# *HEALTH, COMMUNITIES, DISABILITY SERVICES AND DOMESTIC AND FAMILY VIOLENCE PREVENTION COMMITTEE*

**Members present:**

Mr AD Harper MP (Chair)
Mr MC Berkman MP (via teleconference)
Mr MF McArdle MP (via teleconference)
Mr BL O'Rourke MP (via teleconference)
Ms JE Pease MP

**Staff present:**

Mr R Hansen (Committee Secretary)
Ms R Mills (Assistant Committee Secretary)

## PUBLIC BRIEFING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL 2019

### TRANSCRIPT OF PROCEEDINGS

**MONDAY, 9 DECEMBER 2019**

**Brisbane**

# MONDAY, 9 DECEMBER 2019

**The committee met at 2.02 pm.**

**CHAIR:** I now declare this public briefing of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee open. I would like to start by acknowledging the traditional owners of the land on which we are meeting today. I am Aaron Harper, the chair of the committee and the member for Thuringowa. We have three committee members on the phone: Mark McArdle, the member for Caloundra and our deputy chair; Michael Berkman, the member for Maiwar; and Barry O'Rourke, the member for Rockhampton. Here with me is Joan Pease, the member for Lytton. We have an apology for Marty Hunt, the member for Nicklin.

This afternoon's briefing is part of the committee's inquiry into the Health Legislation Amendment Bill 2019. The bill was introduced and referred to the committee on 28 November 2019. The reporting date for the bill is 21 February 2020. This public briefing of the committee is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. The committee will not require evidence to be given under oath, but I remind all witnesses that intentionally misleading the committee is a serious offence. I remind members of the public that, under the standing orders, the public may be admitted to, or excluded from, the hearing at the discretion of the committee.

Hansard will record the proceedings and you will be provided with a copy of the transcript. This hearing will also be broadcast live on the parliament's website. The program for today has been published on the committee's web page, and there are hard copies available from committee staff. I welcome everyone who is here in the public gallery.

## MAHLER, Mr Karson, Manager, Legislative Policy Unit, Queensland Health

## MATTHIAS, Ms Tricia, Acting Director, Legislative Policy Unit, Queensland Health

## WAKEFIELD, Dr John, Director-General, Queensland Health

**CHAIR:** Welcome and thank you for your attendance today. This bill amends five separate acts and two regulations. We would deeply appreciate it if you could step through each one, and we will move to questions after that. I invite you to make an opening statement, Dr Wakefield.

**Dr Wakefield:** Good afternoon. I also start by acknowledging the traditional owners of the land on which we meet today and elders past, present and emerging. My name is John Wakefield, Director-General of Queensland Health. I am joined by my colleagues Tricia Matthias and Karson Mahler. I plan to provide a short summary of the bill for the committee's benefit. I am aware of the fact that you probably have not had a lot of time to read through it, given the notice.

We are going to start by talking about strengthening networked governance. The bill contains amendments to strengthen the networked governance of the public health system. Earlier this year the minister asked an expert panel comprising Mr Jim McGowan, Professor Anne Tiernan and Dr Pradeep Philip to provide advice on Queensland Health's governance framework in the Hospital and Health Boards Act. Under this devolved governance model, the Department of Health is the system manager and is responsible for the overall leadership and management of Queensland's public health system. The 16 hospital and health services are responsible and accountable for the delivery of public health services within their specific remit. The Queensland Ambulance Service is established under separate legislation but, through machinery-of-government changes, operates also as part of Queensland Health.

Overall, the panel found that Queensland Health's current devolved governance model is working well. It facilitates greater community engagement and local decisionmaking and it is an appropriate model for a system as large and as complex as Queensland Health. However, the panel considered that there was an opportunity to strengthen the system by moving to a networked governance model. This networked approach would emphasise that each part of the system has obligations to the system as a whole and to each other. In practical terms, it means that all parties within the system have mutual and reciprocal obligations to each other and an obligation to consider the impact of their decisions on the broader public sector health system as a whole.

To give effect to the panel's recommendations, the bill will amend the Hospital and Health Boards Act to require hospital and health services and their governing boards to have regard to the effective and efficient use of resources for the public sector health system as a whole and the best interests of patients and other users of public sector health services throughout Queensland. The bill will also amend the Hospital and Health Boards Act and the Ambulance Service Act to recognise that the Queensland Ambulance Service and the hospital and health services must collaborate to manage the interaction between the services they provide. The amendments do not change the current model of hospital and health services being responsible for delivering local public health services. Amendments in the bill signal the high-level policy intent for the department, the hospital and health services and the Queensland Ambulance Service to share resources and collaborate more effectively with each other in the best interests of the system as a whole and, of course, the Queenslanders they serve.

I will move now to strengthening the commitment to health equity. Queensland Health has been leading the way in working toward health equity for Aboriginal people and Torres Strait Islander people. In 2010, Queensland was the first state to introduce a health services cultural capability framework, which is a critical element in closing the gap. The framework provides information to help hospital and health services provide culturally capable health care to Aboriginal people and Torres Strait Islander people. In 2017, the hospital and health boards and Queensland Health developed and agreed to a *Statement of action towards closing the gap in health outcomes*. As part of that statement of action, each hospital and health service committed to developing and implementing a closing the gap statement of action health plan. Each service agreement with a hospital and health service includes a requirement to have a statement of action health plan.

The panel recommended that the Hospital and Health Boards Act be amended to embed in legislation this commitment to closing the gap in Aboriginal and Torres Strait Islander health. To give effect to this recommendation, the bill introduces two new guiding principles in the act. These principles are: firstly, a commitment to achieving health equity for Aboriginal and Torres Strait Islander people; and, secondly, a commitment to the delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people.

The bill also requires each hospital and health service to have an Aboriginal and Torres Strait Islander health equity strategy and to consult when developing and implementing these strategies. It is proposed that closing the gap health plans will change to become health equity strategies to emphasise strength based actions towards health equity for Aboriginal and Torres Strait Islander people. Legislating to require hospital and health services to have health equity strategies and to require consultation on the development and implementation of these strategies will strengthen existing requirements, and it ensures that strategies are developed collaboratively and co-designed with local communities. The strategies need to be suitable for each service's unique needs.

The bill also requires that one or more hospital and health board members must be an Aboriginal person or a Torres Strait Islander person. The government has committed to increasing Aboriginal and Torres Strait Islander representation on all Queensland government boards and committees through the Reconciliation Action Plan 2018-2021. Queensland Health already proactively encourages applications from suitably qualified Aboriginal and Torres Strait Islander persons for board membership. Currently, I am pleased to say, nine of the 16 hospital and health boards already have at least one Aboriginal or Torres Strait Islander member. Five boards have more than one Aboriginal and Torres Strait Islander member. However, it is important to ensure that each board has representation from our First Nation peoples. Therefore, the bill goes beyond the Reconciliation Action Plan to mandate representation on hospital and health boards and thus ensure that First Nations people have a voice at this level of government.

I will turn now to conversion therapy. The bill will prohibit the practice of conversion therapy by health service providers in Queensland. While several states and territories have announced plans to ban conversion therapy, Queensland will be and is the first jurisdiction to introduce legislation to protect LGBTIQ persons from these harmful and degrading practices. Conversion therapy refers to practices that try to change or suppress a person's sexual orientation or their gender identity. There is overwhelming evidence that conversion therapy is harmful, and it is correlated with higher rates of suicidality and self-harm. For example, a 2018 report from La Trobe University found significant negative health outcomes for individuals who have undergone conversion therapy.

The Australian Psychological Association, the Australian Medical Association and the World Health Organization all formally oppose conversion therapy as both harmful and unethical. In November 2018, the minister convened the Ending Sexual Orientation Conversion Therapy

Roundtable to consider how to end conversion therapy in Queensland. The round table was attended by representatives of the community and of government. The round table concluded that government should consider legislation making it an offence for health practitioners to perform conversion therapy.

It also recommended that consideration be given to protecting children, young people and vulnerable groups from these practices. The bill amends the Public Health Act to create a new indictable offence for a health service provider to perform conversion therapy. This definition of conversion therapy does not include treatments that affirm or support a person's sexual orientation or gender identity. It also does not include any treatment that is reasonably necessary to provide a health service in a safe and appropriate manner or to comply with a health provider's legal or professional obligations. This exception is to ensure that the bill does not discourage practitioners from treating LGBTIQ patients out of concern that clinically appropriate decisions could be perceived as not affirming or supporting the patient. For example, the exception would apply to a doctor who advises against surgery because the patient has a pre-existing condition that means the surgery is not safe.

The bill's prohibition of conversion therapy is limited to health service providers. The term 'health service provider' is defined in the Health Ombudsman Act 2013 and includes anyone who provides services for maintaining a person's health or wellbeing. It is a broad term that captures registered health practitioners such as doctors, nurses and psychologists and unregistered health practitioners such as counsellors, naturopaths and social workers. The prohibition is limited to health service providers because as health professionals they have an ethical obligation not to engage in practices that are harmful and not evidence based.

In conclusion, the bill will also make other minor amendments to the health portfolio legislation which I am happy to take questions about or direct to my colleagues.

**CHAIR:** Thank you very much, Dr Wakefield. The first topic you discussed was strengthening networked governance. I was particularly interested in the interaction between Queensland ambulance and Health. I was around when the machinery of government changed over, but the two reporting systems are separate in that the Queensland Ambulance Service uses an electronic format of documentation. Do you foresee the department exploring options in the shared collaboration space to get both systems talking to each other in the future?

**Dr Wakefield:** It is important to point out that the Queensland Ambulance Service and the commissioner report through the director-general as part of the health system more broadly and through to the minister. Certainly since the time of the machinery-of-government change, and probably well before that, there has been a significant joint interest of organisations particularly around the acute care of patients. That has always been the case. The sharing of information, the relationship, the mutual obligation and the culture of Health and Ambulance have meshed considerably. I think it is fair to say that legislation has not been required to make that happen, but this legislation makes it more explicit in the Queensland ambulance legislation and more generally frames the policy of that system integration in legislative terms.

To specifically answer your question, we are already significantly sharing data from Queensland ambulance and health systems, most notably at the level of the PACHs—those hubs, particularly in the south-east corner, although there is one being set up in Cairns—where we have Ambulance and Health together sharing data to make sure that patients get to the right place at the right time for the right care. Significant sharing of data is already occurring. I can only see that expanding.

**CHAIR:** Would an example of that be access to the Viewer?

**Dr Wakefield:** Yes. I think we have talked about this before, but the Viewer is essentially a window into a hospital and health service's systems that allows a practitioner to dial up a patient and basically have a window into their health records from wherever they have been in contact with our system across Queensland. It is incredibly important in emergency situations to make sure that we get quick information about pathology tests, issues with radiology tests, a history of that patient's allergies and the like but also, particularly for older people in residential aged care, their specific wishes about end-of-life care and so on. That system has been opened up to paramedics. It is opened up to all GPs across our system, and plans are afoot to make sure that it will be accessible to nurses within residential aged care as well.

**CHAIR:** In the minister's introductory speech he mentioned that the bill will amend the Hospital and Health Boards Act and the Ambulance Service Act to give effect to three of the panel's recommendations. What are those three recommendations? I am happy to place that question on notice.

**Dr Wakefield:** No, that is fine. I think they are recommendations 1, 2 and 5. Perhaps I will speak to those recommendations specifically. These are fairly long recommendations so I will not read them in full.

Recommendation 1 is really about the current governance model to drive greater network and system characteristics. In the seven years since devolution—since the one system was devolved into 16 hospital and health services which have a degree of sovereignty. They are board governed. The predominant feature of that governance was what would be termed in the report as a federated model. There is a relationship between the centre, the system manager and leader—the department—and each individual health service. It is like a one-to-one bilateral relationship and it is manifested through a contract. That federated model, as elucidated in the report, has led to significant benefits, particularly driving more local accountability in decision-making.

What the reviewers found, though, was that an unintended consequence of having a sovereign health service whose board is required to focus on the interests of that health service is that there are at times decisions that a health service might make where it would be better for it to turn its mind to the system consequences rather than the individual health service interests. The move from a federated to a networked model—which is recommendation 1—really gives life to the fact that not only is that relationship between the centre and each health service but it is also between all of the health services. It is this notion of reciprocity and mutual obligation, because patients and staff move across those boundaries. Certainly it is part of how the system operates, but this was deemed to give it more strength by recognising it explicitly in legislation.

Recommendation 2 is really about the Queensland Ambulance Service being a critical component of that system and similarly making it very explicit in that legislation that the Queensland Ambulance Service is part of that system and part of that reciprocity and mutual obligation. That just makes very explicit a policy expectation which is part of how we do business but nevertheless is important.

Recommendation 5 really relates to those changes that are seeking to give more explicit acknowledgment of our obligations to our Aboriginal and Torres Strait Islander people in terms of closing the gap. There are a number of components to that which we briefly talked about in my opening statement; for example, the move from a 'closing the gap' terminology to a health equity terminology which really frames the challenge in a more positive light. Each health service has to have a specific plan and an obligation to work locally with its Indigenous communities to define what that looks like and also the Indigenous representation on boards. Those are the key recommendations—1, 2 and 5—that this bill particularly relates to.

**Mr O'ROURKE:** With regard to strengthening the commitment to health equity for Aboriginal and Torres Strait Islander people, what cultural training is provided to clinicians and staff within our health services?

**Dr Wakefield:** In terms of detail, I may have to seek advice. Certainly since 2010, I understand, there has been a specific unit that has been responsible for developing and promulgating training for all health services and the department in culturally competent care. That training is provided on an ongoing basis through each health service. Each health service also has a designated position that is responsible for making sure that that training is maintained, up to date and delivered.

The statement of action that I referred to in my opening statement was the result of a review which found that we needed to do better as a system in ensuring that we had reliable closing the gap initiatives in each health service and across the system. The statement of action, which is a published document, highlights the actions that were put in place and maintained to address some of those perceived shortcomings. I am happy to tender that document.

**CHAIR:** Is leave granted? Leave is granted. The ADCQ did a body of work in 2017 identifying each of the HHSs in relation to Aboriginal and Torres Strait Islander engagement and people on boards. We note that they proposed a follow-up audit in 2019-20. Can you advise the committee whether that follow-up audit has occurred or when it will occur?

**Dr Wakefield:** I would have to take that on notice, I think.

**CHAIR:** We will place that question on notice.

**Dr Wakefield:** I will take that on notice and we will see if we can get something back before the close of this session.

**CHAIR:** Thanks for that. Barry, do you have a supplementary?

**Mr O'ROURKE:** No, that will be fine. Thank you for your response.

**Mr BERKMAN:** Just sticking with the topic of health equity, the report of the Anti-Discrimination Commission had some pretty stark figures in that 10 of the HHSs were assessed as having very high levels of institutional racism and the remaining six had high levels. In any follow-up work you have done, can you give an indication of what those levels might be now? Has there been any subsequent assessment under the matrix and what is the current state of play?

**Dr Wakefield:** I can speak to some of the work that has been done. Aligned to the statement of action and the priorities, there has been significant implementation through our health services and also through the work of the branch. One of the significant achievements I think has been the establishment of the Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Haylene Grogan, who commenced a little earlier this year, which I think is a significant step in acknowledging that. That is a deputy director-general position and it is the first across government and nationally, I understand.

Aligned to that, significant work has occurred around each health service establishing a plan and implementing their local closing the gap plans. Again, they are all available publicly. In addition to that, I know that there has been significant attention paid to that through the performance agreements and contracts with health services, so the department has a strong monitoring role in relation to actions of health services around closing the gap. I would never say that there is never much more to do but, again, I think we are proud of our progress. As it pertains to your specific question of our individual health service status, I do not have an answer to that and I am happy to take that on notice and bring that back in terms of whether a specific piece of work has been done at that level.

**Mr BERKMAN:** Thanks. That sits very neatly with the question on notice from the chair about whether that follow-up has been done during 2019-20. The question is ultimately whether any measure or reassessment under that matrix of the level of institutional racism has been done perhaps in concert with that review.

**Dr Wakefield:** Thank you, but I would ask my colleague to address that.

**Ms Matthias:** Specifically in relation to the matrix tool which was raised, this has been provided to all of the hospital and health services for their internal use to measure the change and improvements, and Queensland Health is supportive of the HHSs using the tool. It is our understanding that the Human Rights Commission may implement the matrix tool next year and continue to monitor the change and improvement in health equity through this, so there may be more work to be done next year on that. The idea is that the matrix tool will continue to be refined.

**Mr BERKMAN:** I have a question about the proposed change to the guiding principles. I am curious what the impact of that is expected to be in specific measurable outcomes. You have touched on some of those changes, but are there specific changes in practice expected as a consequence of that change to the guiding principles and how would its impact be measured?

**Dr Wakefield:** In terms of the networked governance—the shift to a networked system or a federated system—I can say that right now we are coming to the end of a consultation on governance entities going forward for the health system; that is, how do we give life to this recommendation and what does it mean? For me as the director-general, it means thinking and acting differently, working differently. One of the very tangible ways that I have commenced addressing that is to review and change our governance. Our legacy governance really was that there was a fairly strong departmental peak committee that was essentially the advisory and decision-making body and various system level forums and committees. I have sought to strengthen that by the introduction of a system board that will advise me and the minister—and that will comprise members of both service providers and the department and also key stakeholders such as consumer representation—to make sure that we are making solid system decisions informed by a systems strategy and that we close the gap, if you like, between the department and the 16 individual health services; that is, the notion that we would co-design and work together on strategy rather than having that done by the department. That is not yet finalised, but it will be finalised and initiated in the new year. Immediately there will be a change to the top level governance of our health system. With respect to your previous question, the Chief Aboriginal and Torres Strait Islander Health Officer will have a seat and will be a member of that board.

**Mr BERKMAN:** I note that in the briefing the department provided—it was very helpful, thank you—the second dot point on page 3 says that the bill amends health legislation to remove institutional barriers to racism. Quite clearly, that is not what it is intended to mean, so I just thought it might be worth picking that up and changing it to say 'remove institutional barriers to addressing racism' or something along those lines before it gets published and distributed further. I just make that observation.

On to conversion therapy, I am interested in the definition—how the department arrived at the definition that is proposed and what consultation was done with key medical and other interest groups and if there were any concerns raised around the definition.

**Dr Wakefield:** Thank you. I might ask my colleague Karson Mahler to respond to that.

**Mr Mahler:** We developed the definition of conversion therapy based on the recommendations of the Ending Sexual Orientation Conversion Therapy Roundtable. The definition of 'conversion therapy' in the legislation in general was very heavily informed by the recommendations that came out of the round table held in November 2018 by the Minister for Health and Minister for Ambulance Services. That round table consisted of a very diverse group of stakeholders representing the LGBTI community as well as legal organisations, government agencies, a survivor of conversion therapy and a cross-section of different stakeholders. Those stakeholders were supportive of legislative change and felt that legislation could provide a strong platform for changing attitudes and culture around these practices. They also emphasised the need in particular to protect children and other vulnerable persons from these practices, and our understanding of some of the definitional issues came out of some of those conversations.

We also considered available research and evidence. There is quite a comprehensive report that came out of La Trobe University and the Human Rights Law Centre which is the most comprehensive and current report on conversion therapy in Australia. That report—and I would be happy to provide a copy to the committee—provides a very detailed overview of the practice in the Australian context; gives anecdotal evidence of survivors of conversion therapy; and explains concepts around gender identity, gender expression, sexual orientation and really the history of the conversion therapy movement and that sort of thing as well. We have taken a fairly considered approach, taking input from stakeholders but also being aware of available research and evidence.

That is how we have initially arrived at the legislative provisions. We also tested them with a group of stakeholders prior to introducing the legislative provisions. These were a variety of members of that round table and additional interested stakeholders who have experience in LGBTIQ issues, and they were broadly supportive of the definitional provisions in the bill and made a number of suggestions as well for how those could be improved which we incorporated into the final draft of the legislation.

**Ms PEASE:** Thank you very much for coming in today. I begin by going back to the health equity issue. With the decision and the round table and discussions around that, at what level were Aboriginal and Torres Strait Islander people involved in that decision to change the title and the process in terms of the way forward?

**Dr Wakefield:** My understanding is that there was significant involvement from the various representative groups representing Aboriginal and Torres Strait Islander peoples—I have a fairly significant list here—but also a list of key stakeholders, clinical stakeholders, unions, the Queensland Human Rights Commission, academic institutions such as IUIH and the Centre for Indigenous Health Equity Research—Adrian Marrie's area—community health councils such as Cape York and QAIHC, Health Consumers Queensland and of course all our hospital and health service boards and services that I know have done a lot of work over the past two to three years to really deepen the engagement. If I could just give an example, one of the chief executive colleagues in West Moreton now conducts yarning sessions under a tree which I was able to experience recently. Again, in various ways a lot of work has been done to genuinely reach out to Indigenous communities and elders and leaders on a very equal footing.

Significant work has been done to engage, and it is definitely the strong view of our First Nations colleagues—and it is shared by us in Queensland Health—that we need to be constructive, that we need to be much more positive in terms of the language of essentially closing the gap, which in and of itself is a negative term. We are very happy to change that language, on the advice and support of our First Nations colleagues, to one that is much more focused on positive and constructive narratives. That is really where the terminology came from. We will see that start to replace as much as possible the closing the gap narrative.

**Ms PEASE:** Further to that—and it is probably outside the remit of Queensland Health—given that health professionals in whatever capacity have gone through university and training, is there any opportunity to provide culturally appropriate training to health professionals as they are training at university, given that they are going to come through Queensland Health at some point—or does that happen already?

**Dr Wakefield:** I would think absolutely it is critically important. I cannot speak with any great knowledge at this point of undergraduate training. I am sure we could get that information from our undergraduate providers. I think what is definitely the case, though, from a cultural perspective is that,

whatever you get taught in an undergraduate setting, what happens with that very quickly shifts when you hit the workforce. Certainly, if we make sure that our graduates and our trainees who are doing work placements experience a very positive, constructive, respectful and culturally appropriate workplace, they are likely to adopt those behaviours—and the opposite is also true. I am very happy to seek that information. Our primary focus has to be making sure that that is the prevailing culture for our junior clinicians and nonclinicians—that it is just the way we behave.

**Ms PEASE:** In the briefing you gave us about conversion therapy you talked about the penalties that are going to be given out to health service providers who perform these conversion therapies, particularly on vulnerable people or young children. If a vulnerable person has been taken for conversion therapy, is there any requirement for the people who have taken them to get that conversion therapy to be reported to Child Safety for the protection of those vulnerable people?

**Dr Wakefield:** Again, that is a technical question. Is there an obligation at the moment for the reporting of parents of children, for example?

**Mr Mahler:** I hesitate to speak about what requirements might exist under other legislation. I suspect there probably are some provisions in place given the overlap of some of these practices with potential child abuse concerns. However, the bill that we are introducing does not impose any specific new obligations on parents or family members to report. Tangentially, it potentially imposes obligations on health practitioners to report. If a health practitioner were charged with an offence under this bill, because of the way the penalties are set up under the health practitioner regulation national law, if an offence carries a maximum of penalty of 12 or more months imprisonment that triggers an automatic reporting obligation for the practitioner. If a practitioner were charged with any offences under this bill they would have to report them to the national board, and the Office of the Health Ombudsman could take further action as well.

**Dr Wakefield:** I think part of the reason this policy decision has been made, and particularly focusing on health practitioners, is that these practices, were they to occur, are very clandestine. By and large, as I understand it from the literature, if it is a minor, parents are making decisions very much as part of a strong connected peer group. It is unlikely that reports in such a scenario occur, and even if a report did occur at this point the question is: where would it go? Would it be considered an offence for a parent? Would it be considered consistent with any sort of child abuse? I think there would be a lot of confusion about that in terms of the various current statutory obligations in those areas. I think this bill makes it very clear that it is specifically targeting those clinicians or practitioners who engage in this therapy and makes it crystal clear that, if this bill is to pass, this is unethical and unlawful, and particularly for a minor or a vulnerable person the penalties are more severe. I think it is deemed that that is a better way to attempt to regulate behaviour that is very secretive.

**Ms PEASE:** Obviously these practices are going on around us. Can you give us some examples of who they might be and what they are doing?

**Dr Wakefield:** My understanding is that—I will ask Karson to speak to this specifically—because of its very nature, the data around this is very scant. It tends to be anecdotal. It tends to come from reports of people who in some cases underwent such therapy and later in life or several years later chose to speak up about it. Karson certainly has the technical expertise around that particular evidence.

**Mr Mahler:** I think that is absolutely right. It is difficult to quantify the prevalence of these practices in Queensland. As the director-general said, there is a variety of practices. They fall across a spectrum. The bill gives some illustrative examples of what types of practices might constitute conversion therapy. At the more extreme end you have, for example, electroshock therapy or administering nauseating drugs in response to stimuli—for example, a homosexual man looking at a picture of another man and having a nausea-inducing drug administered to try to create a negative response. It is a spectrum. It goes all the way down to more counselling types of practices, where you have a counsellor trying to condition somebody to behave or act in a way that is not consistent with their gender identity or sexual orientation. There are a wide range of practices that would be covered under the bill. The touchstone really is: is the practice attempting to suppress or to change a person's sexual orientation or gender identity? Is it trying to change who they are?

**Dr Wakefield:** Specifically in terms of how much conversion therapy is occurring, the short answer to that is we do not know because it is hidden. What we do know comes out of case reports and stories that people tell. I think the La Trobe work is probably the most detailed work at this point.

**Ms PEASE:** With regard to this legislation on conversion therapy for registered and unregistered health providers, is it conditional on where that conversion therapy might be taking place or could it be in any location? Does it have to be specified at a medical address, for example, or could it be at someone's home, in a church hall or in someone's backyard?

**Dr Wakefield:** It is not linked to a place. It is linked to a person who fulfils the criteria of being a health practitioner, which includes registered health practitioners as defined by the OHO legislation. Again, each case would fall in a context. This legislation cannot and does not ban these sorts of therapies if they are performed as part of a religious ceremony, for example, but if a health practitioner—registered or otherwise—is involved and it is done within a health context then that would fall within the remit of this legislation. Again, from a technical perspective, place is not a factor.

**Mr Mahler:** To add a little bit of nuance, certainly the director-general is correct in that it is linked to a health service provider. Embedded in that definition, though, in the Health Ombudsman Act is that a health service provider is a registered health practitioner or another person or entity who provides a health service. In considering whether someone is a health service provider and would be captured by this bill, one would need to consider that what they are doing is delivering a health service. A health service could be delivered in a medical office but it could also be delivered in a counselling centre. It could potentially be delivered in a school. It could be delivered in a wide range of contexts. A very fact based inquiry would need to happen to understand if this person is engaging in a religious practice that would not fall under the bill or if are they really holding themselves out as a practitioner providing a health service. If so, they would be captured.

**Mr McARDLE:** Can I start by going back to the governance framework. Director-General, you mentioned there was an expert panel and a report. Before talking about the report itself, can I ask you to give us some background as to the circumstances and facts that led to the expert panel being established?

**Dr Wakefield:** I think seven years into these new governance arrangements the minister, I think quite appropriately, felt that it was certainly a reasonable time to take stock of how things were going—what is working well and what is not. My understanding is that the minister commissioned this panel to seek advice after consulting with various stakeholders.

**Mr McARDLE:** The panel would have been given terms of reference, I would imagine. Can you undertake to table a copy of those terms of reference for the expert panel?

**Dr Wakefield:** Yes. The report has now been published. It is in appendix 1 of the report, which is now a matter of public record. I am happy to read through those or tender that. As these things are, it is a fairly lengthy document.

**CHAIR:** We might seek leave to get that tabled. Is leave granted? Leave is granted.

**Mr McARDLE:** As you said, we have only had this bill for a short period of time. Do you have a copy of the report there or could you give the details as to where we can obtain a copy of it?

**Dr Wakefield:** I do. It is currently available on the Queensland Health internet site. I am happy to get the specific URL for the committee. Perhaps it would be useful, given the member's questions, without reading through all of the terms of reference, if I just focus on the dot points around the scope of advice sought, acknowledging the fact that it is only part of that document.

The advice is to consider areas critical to Queensland Health's ability to meet the needs of the community and implement government policy in a timely manner when delivering public health services, including procurement, including the organisational governance of Health Support Queensland; capital and asset management; industrial and human resource management; service planning; reducing variation in costs, structures and outcomes and improving value; and managing capital projects within budget and time frame, including IT projects.

In relation to each of these critical areas the advice will—and I quote three dot points here—assess and benchmark the decision-making process and time frames; consider the appropriateness of the decision-making process and respective roles as between the minister, director-general, health boards and chief executives; and, finally, consider how to strengthen the ability of hospital and health boards to implement government policy and priorities. I think those key points in terms of scope I guess really focus down on several system level functions, but these documents are available online and I will provide that link for you.

**Mr McARDLE:** Can I just clarify your commentary, Director-General? The report that you are referring to and you will give us the link to is the full report, including all recommendations and terms of reference or only that portion relevant to this bill?

**Dr Wakefield:** It is the full report. The title is *Advice on Queensland Health's governance framework*. It is the full report with attachments and appendices.

**Mr McARDLE:** It would appear that the report is a high-level document; would that be a correct statement to make?

**Dr Wakefield:** That is matter of subjective judgement. It is a report, and the terms of reference and the information within it highlight the stakeholders involved in its production. I would say that it has not gone down to great detail, health service by health service. It is deliberately focused on how the organisation functions as a system, but I hesitate to make a comment about whether it is about that.

**Mr McARDLE:** Can I take you to clauses 4 and 9 of the bill where they deal with the word 'collaboration' between the relevant offices: QAS and HHSs. In your commentary, on a number of occasions you referred to an integration of the systems and also that it is more of what is existing policy at this point in time. If it was policy, what was the necessity to put in legislation what I would have thought would be a daily activity—that is, collaboration between the two sectors within Queensland Health to ensure a better outcome for all Queenslanders?

**Dr Wakefield:** I think you are right that we do not specifically need legislation to tell us that our Ambulance Service and our hospitals need to work together to get the best outcome for Queenslanders, but certainly in the light of this report—and part of that report obviously looked at existing legislation. The legacy legislation of, in this case, the Queensland Ambulance Service was such that that was not explicit, because I guess that was created well before this structure of governance was implemented. I think it is more than symbolic—it is certainly giving very explicit life to a policy direction determined by government—but I would agree with you that we have not waited for said legislative text to drive us in that direction.

**Mr McARDLE:** It might be a rhetorical comment and not a question, but it worries me that we have to put in legislation a directive or a collaborative approach that I would have thought would flow from one to the other as a matter of course. We can leave that discussion for another day, potentially. How are you going to gauge the success or otherwise of this?

**Dr Wakefield:** In relation to your last comment, I accept the fact that it is open to question whether this is pedantic—whether this is something that is really material. As director-general, and having had significant time within the system, I think it is important—that is, more than simply symbolic. The reason I say that is: it is quite fundamental that, certainly from a board governance perspective, if you are running a health service, the accountabilities of the directors of that board are to serve the interests of that health service, essentially over and above anything else. I think this makes it very clear, and as it pertains also to the QAS, that as board directors and governors you have to also ask the question about how your decision is impacting on the system as a whole. I think that absolutely applies from an ambulance perspective as well. I would have a view that it does matter.

**Mr McARDLE:** I am keen to understand the time line in relation to this and also how you gauge the success or otherwise of a matter of this nature. I am looking again at clauses 4 and 9.

**Dr Wakefield:** Again, I think this review was seven years into our devolved system. In order to judge whether the changes that are consequential out of this report and this legislation make a positive difference to the health service, I expect that we will have to judge that by virtue of changes that occur and outcomes that get delivered over the medium term—perhaps two to three years. It will require, I imagine, another assessment—objective and external—down the track, to be able to understand what has changed and what difference it made.

Certainly in the short term there are very practical things that I will be leading, in terms of the organisation of the department, that will seek to really anchor more of a system focus, as distinct from an individual health service focus, without removing individual health service authority and obligations to be able to work at the local community level. Giving you an example, Health Support Queensland, which runs pathology services, logistic services and a whole range of other procurement services and so on, will now have a shareholder board, effectively, of health services—that is, the recipients of the services of that part of our business. The same will occur for eHealth Queensland. Instead of simply reporting through me to the minister, eHealth Queensland and the chief executive of eHealth Queensland will soon have a board of—I will call it a shareholder board; it is not called that—essentially the clients of eHealth Queensland, effectively the health services. I think this certainly does flag significant changes to how we govern, and time will tell as to whether that addresses some of the perceived challenges of devolution.

**Mr McARDLE:** In terms of your last comment, that time will tell whether it resolves challenges of devolution, have you identified what those challenges are or does the report identify what those challenges are?

**Dr Wakefield:** The report absolutely identifies what it believes is what essentially is a maturity. The report itself—as I said, it is now a public document—certainly asserts that this devolution was a very positive step and is, on the whole, a good thing for Queenslanders and for health service delivery.

It does identify a maturity from, as I said, a federated system, which is bilateral between the centre and each health service, to a networked system where we also have this reciprocity, this joint accountability. It is for all of us, certainly in our leadership positions, to bring life to that and make that work.

I will give an example, because I know in some ways this sounds like management speak. What do these terms mean? In a practical sense, if I am a junior doctor in training, I generally spend time in many hospitals around the state during the course of my training. I cross all of those boundaries between different health services and, without a very clear system view, I can really expose significant fragmentation where different health services manage and do things differently—right down to leave, accommodation, tenure and all the rest of it. Staff—and it happens to a lot of our staff—go across these boundaries. More importantly, patients and their families do as well. It is really trying to prevent significant differences that affect patient care or staff as they move between health services. That is the best way I can put it in a practical sense.

**Mr McARDLE:** It might be of benefit to us if we read the report as well. That would give us a greater understanding of where you are coming from.

**Dr Wakefield:** The report will give you a very clear understanding of why the recommendations have been put forward.

**Mr McARDLE:** I want to take you to clause 7, under the heading 'Part 3, Amendment of Hospital and Health Boards Act 2011'. The new subclause (5) on page 8 of the bill requires each HHS to have regard to the need to ensure the effective and efficient use of public sector health system resources et cetera. Does that mean that if I am the CEO or the board of the HHS in Cairns I am required in some manner to understand what my decisions will be by way of impact on someone in the Gold Coast HHS? I am trying to get the context of that particular subclause, because it is very wide. What is required by the HHS and how is it achieved, how is it measured and how is it reported?

**Dr Wakefield:** In answering that question I will refer back to the terms of reference of the review in terms of the scope of advice sought—procurement, capital asset management, industrial and human resources management, service planning et cetera. I think your question is a good one: what practical difference is it going to make for the board and/or the chief executive of the Cairns health service in relation to this clause? In a very practical sense, I think the answer is probably best given by an example. Let us put capital on the table as an example.

It is the job of the Cairns health service board and chief executive to drive whatever outcomes they think are best for the Cairns community by way of planning for capital, for example. In the current system, part of the way we would manage that is that, essentially, the department would take on board everything everybody wants around the state and it would somehow, through some logical mechanism, determine who should win—should Gold Coast win over Cairns?—because there is not enough to give everybody what they aspire to.

Part of what the reviewers were getting at was that that is certainly one way of doing business but that, as the organisation matures, a networked business has perhaps a slightly different approach. Rather than having a referee in the centre and everybody individually fighting for their own patch, whilst it does not do away with that, it also creates the obligation for the Cairns board and chief executive to think about the system as a whole in the context of its decision-making. It may be, for example, that they participate in a broader conversation about what is good for patients maybe in that northern sector.

I do not know whether that is a good example or not, but it is really saying that, as an individual hospital board and chief executive, you have an obligation that goes beyond just your own patch. You have to participate as a system steward, and that may mean that some decisions do not go the way that you want them to. Does that help?

**Mr McARDLE:** I am looking at the words of that section. It says it 'requires' the HHS to have regard to the impact—I am paraphrasing—of its decisions in relation to public sector health services throughout the state. How does the Cairns HHS, the CEO or the board take into account the whole of Queensland in relation to it seeking funding for an MRI or something like that? I am grappling with how that sits with the way HHSs operate and how that operational tool, as it currently stands, is going to be amended to say, 'I now need to take into account not just Cairns but the 15 other HHSs before I put my request in through procurement for an MRI.' I do not understand how it works on the ground, I am sorry.

**Dr Wakefield:** That is not the intent, and I do not think that would be a practical approach for any health service board or chief executive.

**Mr McARDLE:** I agree entirely with that.

**Dr Wakefield:** In order to shift from this bilateral, federated model to one which has more of a joined-up obligation—and they do compete at times; there is no doubt about that—as I indicated previously in my evidence, I will be establishing a health system leadership board that will bring together representatives of chief executives, board chairs, departmental leaders, clinical chiefs and the consumer to preside, if you like, over the joined-up piece. I am sure that it will not get down to 'should an MRI go to Cairns or somewhere else?' but it will get down to, I think, probably some of the bigger system strategic decisions. The alternative is simply that the department is a referee, and there is a better way to go.

**Mr McARDLE:** We might talk about the health system leadership board at our next meeting.

**Dr Wakefield:** Yes.

**Mr McARDLE:** Let us go to clause 28 and conversion therapies. I note that a round table was held. I think Mr Mahler made some comments in relation to the composition of that particular meeting. The member for Maiwar posed the question: how was the definition of 'conversion therapy' on page 16 of the bill derived? I am not putting words into Mr Mahler's mouth, but I think he referred to the fact that it derived from recommendations of the round table headed by Queensland Health. There were diverse stakeholders—legal, government and LGBTIQ members and organisations—and from that conversation a definition was derived. Were organisations such as the AMAQ or the Association of Practising Psychiatrists or other professional medical bodies involved in that conversation to come to that definition?

**Mr Mahler:** Just to clarify, I think I mentioned that that definition was informed in part by the consultation that we undertook with the Ending Sexual Orientation Conversion Therapy Roundtable; however, it was also informed heavily by leading research from La Trobe University and from other sources such as prevailing evidence and research on the topic. That definition also tracks very closely with international definitions that are used in other legislation that has been introduced around the world. We did not just pull that language out of thin air. I have a reference that I can give you, because this language is used in some United Nations documents. Just bear with me while I find it.

**Dr Wakefield:** Whilst my colleague is looking for that, I think the answer to that question is that significant work, consultation, engagement with stakeholders and reference to the literature informed those definitions.

**Mr McARDLE:** I accept Mr Mahler's comment. In relation to the round table or post the round table, what professional medical bodies were engaged to assess whether they saw any difficulties with the definition? I am not questioning whether or not conversion therapy has a result. That is clearly established. I am concerned in relation to those bodies who are medically based and professional in nature. Were they consulted on the definition at any time, either at the round table or post the round table?

**Mr Mahler:** Yes, certainly. I am looking at a list of organisations that were part of the initial round table. They included, among medical bodies, the Australian Counselling Association, the Australian Medical Association Queensland, the Australian Psychological Society and the Australian Health Practitioner Regulation Agency. We would be happy to provide—and I believe we already have provided to the committee—a list of all the stakeholders who were consulted.

**Mr McARDLE:** If you could undertake to do that—

**Mr Mahler:** Yes. If we have not already, we will provide the full list.

**Mr McARDLE:** The definition of 'conversion therapy' on page 16 is that it 'is a treatment' but then at subsection (2) 'does not include a practice that' and goes on to list (a), (b), (c), (d) and (e). Dr Wakefield, when you spoke to the bill in your opening comments, you went into an explanation of what is and what is not conversion therapy. What I am trying to understand is that, if I am a male who has an issue with my gender, my sexuality, and I go to see somebody, at what point in time does that particular psychiatrist move to conversion therapy while still trying to assess me as to whether what I am claiming is correct? Do you know what I am trying to get at? There is a blurred line between the two.

**Dr Wakefield:** Again, there is a whole lot of explanatory information within the bill, but I will deal with your specific example, Deputy Chair. When a person presents to a psychiatrist with what is an issue of gender identity, which is sometimes called gender dysphoria, the job of the psychiatrist is not in any way to attempt to get that patient to change their mind—

**Mr McARDLE:** I accept that.

**Dr Wakefield:**—to intervene in some way on the grounds that 'this is something that is fundamentally wrong and my job is to try to change that'. That would be consistent with, as I understand it, conversion therapy, if the psychiatrist engaged in a practice that sought to change or suppress that. However, the job of that psychiatrist in supporting that person across a whole range of therapy is to understand it, assist them with it and, depending on their wishes down the track, assist them to pursue, for example, any physiological or physical changes, assuming they were an adult. That would be entirely consistent with appropriate clinical practice. Does that help?

**Mr McARDLE:** I think it does. You are making a difference a between psychiatric assessment and clinical outcome by way of potentially a sex-change operation.

**Dr Wakefield:** I think it is about intent. Whether someone has a sex-change operation or not is obviously a complex matter, and it is one which a range of health professionals may assist and support that person in making a decision about. We only get into the territory of conversion therapy in any scenario of gender identity or dysphoria if the intent of that practitioner is to somehow seek to force or encourage that person to not have that issue or concern. Again, going to the legislation, it is any attempt to change or suppress a person's sexual orientation or gender identity. It is not about clinical actions, and therapy to help someone deal with their gender identity is not conversion therapy at all. It only becomes so if their intent or their attempt in fact is to change or supress that person's gender identity.

**Mr McARDLE:** On health equity, there is comment made in relation to a matrix that was being used initially that has been amended and is now being used by Queensland Health, if I recall correctly. Is that matrix a document that we can look at?

**Ms Matthias:** I understand it is part of the *Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public health and hospital services*, which was a report to the Anti-Discrimination Commission in March 2017. We can table that document.

**Mr McARDLE:** I tried to access it this morning, but I could not access it on their website.

**CHAIR:** I believe we have it, Deputy Chair, so we will get it to you.

**Dr Wakefield:** If the deputy chair has attempted to access that document and has not been able to, for the record, we will follow that up and make sure—

**Mr McARDLE:** It was not your website.

**Dr Wakefield:** Okay.

**CHAIR:** We will get it through the committee. There being no supplementary questions, we will conclude today's briefing as we are just over time. We have a number of questions on notice, and we would appreciate answers to those by 16 December.

**Dr Wakefield:** Yes, Chair.

**CHAIR:** Thank you very much for your time today. It has certainly informed us greatly on the Health Legislation Amendment Bill. I thank you and your colleagues for your time. I thank members on the phone. I declare this public briefing closed.

**The committee adjourned at 3.30 pm.**