HEALTH AND ENVIRONMENT COMMITTEE

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PUBLIC BRIEFING—INQUIRY INTO THE HEALTH PRACTITIONER REGULATION NATIONAL LAW AND OTHER LEGISLATION AMENDMENT BILL 2022

TRANSCRIPT OF PROCEEDINGS

MONDAY, 23 MAY 2022

Brisbane

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The committee met at 8.59 am.

CHAIR: I now declare this public briefing of the Health and Environment Committee open. I am Aaron Harper, member for Thuringowa and chair of the committee. I would like to start by respectfully acknowledging the traditional custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands winds and waters we all now share. With me today are Mr Rob Molhoek, member for Southport and our deputy chair; Mr Stephen Andrew, member for Mirani; Ms Ali King, member for Pumicestone; Ms Joan Pease, member for Lytton; and Mr Sam O'Connor, member for Bonney.

The purpose of today's briefing with officials from Queensland Health is to assist the committee in its inquiry into the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022. This briefing is a proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. I remind members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left for debate in the House. These proceedings are being recorded and broadcast live on the parliament's website. Please turn off any phones or put them onto silent. We now welcome representatives from Queensland Health to brief the committee.

HAMMER, Ms Amanda, Director, Clinical Workforce Policy, Workforce Strategy Branch, Queensland Health

LIDDY, Mr James, Acting Director, Legislative Policy Unit, Queensland Health

SLAPE, Ms Kirsten, Principal Policy Officer, Legislative Policy Unit, Queensland Health

CHAIR: Thank you for being here today.

Ms Hammer: Thank you for the opportunity to meet with you this morning to brief you in regard to the Health Practitioner Regulation National Law and Other Legislation Amendment Bill 2022. I would also like to start by acknowledging the traditional custodians of the lands on which we meet today, the Jagera and Turrbal people, and pay respects to their elders past, present and emerging.

This is a complex bill and it covers a wide number of reforms. Throughout the briefing today I may be calling on my colleagues to assist with some of the more detailed content, depending on your questions. The bill amends the Health Practitioner Regulation National Law, which I will refer to as the national law. The amendments make significant reforms to the National Registration and Accreditation Scheme for health professions, commonly referred to as the national scheme. These reforms have been approved by all health ministers of participating jurisdictions, including states and territories and the Commonwealth, on behalf of their respective governments.

These reforms have been developed over a very long period of time—more than three years of work—with extensive stakeholder input and collaboration across the country. At a very high level, the amendments will strengthen public safety and public confidence in the delivery of health services. They will also increase efficiency and effectiveness in the operation of the national scheme and its governance. In addition, the bill amends the Health Ombudsman Act 2013 to reflect Queensland's co-regulatory arrangements and makes minor modifications to how the national law applies in Queensland.

Because the national law context differs to other Queensland legislation, I will provide a brief outline of how the national law operates. The national law is enacted and implemented in each state and territory using an adoption of laws model that is commonly used in similar kinds of national scheme legislation. All amendments must be approved by all ministers, standing as the ministerial council, and, as I said, all state and territory ministers as well as the minister for the Commonwealth. In this case the ministerial council approved the amendments to the national law on

18 February 2022. After approval by the ministerial council, amendments to the national law are introduced into the Queensland parliament as we are the host jurisdiction for the national law. It then proceeds through Queensland's parliamentary processes, similar to other Queensland bills.

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. It also, amongst other objectives, supports the continuous development of a mobile, flexible and responsive health workforce for Australia. I appreciate that committee members will be familiar with some aspects of the national scheme, given your responsibility under the Health Ombudsman Act for monitoring and reviewing the operation of the health service complaints management system in this state, but I will provide information for context. Under the scheme there are 15 national boards which regulate 16 health professions across Australia. Currently there are approximately 825,000 health practitioners under the scheme.

The national law establishes the Australian Health Practitioner Regulation Agency, also called Ahpra, as the administering agency for the scheme. As you know, in 2013 Queensland modified the national law and how it applies to Queensland to become a co-regulatory jurisdiction. Co-regulatory arrangements do not impact the national registration of health practitioners, but they do mean that Queensland adopts its own disciplinary arrangements for registered health practitioners. 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, as I said, the Health Ombudsman also has responsibility for oversighting unregistered health practitioners in Queensland. Provisions in the Health Ombudsman Act, along with Queensland-specific modifications of the national law, ensure there continues to be a cooperative and responsive regulatory arrangement in this state.

With that I will give you a brief overview of some of the key reforms in the bill. The bill implements a wide range of reforms to ensure the scheme continues to be contemporary and fit for purpose. The reforms touch on multiple aspects of the national scheme including registration processes, governance, information sharing and investigation and enforcement tools. Many of the amendments will strengthen public safety and confidence in the safety of health services.

There are two important updates to the guiding principles and the objectives of the national law. Firstly, the bill inserts a new guiding principle to make public safety and public confidence the paramount consideration in administering the national law. This actually brings the national law into alignment with Queensland, as Queensland has already modified the application of the national law in this state to make the health and safety of the public a paramount consideration under section 3A of the national law. 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.

Secondly, importantly, the bill adds a new guiding principle and objective to foster culturally safe health services for our Aboriginal and Torres Strait Islander people under the national scheme. The national scheme is well placed to promote safe, responsive and appropriate quality care and positive health outcomes for Aboriginal and Torres Strait Islander people. 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.

The bill also increases and strengthens regulatory responses to risk. It introduces a new power for Ahpra and national boards to issue interim prohibition orders to unregistered practitioners who pose a serious risk to others. An order is designed to prohibit or restrict a person from delivering some or all health services and also prohibit them from using a restricted title, such as calling themselves a registered nurse. This power will complement powers of the Health Ombudsman that we already have in Queensland, but this power will be entirely new in some states and territories. The ability to issue interim prohibition orders enables regulators to take swift action in protecting the public while still enabling them to continue an investigation or finalise an action or a proceeding. There are numerous safeguards, including affording natural justice to practitioners. It requires Ahpra and national boards to provide an opportunity for a practitioner to be heard on the matter and to also provide an ability for a practitioner to appeal a decision to issue an interim order.

The bill also introduces a power for the Health Ombudsman, Ahpra and national boards to make a public statement about a person including a registered practitioner. This enables them to warn the public or relevant entities about risks posed by a particular person. We can talk in more

detail later, but certainly there are very strict criteria that must be met before a regulator can issue a public statement. Obviously they must hold a reasonable belief that the person poses a serious risk to others and a public statement is necessary to protect public health or safety. There are other safeguards requiring the regulator to revoke a public statement if the grounds no longer exist. Also, a decision to make a public statement can be appealed.

Another protection for public safety is requiring registered health practitioners and students to report where they have been charged or convicted of a scheduled medicines offence to their relevant national board. This amendment was recommended by the Office of the Health Ombudsman in a report regarding the constraints of medicine regulation in this state. The report highlighted the risks of drug impaired practitioners who may present themselves to the public. This early reporting requirement will allow national boards to respond quickly to risks that may exist.

Lastly, other amendments are included to provide improved information sharing that will improve the registration process. Other amendments to update the national scheme include improving governance of the scheme by updating the functions of Ahpra as the administering body to better reflect their role. They provide significant accountability and advice to health ministers about all aspects of the scheme's operations and also perform functions on behalf of national boards. It is important that the national law clearly articulates their role.

To improve the efficiency of the running of the scheme, the bill introduces a power for national boards to accept an undertaking, which is a voluntary agreement, when a person first applies for registration. They can currently impose a condition on registration, but that can be quite time consuming and resource intensive. This will certainly free up resources and will hopefully be better received by health practitioners if they have the ability to voluntarily agree to an arrangement. Amendment also provides for renaming Ahpra's governing body from the Agency Management Committee to the Agency Board to better reflect Ahpra's functions and the functions of that particular committee.

Finally, there are a number of amendments to support the co-regulatory arrangements here in Queensland—amendments to the Health Ombudsman Act as well as to how the national law applies in Queensland. For instance, where Ahpra and national boards issue an interim prohibition order, they will be required to notify the Health Ombudsman. They will also have the power to refer a matter to the Health Ombudsman whilst an interim prohibition order is in effect. These modifications were requested by the Health Ombudsman. It also provides the Health Ombudsman commensurate powers to accept an undertaking as an immediate registration action. This will, as I said, provide equivalent powers to those being introduced to Ahpra and national boards.

In conclusion, the national scheme has been in operation for over 10 years, commencing 1 July 2010. It has certainly grown and matured during that time. Health ministers have made a commitment, even before the commencement of the national scheme, to continually review and update the scheme to ensure it meets its objectives.

This bill builds on previous reforms to the scheme to keep them up to date and able to be flexibly adaptable to changing circumstances. Members may recall in more recent times the introduction of two different bills—one in 2017 and one in 2019—that also provided improvements to the national scheme, the first being, you might recall, the introduction of paramedicine into the national scheme from 2018.

The bill incorporates ministers' decisions in response to a number of independent reviews that have provided policy recommendations for strengthening the bill. As Queensland is the host jurisdiction for the national law, we have been integrally involved in the development of the bill and work closely with our partners across all jurisdictions and with Ahpra, the Queensland Ombudsman and other stakeholders here in Queensland as well as nationally.

Although our role has been central to the development of the bill, the day-to-day running of the scheme and the implementation of the reforms will be the responsibility of Ahpra and the Health Ombudsman. This means that there might be some procedural or practical matters where Ahpra or the Health Ombudsman may be better placed to outline how those amendments will operate in practice. We anticipate that the committee may wish to invite Ahpra and the Health Ombudsman to the public hearing on the bill to hear from them directly. Thank you, Chair. My colleagues and I are happy to take questions.

CHAIR: Thank you very much, Ms Hammer. You certainly provided the committee with a good start to getting an understanding of the national law. Yes, we are very aware of the previous iterations of the national law. We in Queensland were very proud to be the first jurisdiction to bring in the paramedicine registration. It looks like we are going first again with this one.

With the committee's current oversight of the Office of the Health Ombudsman and the co-regulatory arrangements with Ahpra, some of the feedback we receive—this goes to your opening statement—is around the practicalities of natural justice. This question may best be asked of Ahpra and OHO. You did say that there were some timelines to allow, say, a health practitioner who might have a health complaint against them some natural justice. Some observations of the committee are that that is criticised sometimes as taking too long. Is there a practical timeline applied to this natural justice period?

Ms Hammer: The provisions of the bill that particularly apply to improving the efficiency and the effectiveness of the scheme are intended to have a positive impact on the way in which notifications are managed and handled and to preclude, potentially, some of those protracted processes that may be impacted because of the constraints of the national law currently. If you like, I can talk to a couple of those.

Mr Liddy: Can I just clarify, Chair? Are you saying that the notifications are taking too long in terms of the public complaints?

CHAIR: No. This is more from the health practitioner who might have a complaint against them in terms of the time period to respond.

Mr Liddy: That they do not have enough time? Is that what you are saying?

CHAIR: Yes. They are some of the observations we have seen over the last couple of years.

Ms Hammer: Thank you for that clarification.

Mr Liddy: The question is really best asked of Ahpra and the Office of the Health Ombudsman, because they are really the ones who are responsible for those processes. It is a tricky balance, because on the one hand there is a need to give practitioners sufficient time—to give them the details of what the allegations are that have been made against them or what the complaint is and for them to take advice from their insurers or to take professional advice, talk to their colleagues et cetera. There is also an overriding public interest in having complaints dealt with in a timely way. That is really a very tricky balance.

Something that also happens in a lot of these matters—the bill does deal with this—is that there are a lot of referrals between different agencies. There is a lot of coordination that has to occur with sometimes the Queensland police, with a hospital and health service, with the person's employer, with medicines regulators—all of those types of things. Sometimes getting to the bottom of the story does take some time. You may not hear as much from the consumer side, but there is definitely the consumer side, who feel that the complaints take too long to resolve. It is a very difficult job being a regulator.

CHAIR: That is probably something that comes through electorate offices, that people who have made a complaint are waiting too long. We understand all of the elements of assessment, triage and the investigation period. Thank you very much for that clarification, Mr Liddy.

Mr MOLHOEK: In the bill there is a proposal to insert a new paramount principle which is about ensuring protection of the public and public confidence. What does that mean practically? What are the practical differences that this amendment will make in the operation of the national law? What does it actually look like? Can you give us some examples?

Ms Hammer: Again, I will talk generally to the paramount principle. If you are not aware, in January 2020 health ministers issued a policy direction under section 11 of the national law to Ahpra and the national boards with regard to the paramountcy of public protection when administering the national scheme. Health ministers have only ever issued four policy directions under section 11 but felt strongly about the need for all entities under the scheme, in terms of their considerations and decision-making, to more heavily weight public safety and public confidence. The bill then goes on to embed this policy decision in the national law. It will certainly provide a responsive and risk based approach to regulation. It will also actually make the national law consistent with provisions we already have in Queensland, as I previously mentioned. As for the application in the decision-making, it may be a question for Ahpra and national boards with regard to how they have been applying the policy direction to date and how they anticipate continuing that into the future.

Mr Liddy: To add to what Amanda said, as we were just talking in terms of the first question, where the national scheme has to balance the rights of practitioners and the rights of health consumers, ministers have said that, where there needs to be a balancing, that balancing needs to come down in favour of consumers rather than practitioners because, ultimately, the purpose of the national scheme, the purpose of registration, is to ensure there is public safety.

Ms Hammer: And protect the public.

Mr Liddy: And to protect the public. It is really important to bear in mind that we are talking about a really small number of practitioners about whom notifications are made. Amanda mentioned in her opening statement that there are some 825,000 health practitioners registered nationally. In Queensland there are about 168,000 health practitioners, the biggest cohort of which is nurses, of which there are some 88,000, followed by medical practitioners, of which there are 26,000, 7½ thousand psychologists and it goes on from there.

There are 168,000 health practitioners providing hundreds and hundreds of episodes of care each year. There were 9,000 complaints made in Queensland in 2020-21. In a significant number of those, no further action was taken. Some of them lead to investigations or outcomes, but the numbers are quite small. For example, in 2020-21 there were 29 immediate actions such as a suspension or a condition imposed on someone's registration; 173 investigations; 32 interim prohibition orders; 11 prohibition orders; and 57 matters referred to QCAT. The numbers are small.

Obviously for the practitioner about whom a complaint or a notification is made and who is being investigated it is a very stressful process. The alternative is allowing practitioners who may be practising unsafely or who may have committed a boundary violation or acted inappropriately in terms of their prescribing rights to continue to do so. We need a system that protects the public whilst respecting our health practitioners, who do work so hard and have been working so hard, especially over the last few years during the pandemic.

Mr MOLHOEK: That applies to all health practitioners, whether they be public or private practitioners?

Mr Liddy: That is right.

Mr MOLHOEK: Does its cover people working in aged care and NDIS?

Mr Liddy: The people who work in aged care and NDIS generally are not registered health practitioners; they are generally unregistered. In Queensland they are regulated by the Health Ombudsman. Complaints can be made to the Health Ombudsman, but there are a number of oversight mechanisms for aged care that apply in addition to Queensland's regulation.

Ms Hammer: Naturally, if a registered nurse or an allied health practitioner who is registered under the scheme is working in aged care, they would be registered under the national law. As James said, there may be other types of health workers who are currently not registered under the national law. As James said, the Health Ombudsman has powers to deal with matters with regard to unregistered health practitioners. Queensland was one of the first jurisdictions to implement the National Code of Conduct for Health Care Workers. That was approved by all health ministers. The national code of conduct is a prescribed document to which the Health Ombudsman can refer when making decisions with regard to complaints around unregistered health practitioners. If you are interested, we are happy to provide a copy of the national code of conduct for your information.

Ms KING: Could I ask you to reiterate the date that the policy statement was made by—was it the council of health ministers?

Ms Hammer: It was then under the COAG Health Council. I understand it was released in January 2020, but it is published on the Ahpra website. It is easily available. It is policy direction 2019- 1.

Ms PEASE: I am particularly interested in the comments that you made in your opening statement around ensuring there is culturally sensitive capacity in the workforce. You spoke about Aboriginal and Torres Strait Islanders particularly. Will culturally appropriate attention also apply to other cultures?

Ms Hammer: The intent of this specific provision came from the recognition of the importance of embedding cultural safety specifically for Aboriginal and Torres Strait Islander peoples. We certainly acknowledge and recognise the impacts that an absence of cultural safety has resulted in in terms of poorer health outcomes for our First Nations peoples. It was strongly recommended that this specifically be included as a new guiding principle and as an objective. The bill does not specifically provide for other culturally diverse groups; however, I am aware that Ahpra and the national boards in their operation would likely consider the needs of all different types of people. Again, that might be a question that could be posed.

Ms PEASE: You mentioned that there will be standards and education with regard to the new objectives. What will be the oversight to make sure that those standards are being met and that education is taking place?

Ms Hammer: Again, the objectives of the scheme apply to all entities in the performance of their functions and responsibilities under the national law. Ultimately, it is health ministers who oversight the national scheme. In terms of operationally, Ahpra and national boards have already established an Aboriginal and Torres Strait Islander advisory committee—excuse me if the name is incorrect—to inform all operations of the scheme and the work of the national boards in setting standards, codes and guidelines. They have also published a cultural capability framework for the national scheme. I am not sure if that answers your question specifically.

Ms PEASE: Perhaps it might be a question for Ahpra. I am trying to understand the practicality of it. How is it going to work out in the community? Will it be maintained by the HHSs or will it begin when practitioners are going through university? That is what I am looking for—an understanding of how it will work practically.

Ms Hammer: I think this principle and objective are complementary to a wide range of initiatives. As you know, we have the health equity framework for Queensland which will continue to drive some of these changes as well. In terms of the national law, it is expected that cultural safety will be considered as part of all of the functions and decision-making. For example, when the national board is considering a registration standard, they would have a specific deliberation around any implications for cultural safety and cultural competence of the workforce. In approving accreditation standards for health education programs that would lead to a qualification that is required for registration, Boards might look for particular elements in those accreditation standards that would require education providers to embed cultural safety as a core element of their program development and delivery.

Mr Liddy: To add to what Amanda said, it is really intended to influence the system at all levels. It will start at the university stage. As Amanda talked about, the accreditation of courses leading to registration for nurses, doctors, pharmacists and other health practitioners would be expected to—and they already do—involve cultural safety. I think this is really sending a message from ministers and from the perspective of the national scheme to say, 'This is an expectation for all health practitioners that we need to lift cultural capability across the country.' The reason for doing it is that the health outcomes for those First Nations people are poorer. It is embedding a sense of collective responsibility as well. It is everyone's job to lift—

Ms PEASE: Finally, just for clarity, that objective will apply to the training of registered professionals, but what about unregistered professionals for whom the Queensland Health Ombudsman has oversight? Will that objective apply to their training as well?

Mr Liddy: The objective in the national scheme does not apply directly to them because it only applies to registered health practitioners. I think this is sending a signal from health ministers that it is something that is very important to them. I would expect that a lot of those unregistered professions are regulated through their own codes of conduct and their own professional bodies. I think those professional bodies would take up the opportunity to embed those types of principles following the lead from the national scheme as well.

Ms Slape: The Health Ombudsman Act also has a paramount principle of safety in it. That would also apply to the unregistered as well as the registered professionals.

CHAIR: Following on from the member for Lytton's question in regard to cultural safety, making sure that we are getting it right, you said that it was strongly recommended. Coming from regional Queensland—the health committee travelled to the Torres Strait and the NPA—who were you consulting with on this? Were groups in rural and remote Indigenous communities consulted?

Ms Hammer: The recommendation arose from the three-year review into the National Registration and Accreditation Scheme as commissioned by all health ministers. That review report was completed in 2014, with health ministers considering and making decisions about the recommendations in 2016. In terms of the consultation process, I am unable to provide specifics about specific groups, but there was certainly a wide national consultation process in regard to the actual review, as well as in regard to developing the policy recommendations for ministers in regard to this specific bill.

The wording of the principle and the objective was carefully developed in collaboration and in consultation with the Aboriginal and Torres Strait Islander Health Standing Committee, which was in place at the time, as well as with Ahpra's own advisory committee. We had representatives from First Nations people from all states and territories who were specifically consulted. I know there was very careful consideration around the specific wording that was placed in the bill. Obviously the wording

needed to be within the context of what the national law is about and to be able to particularly fine-tune that. I know that my colleagues had significant discussion with the New South Wales Parliamentary Counsel in the drafting. We finally settled on wording that all parties were pretty happy with.

Ms Slape: During the consultation on the draft bill, Queensland Health specifically added in stakeholders who were relevant to the national consultation. They included stakeholders such as the Australian Indigenous Doctors' Association, the Queensland Rural Medical Education and Rural Doctors Association of Queensland. Then there was a range of other national stakeholders involved as well.

Mr O'CONNOR: The bill would give Ahpra, national boards or the OHO the ability to issue public statements about a practitioner who is under investigation which would obviously be before any findings of misconduct or otherwise. You touched on natural justice in your opening. Can you go a little further into how an appropriate balance would be found between protecting the public and avoiding irreparable damage to a practitioner's reputation and their business?

Ms Hammer: As you mentioned, the bill allows the Health Ombudsman, Ahpra and national boards to make a public statement about a person. I think the provisions have been quite carefully drafted so that a public statement can only be made about a person who is already the subject of an assessment, investigation or disciplinary proceeding and where the regulator reasonably believes that they have committed a relevant offence under the national law such as using a protected title when they are not registered in that particular profession, performing a restricted practice, prohibited advertising or directing or inciting professional misconduct. The regulator must reasonably believe that the person poses a serious risk to persons because of their conduct, performance or health and it is necessary to do so to protect public health or safety. It was drafted to create quite a high threshold which limits the circumstances for issuing a public statement. Ahpra has advised that as part of the implementation activities it intends to develop processes to ensure that the power to make public statements is used judiciously.

In terms of sufficient protections for practitioners, we have talked about the threshold for issuing public statements. Given the strict criteria, we expect that the powers will be used sparingly, but there are other safeguards in place. Prior to making a public statement, the regulator must undertake a show cause process allowing a practitioner to make a written or verbal submission about the proposed statement, and the regulator must consider those submissions before making a decision. As mentioned before, the regulator must also revoke a public statement if it is satisfied that the grounds for the statement no longer exist or did not exist at the time. A decision to make a public statement can also be appealed to the relevant tribunal. In Queensland that would be QCAT. As James has mentioned previously, with the new paramount guiding principle and the requirement to carefully balance the rights of practitioners with the rights of consumers and the public protection, the ministers agreed that the proposed approach suitably addressed those concerns.

Ms KING: The bill very substantially increases penalties that can be applied, from $5,000 to $60,000 for individuals and from $10,000 to $120,000 for bodies corporate. Can you take us through how those increases were decided upon, what the basis was for the belief that they needed to increase so markedly, and how they are considered to be proportionate to the offences they are linked to?

Ms Hammer: As you outlined, there are a number of penalties that are proposed to be increased not only under the national law but under the Health Ombudsman Act as well. As mentioned, the national law already restricts the way in which services can be advertised by prohibiting advertising that is false or misleading or offers an unreasonable expectation of a treatment outcome. The maximum penalty has been substantially increased. 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.

With regard to directing and inciting offences, 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.

Mr Liddy: Another important thing about the penalties is that they are maximum penalties. Obviously, for any course of conduct there is a range. Some matters fall at the lower spectrum; some fall in the more serious and higher spectrum. This gives the courts the ability to impose higher penalties for the most serious offences. Not everyone will get those higher penalties. In fact, courts often tend to not give maximum penalties. They tend to give them at the lower end or middle.

Ms Slape: In considering penalty amounts we did look at relevant national and Queensland law for comparison—for example, penalties under Australian Consumer Law and the Food Act 2006—just to see what penalties were commensurate. That is also why they were raised in the manner they were.

Mr ANDREW: The bill removes the current prohibition on including testimonials in advertising. What provisions will there be to protect patients from false advertising and false testimonials?

Ms Hammer: As you have said, the bill will remove a current prohibition on the use of testimonials in health service advertising. This has been brought forward because it will bring advertising restrictions under the national law into line with current marketing and advertising practices and consumer expectations about how they get their information. Since the national law was established in 2009 and 2010 the advertising landscape has changed dramatically. With information commonly being available online and in new forms of advertising, consumers now expect to have access to reviews and testimonials. For those reasons, it was considered that it no longer makes sense to regulate testimonials differently to other forms of health service advertising .

Under the amendments to the bill, the use of testimonials will be regulated in the same way as other forms of health service advertising. Testimonials, importantly, will still be prohibited where they are false, misleading or deceptive; where they offer a gift or a discount or induce a person to undertake a health service without stating the terms and conditions for that; if the advertising creates an unreasonable expectation of the outcomes of treatment; and encourages the unnecessary use of health services. 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.

Mr MOLHOEK: Following up on the issue of advertising, it would seem that the proposal is to actually remove the prohibition for testimonials. Do you have any concerns about that? In the explanatory notes it talks about people being able to go on social media and effectively say, 'I went and saw Dr Bob and he was a good bloke.' Are there concerns about the removal of that prohibition?

Ms Hammer: As I mentioned before, there are already established restrictions on advertising and regulations on the use of false advertising, for want of a better word. Testimonials had been included as a separate provision. For example, health practitioners post testimonials on their website, advertising over which they have control, but it is very much recognised that testimonials are out there independently online for practitioners and the health practitioner does not have control over those forms of testimonials. This really takes away from the health practitioner the onus of needing to be concerned or controlling those other forms of online advertising. It does also bring the use of testimonials back into line with other provisions for advertising. As I mentioned, in those circumstances they cannot be false, misleading and deceptive or unnecessarily encourage the use of health services. Would you like to make any comments about consumer law and how it aligns?

Mr Liddy: My understanding is that it is a very resource-intensive activity for Ahpra to regulate the advertising space. It is probably something that is best taken up with them in terms of how they manage it practically. Amanda is saying that the reality of the last 10 years with social media, booking sites and that sort of thing, where you can go on and book appointments with health practitioners all the time, is that some consumers do find it helpful to have peer experiences such as, 'This person is helpful', 'This person is a good listener', 'This person is good with women', 'This person is supportive of the LGBTI community' et cetera. It does have a positive aspect to it. Like everything online, there are good aspects to it and there are downsides.

Mr MOLHOEK: It is a bit of a can of worms.

CHAIR: If there are no further questions, I thank you each for being here today. It was a very informative unpacking of the bill before us. It is the beginning of the process. If we have any further questions we know we can write to you. We thank you for your contribution today; it has been very informative. I now declare this public hearing closed.

The committee adjourned at 9.57 am.