners in sole practice.[355]

350 Queensland Health, correspondence, 10 June 2022, pp 18-19.

351 Queensland Health, correspondence, 10 June 2022, p 19.

352 Queensland Health, correspondence, 10 June 2022, p 19.

353 Bill, cl 75 omits Part 7, division 8, subdivision 3 of the National Law.

354 Explanatory notes, 17.

355 Submission 34, p 3.

4 Compliance with the *Legislative Standards Act 1992*

4.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that 'fundamental legislative principles' are the 'principles relating to legislation that underlie a parliamentary democracy based on the rule of law'. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals
- the institution of Parliament.

The committee has examined the application of the fundamental legislative principles (FLPs) to the Bill. The committee brings the following to the attention of the Legislative Assembly.

4.1.1 Rights and liberties of individuals - administrative power and natural justice

Whether legislation has sufficient regard to the rights and liberties of individuals depends on whether, for example, the legislation:

- makes the rights and liberties, or obligations, dependent on administrative power only if the power is sufficiently defined and subject to appropriate review
- is consistent with the principles of natural justice.[356]

4.1.1.1 Withdrawal of registration

The Bill amends the National Law to enable a National Board to withdraw the registration of a registered health practitioner, if the Board reasonably believes the practitioner's registration was improperly obtained because the practitioner gave the Board information or a document that was false or misleading in a material particular.[357]

From a FLP perspective, it is important that there be an appropriate review process for decisions of a serious nature - such as withdrawing a person's registration - and that the principles of natural justice apply to the making of the decision.

The Bill provides that before a National Board withdraws a registered health practitioner's registration, it must give the practitioner written notice of the proposal and invite the practitioner to make a written or verbal submission to the National Board. Despite this requirement, a National Board may take immediate action in relation to the practitioner, such as by suspending, or imposing a condition on, the practitioner's registration.[358]

After considering any submissions from the practitioner, the National Board must make a decision about the registration and give the practitioner notice of it. The National Board may decide that no further action is required or decide to withdraw the practitioner's registration or refer the matter to a responsible tribunal or take other action under Part 8 of the National Law.[359]

Under the Bill, a decision to withdraw registration would be subject to appeal to a responsible tribunal, e.g QCAT.[360]

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356 LSA, s 4(3)(a) and (b).

357 Bill, cl 70 inserts new section 85A into the National Law.

358 Bill, cl 70 inserts new section 85B into the National Law; National Law, ss 155, 156.

359 Bill, cl 70 inserts new sections 85C and 85D into the National Law.

360 Bill, cl 74 amends section 199 of the National Law; explanatory notes, p 23.

The explanatory notes contend that the power of a National Board to withdraw a practitioner's registration is necessary 'to fulfill the objective of the National Scheme of ensuring only suitably trained and appropriately qualified practitioners are registered'.[361] The explanatory notes add:

> Currently the National Board is unable to re-consider a decision to approve a practitioner's registration, even if it becomes aware that the information it based its decision on was false or misleading. It must, instead, take other disciplinary action, such as suspending the practitioner and initiating proceedings before a tribunal.[362]

The explanatory notes state that making the decision-making power subject to a show cause process and appeal to a responsible tribunal ensures procedural fairness.[363]

Committee comment

The committee is satisfied that the Bill has sufficient regard to the rights and liberties of individuals in this instance.

In reaching this view, the committee noted that the objective of giving National Boards the power to withdraw a practitioner's registration is to ensure only suitably trained and appropriately qualified practitioners are registered. The committee also notes that the process that must be followed to withdraw a practitioner's registration includes input from the practitioner and an avenue for appeal.

4.1.1.2 Power to issue interim prohibition orders

The Bill provides that AHPRA and the National Boards may issue an IPO to an unregistered practitioner, including a practitioner whose registration has lapsed or been suspended.[364] As noted in section 3.1.3.1 of this report, an IPO can prohibit, or restrict, a person from providing a specified health service or all health services and prohibit a person from using a protected title.

This power would impact on a person's rights and liberties, including employment rights, and raises questions as to whether there are appropriate review processes and natural justice applies to the decision making.

The explanatory notes state that this power '… will allow regulators to take swift action to control a serious risk while other action is being finalised or a matter is handed over to another regulator better placed to undertake more comprehensive regulatory action'.[365]

The Bill includes the following safeguards in relation to issuing IPOs:

- AHPRA or the National Board must, prior to issuing an IPO, invite the person to make submissions, unless they reasonably believe it is necessary to take urgent action to issue an IPOS to protect public health or safety[366]
- AHPRA or the National Board must advise of its reasons for the decision to issue an IPO[367]

361 Explanatory notes, p 23.

362 Explanatory notes, p 23.

363 Explanatory notes, pp 5, 23.

364 Bill, Chapter 3, part 2, inserts new part 8, division 7A into the National Law.

365 Explanatory notes, p 6.

366 Bill, cl 94 inserts new sections 159D and 159E into the National Law.

367 Bill, cl 94 inserts new section 159D into the National Law.

- the maximum duration of an IPO is 60 days,[368] although AHPRA or the National Board may extend an IPO for a further period of up to 60 days,[369] if it reasonably believes it is necessary, an application must be made to the relevant tribunal any further extension[370]
- the decision to issue an IPO, or extend it, is appealable to the responsible tribunal.[371]

Committee comment

Given the safeguards in the Bill, the committee is satisfied that the power to issue an IPO has sufficient regard to the rights and liberties of unregistered practitioners. The committee also notes that the new power is complementary to the existing powers of the Health Ombudsman to issue IPOs and prohibition orders.

4.1.2 Rights and liberties of individuals – protection against self-incrimination - power to require production of documents and information

Whether legislation has sufficient regard to the rights and liberties of individuals depends on whether the legislation provides appropriate protection against self-incrimination.[372]

As discussed in section 3.3.4 of this report, the Bill introduces a new power for National Boards to require the production of specified information or documents for the purpose of conducting the preliminary assessment of a notification. A person must comply with the notice unless the person has a reasonable excuse, including that producing the information or document might tend to incriminate the individual.[373]

The explanatory notes state that this power is justified because 'Boards require correct information to effectively assess compliance and risk'[374] and it complements existing powers of the Health Ombudsman'.[375]

Committee comment

The committee is satisfied that the power to require the provision of certain information or documents has sufficient regard to the rights and liberties of individuals given the importance of correct information to assess compliance and risk, and the Bill provides that self-incrimination is a reasonable excuse for not providing the information or documents.

4.1.3 Rights and liberties of individuals – delegation of administrative power – approval of registration standards

Whether a Bill has sufficient regard to the rights and liberties of individuals depends on whether, for example, the Bill allows the delegation of administrative power only in appropriate cases and to appropriate persons.[376]

As outlined at section 3.2.1 of this report, currently the National Boards draft registration standards, and amendments to standards, about the following matters and submit them to the Ministerial Council for approval:

368 Bill, cl 94 inserts new section 159F into the National Law.

369 Bill, cl 94 inserts new section 159H into the National Law.

370 Bill, cl 94 inserts new section 159J into the National Law.

371 Bill, cl 94 inserts new sections 159D and 159H into the National Law.

372 LSA, S 4(3)(f).

373 Bill, cl 92 inserts new section 149A into the National Law and cl 140 inserts new section 150A into the *Health Practitioner Regulation National Law Act 2009*.

374 Explanatory notes, p 23.

375 Explanatory notes, p 69.

376 LSA, s 4(3)(c).

- the registration, or renewal of registration, of persons in a health profession
- the endorsement, or renewal of the endorsement, of the registration of registered health practitioners.[377]

The Ministerial Council may approve a registration standard for a health profession only if the relevant National Board recommends it, and the standard does not provide for a matter about which an accreditation standard may provide.[378]

The Bill allows the Ministerial Council to delegate its power to approve registration standards to an entity it considers appropriate to exercise the power.[379]

The explanatory notes give an indication of the entities to whom the Ministerial Council is likely to delegate power to approve registration standards:

> … the Ministerial Council may consider delegating certain powers to the Agency Management Committee (being re-named by the Bill to the Agency Board) acting on the advice of the National Agency and jurisdictions, or to the Health Chief Executives Forum.[380]

The explanatory notes provided the following justification for the provisions:

> … there are a range of administrative powers under the Act, and it is impractical for the Ministerial Council to exercise day-to-day functions under the Act personally. This was recognised in the *Review of Governance of the National Registration and Accreditation Scheme*, which found that the approval process for registration standards generates unnecessary amounts of work and bureaucracy, resulting in delays in approvals. The Bill implements a recommendation from the review to allow the Ministerial Council to delegate its powers to approve registration standards.[381]

Safeguards for the proposed amendment are provided by section 29 of the *Health Practitioner Regulation National Law Act 2009* (National Law Act) and section 12 of the National Law:

> … a formal instrument of delegation will be established should Ministers choose to delegate these powers, and the Ministerial Council will retain its obligation to ensure that the function is properly exercised. Section 29 also prohibits subdelegation of the powers. The Ministerial Council also retains the power to ask a National Board to review an approved or proposed registration standard.[382]

The explanatory notes advise further that existing provisions of the National Law require delegated decisions to be published.[383]

Committee comment

Whilst noting that the Bill does not specify to whom the Ministerial Council may delegate its power to approve registration standards, the committee is satisfied that the delegation of the Ministerial Council's power to approve registration standards has sufficient regard to the rights and liberties of individuals.

In reaching this view, the committee noted that the Ministerial Council has to consider the delegated entity appropriate to exercise the power, the Ministerial Council retains responsibility for ensuring that the function is properly exercised, and the power to delegate cannot be sub-delegated.

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377 National Law, s 12; explanatory notes, p 49.

378 National Law, s 12. Accreditation standards are developed and approved under Division 3 of Part 6 of the National Law.

379 Bill, cl 54 amends section 12 of the National Law.

380 Explanatory notes, p 12.

381 Explanatory notes, p 19.

382 Explanatory notes, p 19.

383 Explanatory notes, p 28.

In addition, the committee noted that the power to delegate is restricted to approving registration standards (it is not a broad delegation power), any delegation must be in writing, and the Ministerial Council will retain the power to ask a National Board to review an approved or proposed registration standard.

4.1.4 Rights and liberties of individuals – penalties

The creation of new offences and penalties affects the rights and liberties of individuals. A penalty should be proportionate to the offence, and penalties within legislation should be consistent with each other.[384]

4.1.4.1 Penalties relating to interim prohibition orders

The Bill introduces offences relating to the new power to issue IPOs, under the National Law, and to increase the penalties for related offences in the HO Act.

The Bill would amend the National Law to make it an offence:

- to contravene an IPO - maximum penalty of $60,000 or 3 years imprisonment or both[385]
- for a person who is subject to an IPO (a prohibited person) to fail to give written notice of the order to specified persons or entities - maximum penalty of $5000[386]
- to advertise a health service to be provided by a prohibited person unless the advertisement states that the prohibited person is subject to an IPO - maximum penalty of $5000.[387]

The Bill would amend the HO Act to increase the penalties for contravening an IPO, or prohibition order, to a level similar to those proposed to be included in the National Law. That is, it would increase the maximum penalty for contravening an interim prohibition order[388] or a prohibition order[389] from 200 penalty units ($27,570) to 450 penalty units ($62,032.50) or 3 years imprisonment.[390]

The explanatory notes justify the increase in penalties for the offences of contravening an IPO or prohibition order, under the HO Act, in light of their seriousness:

> The increase in penalties under the Health Ombudsman Act is considered reasonable and appropriate in light of the seriousness of the offences, which apply to persons who wilfully ignore a lawful order and continue to practise in a way that could seriously harm the public.
>
> The alignment of penalties with the National Law also avoids having different penalties apply to the same conduct depending on which regulator issues an order.[391]

The Bill also provides that an offence of contravening an IPO or a prohibition order under the HO Act is an indictable offence that is a misdemeanour.[392] The explanatory notes advise that this 'is consistent

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384 Office of the Queensland Parliamentary Counsel (OQPC), *Fundamental legislative principles: the OQPC notebook*, 2008, p 120.

385 Bill, cl 94 inserts new section 159O(1) into the National Law.

386 Bill, cl 94 inserts new section 159O(2) into the National Law.

387 $10,000 for a corporation. Bill, cl 94 inserts new section 159O(3) into the National Law.

388 Or corresponding interstate interim order. Health Ombudsman Act, s 78.

389 Or corresponding interstate order. Health Ombudsman Act, s 90P.

390 Bill, cl 18 and 21 inserts new sections 78 and 90P into the HO Act. The current value of a penalty unit is $137.85: Penalties and Sentences Regulation 2015, s 3. From 1 July 2022, the value of a penalty unit will be $143.75: Penalties and Sentences (Penalty Unit Value) Amendment Regulation 2022.

391 Explanatory notes, pp 24-25.

392 Bill, cl 28 inserts new section 271 into the HO Act.

with the designation of related offences under the National Law that are subject to similar penalties'.[393]

The Bill further provides that a proceeding for an indictable offence is to be heard and decided summarily, except in exceptional circumstances or if punishment on summary conviction would not be adequate.[394] The maximum penalty that may be imposed on a summary conviction for an indictable offence is 165 penalty units ($22,745.25).[395] This means that the maximum penalty for contravening an IPO or prohibition order under the HO Act (450 penalty units or 3 years imprisonment) 'will be limited to cases where the Magistrates Court considers there are exceptional circumstances or that an adequate punishment may not otherwise be obtained'.[396]

The proposed penalty under the National Law for contravention of an IPO aligns with the penalty for contravening a prohibition order under that legislation,[397] and, according to the explanatory notes, 'reflects the seriousness of the offence'.[398]

Regarding the offences relating to the requirements to provide notice of the order to certain people,[399] the explanatory notes state:

> This provides transparency and ensures the public, employers, and other practitioners are aware that the person may not provide certain services or have other restrictions imposed on the provision of all or specified health services.[400]

Committee comment

The committee notes that, at present, the only penalty available under the HO Act for the offence of contravening an IPO or a prohibition order is a monetary penalty.

While the Bill proposes to significantly increase the monetary penalty from 200 to 450 penalty units (an increase of 225%), the proposed inclusion of imprisonment of up to 3 years as a maximum penalty also raises potential FLP issues.

Apart from stating that the proposed new penalty of 450 penalty units or 3 years imprisonment 'reflects the seriousness of these offences, which apply to persons who wilfully ignore a lawful order and continue to practise in a way that could seriously harm the public',[401] the explanatory notes do not comment with respect to FLP on the proposed inclusion of 3 years imprisonment in the maximum penalty of the existing offence in the HO Act or in the new offence of contravening an IPO under the National Law.

The committee considers that such a penalty greatly impacts on the rights and liberties of those individuals found guilty of these offences. The committee, therefore, considers that the inclusion of an imprisonment should have been specifically justified with respect to FLPs in the explanatory notes.

393 Explanatory notes, p 25.

394 Bill, cl 28 inserts new section 271 into the HO Act.

395 Bill, cl 28 inserts new section 271 into the HO Act.

396 Explanatory notes, p 25.

397 National Law, s 196A.

398 Explanatory notes, p 25.

399 Bill, cl 94 inserts new section 159O(2) into the National Law.

400 Explanatory notes, p 73.

401 Explanatory notes, p 8.

The statement of compatibility addresses the inclusion of imprisonment as a potential penalty in the HO Act in its discussion of the right to liberty with respect to the HRA, stating:

> Under the amendments, a penalty of imprisonment can only be imposed after lawful court proceedings and only if a Magistrates Court abstains from dealing with the charge summarily. Imprisonment is reasonable and justifiable in circumstances in which health practitioners wilfully ignore a lawful order and continue to practise in a way that could seriously harm the public.[402]

The more than doubling of the penalties for existing offences relating to contravention of IPOs and prohibition orders in the HO Act would bring that Act in line with the National Law. The maximum penalty of 450 penalty units under the HO Act would, however, only be invoked in those cases where there are exceptional circumstances or adequate punishment is not available on summary conviction.

The committee considers that, on balance, the new penalties introduced by the Bill are reasonable and proportionate.

4.1.4.2 Penalties relating to the provision of documents

The Bill introduces new offences for a failure to comply with a notice given by a National Board to provide specified information or documents, unless the person has a reasonable excuse. The proposed maximum penalty is $5000.[403] It is a reasonable excuse for an individual not to give information or produce a document if giving the information or producing the document might tend to incriminate the individual.

The explanatory notes comment that the proposed amendments 'complement existing powers of the Queensland Health Ombudsman',[404] relevantly section 48 of the HO Act provides that a person must comply with a notice to give stated information to the Health Ombudsman, unless the person has a reasonable excuse. The maximum penalty for contravening this requirement is 50 penalty units ($6892.50).

A similar offence in the National Law, the offence of failing to give stated information to an investigator without reasonable excuse, also has a maximum penalty of $5000.[405]

Committee comment

The committee is satisfied that the penalties for the offences relating to the provision of information or documents are appropriate in the circumstances.

4.1.4.3 Penalties relating to advertising offences

Currently, the maximum penalty in the National Law for an advertising offence is $5000.[406] The Bill would increase this maximum penalty to $60,000, a twelvefold increase.[407]

The explanatory notes provide the following justification for this increase:

> The current penalties for advertising offences are not considered a sufficient deterrent.
>
> The increase in penalties is appropriate and reasonable in light of the harms that could arise from misleading advertising about health services. The new penalty also aligns with other serious offences in the National Law, such as those for misusing a protected title in section 113.

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402 Statement of compatibility, p 18.

403 $10,000 in the case of a body corporate; Bill, cl 92 and 140 insert new sections 149A and 150A into the National Law.

404 Explanatory notes, p 69.

405 $10,000 in the case of a body corporate. National Law, sch 5, s 2(1).

406 $10,000 in the case of a body corporate. National Law, s 133.

407 $120,000 in the case of a body corporate. Bill, cl 85 amends section 133 of the National Law.

> The current penalties under the National Law are significantly lower than the penalties for engaging in misleading or deceptive conduct under the Australian Consumer Law, which can exceed $10 million for corporations and be as much as $500,000 for individuals. Misleading or deceptive advertising relating to sale of food under section 37 of the *Food Act 2006* has a maximum penalty of 500 penalty units (or $68,500).[408]

Committee comment

The committee is satisfied by the justification provided in the explanatory notes for the significant increase in the maximum penalty for a breach of an advertising offence, and considers that the new penalties introduced by the Bill are reasonable and proportionate.

4.1.4.4 Penalties relating to directing and inciting unprofessional conduct or professional misconduct

The Bill doubles the maximum penalty (from $30,000 to $60,000[409]) for the offence of directing or inciting a registered health practitioner to do anything that, in the course of the practitioner's practice of the health profession, amounts to unprofessional conduct or professional misconduct.

The justification provided by the explanatory notes for the amendment is that it would bring the penalty 'into line with the penalties for other serious offences under the National Law'.[410]

Committee comment

The committee is satisfied with the justification provided in the explanatory notes for the doubling of the maximum penalty for directing or inciting unprofessional conduct or professional misconduct, and considers that the new penalties introduced by the Bill are reasonable and proportionate.

4.1.5 Rights and liberties of individuals - privacy

The right to privacy, and the disclosure of private or confidential information, is relevant to a consideration of whether legislation has sufficient regard to individual rights and liberties.[411]

4.1.5.1 Public statements

The Bill amends the National Law and HO Act to provide that AHPRA, a National Board and the Health Ombudsman may make a public statement about a person, if either of the following applies:

- the regulatory authority reasonably believes the person is contravening, or has contravened, a relevant *provision*,[412] or
- the person is the subject of an assessment, investigation or other proceeding.[413]

408 Explanatory notes, p 24.

409 $60,000 to $120,000 in the case of a body corporate. Clause 86 (National Law, s 136).

410 Explanatory notes, p 24.

411 LSA, s 4(2)(a); OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 113.

412 *Relevant provision* is defined in proposed new sections 90AA(5) of the HO Act and new section 159P of the National Law to mean any of the following sections of the National Law: s 113 (restriction on use of protected titles); s 115 (restriction on use of specialist titles); s 116 (claims by persons as to registration as health practitioner); s 117 (claims by persons as to registration in particular profession or division); s 118 (claims by persons as to specialist registration); s 119 (claims about type of registration or registration recognised speciality); s 121 (restricted dental acts); s 122 (restriction on prescription of optical appliances); s 123 (restriction on spinal manipulation); s 133 (advertising) and s 136 (directing or inciting unprofessional conduct or professional misconduct).

413 Bill, cl 20 inserts new sections 90AA to 90AD into the HO Act; Bill, cl 100 inserts new sections 159P to 159T into the National Law.

The regulatory authority must also reasonably believe that the person poses a serious risk to persons because of their conduct, performance or health and that a public statement is necessary to protect public health or safety.[414]

A public statement can be made in a way the regulatory authority considers appropriate. It may give warnings or information about a person or health services provided by a person, if the regulatory authority considers it appropriate to do so in the circumstances.[415]

As outlined in section 3.1.3.2 of this report, the ability of the regulatory authority to make public statements about an individual's private information (such as whether they have contravened a relevant provision or are under investigation due to a complaint being made about them) has a considerable impact on that person's right to privacy. This is particularly so in circumstances where an assessment or investigation is still being undertaken with regard to an individual and no findings have been made.

As acknowledged by the statement of compatibility in considering this issue from a human rights perspective:

> Public statements could have a significant adverse impact on a person's private life and reputation. The warning to the public could hamper a practitioner's ability to continue to work with others in their profession, or even jeopardise their career.[416]

In examining issues of a similar nature in regard to public health law, parliamentary committees have considered the ultimate question was whether an acceptable balance has been struck between the obvious need to adequately protect and promote the health of the public on the one hand and the rights and liberties of the individual on the other.[417]

The explanatory notes for the Bill consider that a departure from FLPs is justified on the basis that public statements can only be made about matters that 'meet a high threshold of risk',[418] stating that:

> The regulator must reasonably believe it is necessary to make a public statement to protect health or safety and that a person's conduct, performance or health pose a serious risk to others. With this threshold, the circumstances for issuing a public statement are inherently serious and have potentially serious public health consequences. For example, a public statement warning that a practitioner routinely failed to follow sterilisation procedures and potentially exposed patients to an infectious disease, may notify members of the community of their potential exposure and allow them to receive early treatment to mitigate the risks to their health.[419]

Further, the explanatory notes outline the following safeguards contained in the Bill:

- a show cause process (to give an individual the opportunity to make a submission about a proposed public statement)[420]

414 Bill, cl 20 inserts new section 90AA(1)(b) into the HO Act; Bill, cl 100 inserts new section 159Q into the National Law; explanatory notes, pp 37-38.

415 Bill, cl 20 inserts new section 90AA(2) and (3) into the HO Act; Bill, cl 100 inserts new section 159Q into the National Law; explanatory notes, pp 37-38.

416 Statement of compatibility, p 19.

417 OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 115.

418 Explanatory notes, p 21.

419 Explanatory notes, p 21.

420 Bill, cl 20 inserts new section 90AB into the HO Act; Bill, cl 100 inserts new section 159R into the National Law.

- a requirement to revoke a public statement if the grounds for the statement no longer exist or did not exist at the time the statement was made[421]
- the ability for an individual to appeal a public statement.[422]

The explanatory notes also highlight that similar statements (called 'statement of warning') are used under the *Medicines and Poisons Act 2019.*[423]

The committee that considered the Medicines and Poisons Bill found that the ability to issue a public statement of warning which may identify particular individuals is a significant power, but that departure from FLPs was justified in those circumstances by the reasons given for the power (being that publication is in the public interest, which may include preventing or minimising a health risk).[424]

Committee comment

The committee is satisfied that, on balance, there is sufficient justification for the impacts on an individual's privacy in these circumstances, taking into account the need to protect the health of the public on the one hand and the rights and liberties of the individual on the other. The committee also considers that the power to issue a public statement is subject to a high threshold and safeguards including a show cause process and appeals to a responsible tribunal.

4.1.5.2 Notifications of risk

As outlined in section 3.1.4.2 of the report, the Bill amends the National Law and HO Act to increase the ability of National Boards and the Health Ombudsman to share information with certain individuals and entities who have an employment or other arrangement with a health practitioner in the event the practitioner is subject to disciplinary action, or may pose or has posed a risk to persons or the public.[425]

The ability of the Health Ombudsman, AHPRA and National Boards to share information about a health practitioner to a broader range of entities and individuals has an impact on that health practitioner's privacy. As acknowledged in the statement of compatibility, the amendments may harm a practitioner's professional relationships and their professional reputation.[426]

In particular, the ability for the National Board to notify employers and other associates of risks stemming from a registered practitioner's health, conduct or performance prior to any disciplinary action being taken is a considerable breach of a person's privacy.

Further, it is not clear what protections will be given to the information once it has been shared (e.g. what steps, if any, employers or associates will take to protect the privacy of the information relating to the practitioners).

The explanatory notes justify these amendments on the basis that sharing information in a timely manner will mitigate ongoing health risks and avert harm to patients and the public.[427] Specifically, the explanatory notes put forward the following justifications:

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421 Bill, cl 20 inserts new section 90AD into the HO Act; Bill, cl 100 inserts new section 159T into the National Law.

422 Bill, cl 24 amends section 94(4) of the HO Act; Bill, cl 101 amends section 199(hb) of the National Law; explanatory notes, p 21.

423 *Medicines and Poisons Act 2019*, s 127; explanatory notes, p 21.

424 State Development, Natural Resources and Agricultural Industry Development Committee, *Medicines and Poisons Bill 2019*, Report No. 32, 56th Parliament, p 45.

425 Explanatory notes, p 21.

426 Statement of compatibility, p 23.

427 Explanatory notes, p 21.

- the powers are discretionary and subject to appropriate safeguards, being that notifications can be made only to specific persons, such as former employers and associates of the practitioner, and only if the Health Ombudsman or National Board reasonably believes the practitioner's conduct posed a risk of harm at the time the practitioner had an employment or other arrangement with those persons[428]
- the powers are necessary to improve information sharing between employers and regulators and allow for identification of previously unknown risks to the public. The persons who can be notified are restricted to those that are in a position to act to protect the public.[429]

In relation to notifications being given prior to disciplinary action being taken, the explanatory notes state:

> This amendment is intended to allow a National Board to share vital information in the small number of cases where it has formed a reasonable belief that a practitioner poses a serious risk to the public but has yet to take action, including where the regulator is waiting for further information to finalise a complex matter involving multiple health, performance or conduct concerns.
>
> …
>
> Notifying employers or other relevant persons or entities that a practitioner is under investigation in relation to a relevant serious matter will allow them to take immediate steps to protect the public, such as contacting persons who may be at risk; implementing restrictions or supervision requirements while the matter is investigated; and improving organisational policies, safety protocols and training requirements.[430]

The explanatory notes emphasise that this power in particular is subject to limitations:

> Disclosures under the amended provisions would generally only be made to persons who are affected by, or in a position to mitigate, the risks posed by the practitioner to whom the disclosure relates. The information provided should only include information about the practitioner and about the risks believed to be posed by the practitioner. Also, this section does not allow the Board to disclose personal health information about a patient. Further, a Board may decide not to share information under new section 220A if it decides it is not in the public interest to do so, for example where sharing the information may impact an investigation or place a notifier at risk, or where the public interest is outweighed by the practitioner's right to privacy.[431]

The explanatory notes stated that the overall justification for the breach of an individual's privacy in these circumstances is to mitigate health risks and protect the public, however, there is little consideration given in the explanatory notes as to how an individual's private information will be dealt with by an entity or associate once it is received through such notifications.

Whilst it may be the case that the HO Act and National Law already provide for the sharing of information in some circumstances, expanding the scope of the categories of what information can now be provided, and to who, warrants a consideration of these broader privacy issues in the context of FLPs.

Committee comment

The committee notes that the amendments proposed by clauses 29, 30, 84, 100 and 111 of the Bill would have a significant impact on an individual's privacy; however, on balance, the committee considers that these impacts are justified by the overall objective to mitigate health risks and protect the public.

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428 Explanatory notes, pp 21-22.

429 Explanatory notes, p 22.

430 Explanatory notes, p 80.

431 Explanatory notes, p 80.

4.1.5.3 Reporting of scheduled medicine offences

As outlined in section 3.1.4.1 of this report, the Bill amends the National Law to require health practitioners and students to report to the relevant National Board charges and convictions of offences related to regulated medicines and poisons.[432]

Requiring a person to notify if they are charged with, or convicted of, a scheduled medicines offence raises issues in relation to the privacy of an individual (in particular, the mandatory disclosure of personal information).

The explanatory notes do not address this issue in the context of FLPs, though the statement of compatibility does consider this provision in regard to the human right to privacy.[433]

It is noted that the National Law currently requires disclosure of a person's criminal history as part of the registration process and authorises the National Board to check a person's criminal history at any time. There are penalties for unauthorised disclosure of protected information under section 216 of the National Law, together with broader limits on disclosure under part 10, division 2 of the National Law.

Committee comment

The committee is satisfied that the impact on an individual's privacy resulting from the mandatory reporting of scheduled medicine offences is justified by the overall need for the National Board to have such information to mitigate any risk to public health and safety.

4.1.5.4 Publication of information about interim prohibition orders

As discussed above in the context of administrative power, the Bill amends the National Law to introduce a power for AHPRA to issue IPOs to unregistered persons.

The Bill would require AHPRA to publish certain information on its website about a person subject to an IPO unless an exception applies. It must publish the person's name, the day the order starts, and the actions prohibited or the restrictions imposed by the order.[434]

The publication of an individual's personal information on a public website will have an impact on that person's privacy.

This is particularly the case in circumstances where an IPO is issued urgently, and as a result, the regulatory body does not have to follow the show cause process. In other words, it is possible for an individual's personal information to be published before they have had a chance to make a submission about a proposed IPO.

Whilst the explanatory notes do not address this issue in the context of FLPs, elsewhere the explanatory notes set out the exceptions to the publication requirement which act as a safeguard to protect a person's privacy in these, and more general, circumstances:

> An exception to the requirement to publish information is if the person subject to the order asks the regulatory body not to publish it, and the body reasonably believes publication would present a serious risk to the health and safety of the person or someone else. A regulatory body may also decide not to publish information if it issued the order prior to a show cause notice being undertaken and it reasonably believes there is no overriding public interest in the publication of the information prior to confirming the order after a show cause process.[435]

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[432] Bill, cl 81 amends section 130 of the National Law.

[433] Statement of compatibility, pp 3, 10.

[434] Bill, cl 94 inserts new new s 159N(1) into the National Law.

[435] Explanatory notes, pp 72-73. Bill, cl 94 inserts new section 159N(3), (4) and (5) into the National Law.

The statement of compatibility addresses this issue in the context of the human right to privacy, and ultimately concludes that if there is a limit on the right to privacy, it is proportionate to the objective of protecting the public.[436]

Committee comment

The committee considers that whilst there are legislative safeguards in the form of exceptions to the requirement to publish personal information, the general rule is that a regulatory body is required to publish personal information about a person the subject of an IPO, which will have an impact on that person's privacy.

However, on balance, the committee is satisfied that this impact is justified by the overall objective of the clause to protect the public.

4.1.6 Institution of Parliament - amendment of an Act

Whether a Bill has sufficient regard to the institution of Parliament depends on whether, for example, the Bill authorises the amendment of an Act only by another Act.[437]

The Bill amends the National Law Act to enable the Governor in Council to make regulations under the Act.[438]

The explanatory notes advise that the general regulation-making power has been included as part of the amendments in relation to the reporting of scheduled medicine offences,[439] but it may be used for other matters.

As discussed above with respect to privacy, under the Bill, registered practitioners and students are required to report to the relevant National Board certain charges and convictions related to regulated medicines and poisons, including scheduled medicine offences.

The explanatory notes explain how the general regulation-making power would be used:

> Because there are significant differences in the types of offences that exist under each jurisdiction's medicines and poisons laws, the Bill will allow a participating jurisdiction to declare that offences defined under the law of that jurisdiction are not scheduled medicine offences for purposes of the reporting requirements in the National Law. This will ensure that the new reporting requirements relate to relevant offences and are no broader than necessary to protect the public.[440]

The explanatory notes add that the general regulation-making power 'will ensure that regulations can be made in the future, if necessary, and aligns Queensland with most other jurisdictions, which already have a general regulation-making power under the National Law'.[441]

A provision of an Act that enables the Act to be expressly or impliedly amended by subordinate legislation or Executive action is known as a 'Henry VIII clause'.[442] Parliamentary Committees have expressed disquiet over the use of Henry VIII clauses that have not been justified.[443]

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436 Statement of compatibility, pp 16-17.

437 LSA, s 4(4).

438 Bill, cl 147 inserts new section 9A into the National Law Act.

439 Explanatory notes, p 9.

440 Explanatory notes, pp 8-9.

441 Explanatory notes, pp 8-9.

442 Scrutiny of Legislation Committee, *The use of "Henry VIII Clauses" in Queensland Legislation*, 1997, p 56, para 5.7.

443 OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 159.

Facilitating the application of national schemes of legislation is an example of when Henry VIII clauses may be justified.[444]

The relevant provision could be considered a Henry VIII clause because including an offence in subordinate legislation would mean that it no longer a scheduled medicine offence for the purpose of the reporting requirements in the National Law.

With respect to FLPs, the explanatory notes justify the provision as follows:

> General powers to make regulations are common in Queensland Acts and provide much needed flexibility given the nature and complexity of modern legislation. All regulations made under this provision will be tabled in the Legislative Assembly and will be subject to Parliamentary scrutiny and disallowance procedures and to the fundamental legislative principles applicable to subordinate legislation.[445]

Committee comment

The committee is satisfied with the justification provided in the explanatory notes for the general regulation-making power.

4.2 Explanatory notes

Part 4 of the LSA requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly, and sets out the information an explanatory note should contain.

Explanatory notes were tabled with the introduction of the Bill. Overall, the committee considers that the explanatory notes comply with section 23(1)(f) of the LSA, which requires a brief assessment of the consistency of the Bill with FLPs and, if inconsistent, the reasons for the inconsistency. However, the committee notes that there were some FLP issues that were not raised in the explanatory notes, or where justifications for inconsistency with FLPs could have been more comprehensive.

The explanatory notes are otherwise quite detailed and contain the information required by Part 4 of the LSA and a sufficient level of background information and commentary to facilitate understanding of the Bill's aims and origins.

444 Scrutiny of Legislation Committee, *The use of "Henry VIII Clauses" in Queensland Legislation*, 1997, p 56, para 5.9.

445 Explanatory notes, p 26.

5 Compliance with the *Human Rights Act 2019*

The portfolio committee responsible for examining a Bill must consider and report to the Legislative Assembly about whether the Bill is not compatible with human rights, and consider and report to the Legislative Assembly about the statement of compatibility tabled for the Bill.[446]

A Bill is compatible with human rights if the Bill:

- does not limit a human right, or
- limits a human right only to the extent that is reasonable and demonstrably justifiable in accordance with section 13 of the *Human Rights Act 2019* (HRA).[447]

The HRA protects fundamental human rights drawn from international human rights law.[448] Section 13 of the HRA provides that a human right may be subject under law only to reasonable limits that can be demonstrably justified in a free and democratic society based on human dignity, equality and freedom.

Having considered the explanations provided in the statement of compatibility and examined the clauses of the Bill, the committee is satisfied that the Bill is compatible with human rights and the identified limitations on human rights are reasonable and justified in a democratic society.

A summary of the committee's consideration of these matters is set out below.

5.1 Human rights compatibility

In the statement of compatibility accompanying the Bill, the Minister acknowledges that the Bill engages a number of human rights, including:

- rights related to the standard of health services provided by health practitioners – notably the right to life, the right to the security of the person and the right to health services
- rights related to the ability to practise a profession – notably, the right to property and right to privacy
- rights related to protecting against reputational harm – notably, the right to privacy and the right to protection against reputational harm.[449]

5.1.1 Right to health

The committee considers that the key human rights concern of the Bill is the realisation of the right to health.

The right to health is protected in section 37 of the HRA and Article 25 of the Universal Declaration of Human Rights, and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), as rights "recognised under another law" for the purposes of section 12 of the HRA. The committee considers, therefore, that all of the potential limitations to human rights triggered in the Bill should be read pursuant not only to public health objectives, but also the right to health of each member of the public served by the relevant legislation.

The proposed paramount principle, inserted by the Bill, of public confidence in the health sector and health services, directly serves the realisation of the right to health.

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446 HRA, s 39.

447 HRA, s 8.

448 The human rights protected by the HRA are set out in sections 15 to 37 of the Act. A right or freedom not included in the Act that arises or is recognised under another law must not be taken to be abrogated or limited only because the right or freedom is not included in this Act or is only partly included; HRA, s 12.

449 Statement of compatibility, p 2.

Therefore, in the committee's view, pursuing public trust and confidence in health services directly advances the right to health mandate of the legislation, and should be read not only as a public policy objective, but also as a human rights goal. It is a consideration that affects the balancing of the rights of health professionals potentially affected by the Bill.

5.1.1.1 Rights of Indigenous Peoples

The Bill adds specific provisions to ensure and enhance culturally appropriate services for Aboriginal and Torres Strait Islander people, particularly in building cultural awareness and the elimination of racism in the provision of health services. The committee considers that both are appropriate goals that align with the promotion of the right to health in a culturally appropriate way. The committee notes that the right to culturally appropriate health is protected not only by general instruments like the ICESCR, but also specific instruments like the United Nations Declaration on the Rights of Indigenous Peoples of 2007 (UNDRIP). Article 24 of the UNDRIP provides that:

> Article 24
>
> 1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
>
> 2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Committee comment

The committee considers that the amendments proposed in the Bill can be seen as furthering the rights of Indigenous people and peoples' right to health.

5.1.2 Right to practice a profession – right to privacy and property

A number of provisions in the Bill impact on the right of medical practitioners to exercise a profession, which derives from their rights to property and their rights to privacy. For example:

- the Bill permits the Health Ombudsman and National Boards to accept undertakings from a health practitioner, which may limit the scope of the services the practitioner may provide[450]
- the Bill permits AHPRA to issue IPOs to unregistered persons, which can prohibit the person from providing a specified health service or all health services.[451]

The potential infringement of these rights stems from the limitation imposed by the Bill, which restrict existing freedoms of medical professionals. The Bill would mean that the restriction is required by law, clearing the first prong of the proportionality test adopted in international human rights law, and as outlined in section 13 of the HRA. The questions that remain are whether the restriction is tied to a clear and legitimate purpose; and whether it is a proportionate limitation.

In relation to whether the limitation is tied to a clear and legitimate purpose, the committee notes that the right to health is a key objective of the Bill, itself a human right. Increasing public confidence on health professionals and services is integral to the full realisation of this right, aligning with international and domestic mandates for the advancement of the right to health. It is also closely in line with section 37 of the HRA.

Accordingly, in the committee's view, there is no human rights concern in relation to the connection between the Bill and a legitimate purpose, which can be framed either as the rights of others (to health), or the pursuance of public health objectives.

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450 Bill, chapter 2, cl 7 and chapter 3, part 9.

451 Bill, chapter 3, part 21.

In relation to whether the provisions are a proportionate limitation, the question is one of balancing. Section 13 of the HRA invites the consideration of a range of factors in assessing the proportionality of limitations. The committee has considered each of these matters in turn.

5.1.2.1 Nature of the human right

In relation to the nature of the right, the committee notes that the rights being limited (property and privacy) are central human rights, particularly the right to privacy. These rights are not, however, absolute rights, and the right to health, insofar as it is protected both as an autonomous human right and as part of the right to life (right to a dignified life, as interpreted by the United Nations Human Rights Committee),[452] needs to be balanced. There is nothing, in the committee's view, inherent about the nature of the rights affected that warrants exclusion of further proportionality analysis.

5.1.2.2 Nature of the purpose of the limitation

In relation to the nature of the purpose of the limitation, including whether it is consistent with a free and democratic society based on human dignity, equality and freedom, the committee considers that the limitation pursues an important right, consistent particularly with the dignity of the population at large (see above on the right to a dignified life, and below on the right to dignity), as well as equality, particularly for Aboriginal and Torres Strait Islander people. The committee considers, therefore, that that this is an appropriate limitation.

5.1.2.3 Relationship between the limitation and its purpose

With regard to the relationship between the limitation and its purpose, including whether the limitation helps to achieve the purpose, the committee considers that the limitation in place aims to achieve the right to health by building more trust in the health system and health professionals. The committee considers that this purpose would be achieved by the Bill, if enacted.

5.1.2.4 Whether there are any less restrictive and reasonably available ways to achieve the purpose

In relation to the question of whether there are any less restrictive and reasonably available ways to achieve the purpose, the committee considers that increasing trust in the health system is best achieved, in the terms of the Bill, by naming medical professionals who commit infractions. The public will, therefore know to exercise more caution when using those professionals, as well as the eventual disciplining and even loss of licence of infringing professionals.

All these measures are directly related to transparency and openness, which are ideal means through which increased public trust can be achieved in the system. The committee considers that alternatives would only perpetuate a perception of secrecy and protectiveness within the system, and there does not seem to be a feasible middle alternative between disclosure and non-disclosure. The committee notes that safeguards are in place to ensure that disclosures are done pursuant to a legal process with numerous safeguards for the affected medical professionals, which minimise risks of over-exposure and disproportionate harm to affected medical professionals. Accordingly, the committee considers there are no less restrictive ways to achieve the Bill's human rights objective.

5.1.2.5 Importance of the purpose of the limitation

With regards to the importance of the purpose of the limitation, as discussed above, the purpose of the limitation in the committee's view is to enhance the right to health of the population, which is a vital purpose. The committee, therefore, considers that an important purpose is being pursued by the limitation.

5.1.2.6 Importance of preserving the human right

In relation to the importance of preserving the human right, taking into account the nature and extent of the limitation on the human right, the committee notes that the human rights affected, property

[452] UN Human Rights Committee (HRC), General comment no. 36, Article 6 (Right to Life), 3 September 2019, CCPR/C/GC/35

and privacy, are only affected in certain circumstances. These are weighed against the purpose of realising the right to health. Therefore, while it is important to preserve the rights to property and privacy, the nature and extent of the limitation do not raise, in the committee's view, any significant new questions under this element that would shift the assessment of proportionality of the restriction.

5.1.2.7 Balance between importance of the purpose of the limitation and preserving the human right

The committee considers that the balancing of the importance of the purpose of the limitation and preserving the human right is appropriate, and no significant human rights issues arise from the Bill with respect to the rights to property and privacy.

Committee comment

The committee finds the provisions of the Bill are compatible with human rights, including the requirements under the HRA and relevant international standards.

5.1.3 Freedom of expression

The right to freedom of expression, as contained in section 21 of the HRA and in multiple applicable human rights instruments, is a core human right at the foundation of democratic societies. Therefore, any potential impact on this right must be closely scrutinised.

Clause 85 of the Bill, by increasing advertising offences, has the potential to limit the freedom of expression of medical professionals, particularly by having a chilling effect on expression. Therefore, the committee has undertaken a proportionality analysis under section 13 of the HRA.

5.1.3.1 Nature of the human right

The right to freedom of expression is a core right. However, this right is not absolute, and it may be limited in pursuance of key objectives, for example, public health, and the rights of others. The International Covenant on Civil and Political Rights (ICCPR), explicitly listed by section 12 of the HRA as an instrument under which rights can be "recognised under another law", indicates as much in its Article 19(3)).

5.1.3.2 Nature of the purpose of the limitation

In relation to the nature of the purpose of the limitation, including whether it is consistent with a free and democratic society based on human dignity, equality and freedom, the committee notes that whereas freedom of expression is central to a democratic society, so is the right to health in pursuance of a dignified life, as indicated above. Accordingly, the committee considers that the limitation can be consistent with the key values of a democratic society.

5.1.3.3 Relationship between the limitation and its purpose

With regards to the relationship between the limitation and its purpose, including whether the limitation helps to achieve the purpose, the committee notes that the limitation in place aims to achieve public health and the rights of others, both of which are permissible under the ICCPR.

5.1.3.4 Whether there are any less restrictive and reasonably available ways to achieve the purpose

In relation to the question of whether there are any less restrictive and reasonably available ways to achieve the purpose, the committee considers that the nature of financial penalties requires a delicate balance between punishment and deterrence. The committee notes that government departments enjoy certain discretion in making this assessment, and therefore accepts the Minister's comments, in the statement of compatibility, that a lower penalty would not enjoy the same deterrent effect, and therefore no less restrictive penalty would be available to achieve the same purpose.

5.1.3.5 Importance of the purpose of the limitation

With regards to the importance of the purpose of the limitation, the purpose of the limitation in the committee's view is to enhance public health and the rights of others to health via building confidence in the health system, which are vital purposes.

5.1.3.6 Importance of preserving the human right

In relation to the importance of preserving the human right, taking into account the nature and extent of the limitation on the human right, the committee notes that the human right affected, freedom of expression, is only affected in certain circumstances, which are weighed against the legitimate purposes of the restriction, and only apply in fairly narrow circumstances after the observance of a legal-judicial process. The committee, therefore, considers that the nature and extent of the limitation do not raise any significant questions.

5.1.3.7 Balance between importance of the purpose of the limitation and preserving the human right

The committee considers that the balance between the importance of the purpose of the limitation and preserving the human rights is appropriate, and no significant human rights issues arise from the Bill with respect to the right to freedom of expression.

Committee comment

Accordingly, the committee considers that any potential impacts of the Bill on the right to freedom of expression, under section 21 of the HRA, are compatible with the limitations requirements under section 13 of the HRA.

5.1.4 Right to dignity and protection against reputational harm

The Bill also potentially impacts on the right to dignity, which, although not spelled out as such in the HRA, is an important precondition for the exercise of all human rights, and recognised repeatedly in the Preamble to the HRA. It is closely tied to the right to have one's reputation attacked, protected by section 25(b) of the HRA.

The committee notes that these rights are affected by multiple provisions of the Bill. The same proportionality analysis under section 13 of the HRA applies.

The proportionality considerations, under section 13 of the HRA are the same as above in relation to the right to privacy, given the close connection between reputational rights and the right to privacy (evidenced by both rights being under section 25 of the HRA).

The only additional consideration undertaken by committee was the restrictiveness of the means through which the purpose is achieved (section 13(d) of the HRA). Specifically, any potential impact on reputation is tempered by the fact that findings against a medical professional, which can cause reputational harm, are only made public after a corresponding process. This process minimises reputational risk. Therefore, under the theory of abuse of rights recognised under international human rights law,[453] affected medical professionals would be unable to claim reputational harm.

Committee comment

The committee considers, therefore, that the Bill is compatible with these human rights.

[453] *See*, for instance, Article 17 of the European Convention on Human Rights.

5.2 Statement of compatibility

Section 38 of the HRA requires that a member who introduces a Bill in the Legislative Assembly must prepare and table a statement of the Bill's compatibility with human rights.

A statement of compatibility was tabled with the introduction of the Bill as required by section 38 of the HRA. Generally, the statement contained a sufficient level of information to facilitate understanding of the Bill in relation to its compatibility with human rights.

The committee considers, however, that statement of compatibility's analyses of privacy and property rights focuses only on whether the restriction is unlawful and/or arbitrary, and do not undertake a fuller analysis of limitations in light of section 13 of the HRA.

The committee considers that it is insufficient, and incompatible with international human rights standards that inform the interpretation of the HRA, to say that a limitation or restriction upon a right occurs only when it is unlawful or arbitrary. To the contrary, restrictions are based on law, and not arbitrary, most of the time.

The committee, therefore, suggests that the Minister, in the spirit of the HRA's overarching objective 'to help promote a dialogue about the nature, meaning and scope of human rights' (section 3(c) of the HRA), engage more fully with section 13 in future statement of compatibility documents.

Appendix A – Submitters

Sub #	Submitter
001	Confidential
002	Professor Anand Deva
003	Australian Dental Association Queensland
004	Australian College of Emergency Medicine
005	Speech Pathology Australia
006	Dr Margaret Faux
007	Royal Australian College of General Practitioners
008	Australian Paramedics Association – Queensland
009	Australian Doctors' Federation
010	Exercise and Sports Science Australia
011	Eucalyptus
012	Queensland Nurses and Midwives' Union
013	Australian Medical Association
014	Australian Society of Aesthetic Plastic Surgeons
015	Australian Association of Psychologists
016	Insurance Council of Australia
017	Australian Medical Association Queensland
018	Queenslanders with Disability Network
019	Pharmacy Guild of Australia – Queensland
020	United Workers' Union
021	Australian Health Practitioner Regulation Agency (AHPRA)
022	Allied Health Professions Australia
023	Australian Medical Professionals Society and Nursing Professional Association of Australia
024	Australian Lawyers Alliance
025	Doctors' Health in Queensland
026	Operation Redress
027	MIGA
028	Queensland Law Society
029	Royal Australian and New Zealand College of Psychiatrists
030	Australian Society of Plastic Surgeons
031	Avant Mutual
032	Ray Bange OAM

033	Office of the Health Ombudsman
034	Australian College of Nursing
035	Australian College of Rural and Remote Medicine
036	CRANAplus
037	Australian Society of Ophthalmologists
038	Australian Society of Rehabilitation Counsellors
039	National Health Practitioner Ombudsman
040	Royal Australasian College of Surgeons

Appendix B – Officials at public departmental briefing

Queensland Health

- Amanda Hammer, Director, Clinical Workforce Policy, Workforce Strategy Branch
- James Liddy, A/Director, Legislative Policy Unit
- Kirsten Slape, Principal Policy Officer, Legislative Policy Unit

Appendix C – Witnesses at public hearing

Professor Anand Deva – Macquarie University

Dr Margaret Faux – Synapse Medical

Australian Lawyers Alliance

- Lidia Monteverdi, Representative of Medical Law Special Interest Group

Australian Society of Plastic Surgeons

- Dr Daniel Kennedy, President

Eucalyptus

- Lyndon Goddard, Senior Legal Counsel

Queensland Nurses and Midwives' Union

- Jamie Shepherd, Professional Officer - Team Leader
- Ashleigh Pawsey, Research and Policy Officer

United Workers' Union

- Dermot Peverill, Industrial Officer

Australian Medical Association

- Dr Omar Khorshid, Federal President

Australian Medical Association – Queensland

- Dr Maria Boulton, President

Australian Association of Psychologists Inc

- Anne Marie Collins, President
- Amanda Curran, Chief Services Officer

Insurance Council of Australia

- Aparna Reddy, General Manager Policy

MIGA

- Cheryl McDonald, National Manager – Legal Services

Avant Mutual

- Georgie Haysom, General Manager, Advocacy, Education and Research
- Patrick Clancy, Senior Medical Advisor

Australian Health Practitioner Regulation Agency

- Martin Fletcher, Chief Executive Officer
- Nick Lord, National Director, Engagement and Government Relations
- Jamie Orchard, General Counsel

Office of the Health Ombudsman

- Dr Lynne Coulson Barr OAM, Health Ombudsman
- Scott McLean, Executive Director Legal Services/Director of Proceedings

Statements of Reservation

STATEMENT OF RESERVATION

Overview:

At the outset, as Opposition Members of the Committee, we recognise the importance of legislation which ensures health professionals in our state are held to the highest standards. It goes without saying that Queenslanders must have complete confidence in the health practitioners working across our state. It is proper that these practitioners are appropriately regulated, and the right checks and balances exist across the sector.

Throughout the Committee's consideration of the *Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022*, a number of concerns were raised with the Committee about the Bill in its current form.

After considering the submissions provided to the Committee, both in writing and during public hearings, we hold reservations with respect to two components of the Bill.

Issues concerning Natural Justice:

Stakeholders across the sector have raised concerns with natural justice being subverted due to the proposed amendments to the *Health Ombudsman Act 2013*. We believe these concerns are warranted.

The Bill will allow for a Public Statement to be issued prior to a proper investigation being completed into alleged practitioner misconduct. We believe that no such statement should be made without a comprehensive investigation being conducted, and finalised. This could result in practitioners being inadvertently penalised for complaints which are later proven to be vexatious or unsubstantiated. If this situation were to arise, it could do untold professional, reputational, and emotional damage to the practitioner involved.

We note that alternate options are available to regulatory authorities to ensure patient safety, without issuing a Public Statement. We also wish to convey that should an investigation into misconduct be substantiated then swift action should be taken. This of course should also include a Public Statement being issued.

Issues concerning Testimonial Advertising:

We also wish to place on the record our reservations with respect to testimonial advertising. A broad cross section of stakeholders, almost unanimously, recognised that removing the prohibition of testimonial advertising will not lead to improved patient outcomes.

In fact, many believe that the manipulation of testimonial advertising has the potential to worsen the current situation. Both in the public discourse, and through the Committee's review, there was an acknowledgement that regulators are routinely unable to monitor and penalise unscrupulous operators and clinicians who breach testimonial advertising conditions. We hold concerns that if the proposed

amendments are passed it could lead to worsened patient outcomes given the difficulty regulatory agencies have in enforcing the law as it stands now.

Conclusion:

Patient safety is paramount - as parliamentarians we should do all we can to protect patients in this state from those who stray from their obligations as health practitioners. As members of this Committee, our commitment to that philosophy is unwavering.

It is incumbent on us to ensure that the right balance is struck between protecting patients and ensuring that the health practitioner workforce is able to appropriately undertake their job.

We understand that the Bill is hinged to nationally agreed laws but do note that there are issues with the Bill as it stands, as we have outlined above.

Rob Molhoek MP
Member for Southport
Deputy Chair

Sam O'Connor MP
Member for Bonney

DISSENTING REPORT

RE: HEC REPORT ON THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2022

BY: STEPHEN ANDREW, MP (HEALTH & ENVIRONMENT COMMITTEE)

Date: 27 June 2022

It is my considered view that the proposed Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022 (the Bill) should not be passed.

The proposed Bill bestows far too much executive power on the Australian Health Practitioner Regulation Agency (AHPRA), the national organisation responsible for implementing the National Registration and Accreditation Scheme (the National Scheme) across Australia.

It is important to note from the outset that AHPRA is an unelected executive government agency that answers to no single jurisdiction in the country. Its decision-making processes, moreover, are shrouded in secrecy and there is a negligible amount of transparency or accountability around its various activities.

The Bill essentially hands AHPRA the power to do whatever it deems "necessary or convenient" to safeguard a set of broadly drafted and undefined new 'objectives'.

On Page 12 of the Bill's Explanatory Notes, it states that:

> "*the Bill clarifies that the National Agency may do anything necessary or convenient for the effective and efficient operation of the National Scheme, within the scope of the National Law*".

As the Australian Doctors Federation commented on page 3 of their submission "*Who defines what is necessary or convenient*?"

This is particularly relevant given that there have been a number of recent court cases where AHPRA/Medical Board disciplinary procedures against medical practitioners were subsequently overturned in court as 'unwarranted'.

The proposed Bill's provisions will mean APHRA is now the final arbiter of what is "necessary" to be done in the interests of "public health and safety", which will make their decisions very difficult, if not impossible, to overturn in court in the future.

This significantly increases the risk of serious human rights abuses and miscarriages of justice occurring if this Bill is enacted.

According to page 4 of the Explanatory Notes, the Bill establishes "broad" primary objectives to:

1. *Strengthen public safety and confidence in the provision of health services;*
2. *Improve the governance of the National Registration and Accreditation Scheme for health professionals (National Scheme); and*
3. *Enhance the effectiveness and efficiency of the scheme.*

Such broad and loosely worded objectives are extremely problematic from the point of view of human rights and fundamental legal principles.

At a minimum, it will grant AHPRA extraordinary power over doctors and the medical profession in Queensland.

AHPRA is a monopoly which does not appear to answer to anybody.

This means that nothing they say or do can be independently questioned, let alone verified.

I therefore oppose the Bill's broad discretionary powers being granted to AHPRA – regulators should not be given a blank cheque to do whatever they like, EVER.

Section 3A of the Bill sets out new 'Guiding principles' as follows:

> *(1) The main guiding principle of the national registration and accreditation scheme is that the following are paramount—*
>
> *(a) protection of the public;*
>
> *(b) public confidence in the safety of services provided by registered health practitioners and students.*
>
> *(2) The other guiding principles of the national registration and accreditation scheme are as follows*
>
> *(a) the scheme is to operate in a transparent, accountable, efficient, effective and fair way;*
>
> *(b) fees required to be paid under the scheme are to be reasonable having regard to the efficient and effective operation of the scheme;*
>
> *(c) restrictions on the practice of a health profession are to be imposed under the scheme only if it is necessary to ensure health services are provided safely and are of an appropriate quality.*

This refocusing of the objectives and guiding principles of the National Law to make "public safety and confidence" the primary consideration for healthcare poses a significant risk to individual patients' health and safety, by enforcing a one-size-fits-all truth for medical care.

Doctors and other health practitioners should be free to exercise their professional judgement on the effectiveness of treatment options for individual patients and to freely advise their professional opinions on any matter raised in the course of a clinical consultation.

If a doctor can no longer provide advice based on **their** knowledge and understanding of an individual patient's particular health status or help them weigh up the relevant risks and benefits of a particular type of medical care, why even bother going to a doctor for advice at all? Or seeking a 'second opinion'?

Health Professionals abide by an international code of ethics which clearly state they owe their patients complete loyalty and all scientific resources available, when providing them with their considered medical advice and recommendations.

Public confidence is fostered when people know that doctors are free to speak without threat or intimidation, in accordance with their many codes of conduct, including the Hippocratic Oath, the Declaration of Geneva and the International Code of Ethics.

These ethical undertakings must be respected at all times.

Moreover, the new guidelines would mean doctors could be disciplined for public speech, including social media likes and comments, on subjects completely unrelated to the actual treatment of patients.

It is imperative that questions of science, medicine, and public health are not politicised or weaponised, which is what I believe this legislation will do.

Doctors have a right to practice their profession ethically without political interference and their rights as human beings, which includes the right to freedom of expression, must be preserved.

The bar for stifling or demonising doctors who hold alternative positions in good faith therefore needs to be very high - much higher than is provided for in this Bill.

Elsewhere in the Bill, amendments grant APHRA enhanced executive powers for publicly naming and shaming practitioners who it regards as 'posing a risk to public safety', without defining what those risks are or exactly how they pose a risk to public safety.

Proposed new section 90AA 'Making of public statement', reads in part:

> *(1) The health ombudsman may make a public statement about a person if—*
>
> *(b) the health ombudsman reasonably believes that—*
>
> *(i) because of the person's conduct, performance or health, the person poses a serious risk to persons; and*
>
> *(ii) it is necessary to issue a public statement to protect public health or safety*

I am against the naming and shaming of doctors before they have been found guilty of any offence.

The proposed section will have a significantly adverse impact on a person's reputation and rob them of the presumption of innocence, natural justice and due process.

Such powers should only be exercised in strictly limited circumstances where evidence of objective patient harm can be demonstrated by the regulatory body.

I therefore oppose the proposed amendments to 90AA.

Conclusion

Overall, the proposed Bill grants a public health regulatory body with extraordinary coercive powers to enforce Government narratives and agendas.

Powers that will inevitably become a tool of political oppression against doctors who hold dissenting expert views, going by recent experience.

The amendments, moreover, contain no ‘right of reply’ for health professionals on evidence-based research and objective data.

I fail to see how public health and safety can possibly be served by this coerced compliance with government public health messaging that may be completely unsupported by any publicly available evidence.

During the committee process, there were a number of references to the term ‘misinformation’, although at no point was this term actually defined.

In the end, I decided that the definition of terms like misinformation or disinformation seems to amount to anything that might prevent someone from complying with or questioning the Government Public Health guidelines and recommendations.

APHRA must NOT be given the last word on what ‘truth in medicine’ is. There should always be room for ‘dissenting’ views and debate.

This Bill would prohibit doctors from giving any medical advice or treatment that the State decides is ‘off limits’. It is a clear case of government overreach and unwarranted interference in doctors and other health practitioners’ professional independence, something that is absolutely essential for the purposes of ‘public trust and confidence’ in the advice they are receiving.

The Bill would confer a ‘right to discipline’ doctors who step outside public policy guidelines for treating their patients and to regulate treatment options for patients based on a ‘one size fits all’ model.

Medicine is predicated on the belief that every patient has individual needs based on their own unique biology, circumstances, condition and genetics.

If doctors aren’t allowed to discuss alternatives to the mainstream medical approach with their clients, not only are the legal requirements of informed consent not being satisfied, but a doctor’s ability to treat individual patients will suffer.

Protocols will end up being enforced, not through evidence and experience-based medical knowledge, but through the issuing of diktats by public health officials, bureaucrats, regulators and administrators who may never have treated a single patient in their lives.

Stephen Andrew, MP
Member for Mirani