Speech by

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STATE MEMBER FOR KURWONGBAH

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HEALTH PRACTITIONER REGISTRATION BOARDS (ADMINISTRATION) BILL
HEALTH PRACTITIONERS (PROFESSIONAL STANDARDS) BILL

Mrs LAVARCH (Kurwongbah—ALP) (3.27 p.m.): I rise to support both Bills presently before the House. In my contribution to the debate this afternoon, I wish to concentrate on the complaint and disciplinary procedures established by the Health Practitioners (Professional Standards) Bill and the proposed amendments to the Health Rights Commission Act.

The starting point is that this Bill changes the way in which the Health Rights Commission and the registration boards interact. The roles, priorities and accountabilities of the boards and the Health Rights Commission are also clarified. As well, the relationship between the boards and the Health Rights Commission will be streamlined. This has been done to ensure proper protection of the public from health practitioners who practise in an unsatisfactory manner.

To put the proposed complaint and disciplinary regime into context, it is worth while having a look at the history of the Health Rights Commission, considering the current problems and discussing how the reforms will address those problems and thereby provide greater consumer protection. For the benefit of the member for Burleigh I might add that the Health Rights Commissioner, in the reports of 1996 and 1997 and the sixth annual report of 1997-98, commented on the problems that exist with the Health Rights Commission Act.

Before I look at those problems and what this Bill will do to address them, I would like to make a quick comparison of the current complaint system to that proposed. Currently, complaints are either received by the Health Rights Commission or by the boards. If a complaint is received by a board, it is required to refer the complaint to the Health Rights Commission, but if that complaint is received by the Health Rights Commission there is no reciprocal requirement for the commission to refer the complaint to the board. Section 121 of the Health Rights Commission Act provides that in assessing a health service complaint, the commissioner may refer a complaint about a registered practitioner to a registration board if it is not suitable for conciliation and should be investigated and, if the commissioner considers that the board has adequate functions and powers of investigation, the commissioner must consult with the board before referring the complaint to it, but there is no legislative provision to enable boards to require referral of complaints on which they wish to take action. The lack of investigative powers by all boards, except the Medical Board, has on a narrow reading effectively neutered this provision.

Under the existing scheme, the Health Rights Commission accepts complaints about unreasonableness while the board is limited to accepting complaints concerning conduct which is "substantially below the standards of the profession". In some respects the commission's jurisdiction to accept complaints is broader than a board's ground for disciplinary action and narrower in others. Under the current scheme the Health Rights Commission has sole discretion regarding the referral of the matter to a board.

Just to give honourable members some idea about the number of complaints, there are about 400 to 650 complaints made each year regarding registered health practitioners and 60 to 80 complaints per year are referred from the Health Rights Commission to the board. Of the 10 to 15 cases where serious disciplinary action is taken each year, more than half relate to doctors.

The proposed new framework for the complaint process is that a complaint can be made to either a board of registration or the Health Rights Commission, or the boards will be able to initiate the process themselves. In general, it is expected that complaints to a board made by a health service consumer or its representative will be referred immediately to the Health Rights Commission. However, the board and the Health Rights Commission may agree to let the board handle the matter if it is in the public interest for this to occur. Complaints may be split by the Health Rights Commission and investigated and/or conciliated by the different bodies if it is so required. The boards and the Health Rights Commission give each other copies of all complaints received regarding registrants. Complaints against registrants and third parties, particularly other members of the profession, would generally be dealt with by the board. This is because many third party complainants have expressed the view that they feel better complaining to a board rather than to the Health Rights Commission.

What is anticipated by this model is that it will allow the Health Rights Commission to continue to oversee the handling of complaints about health services and, in so doing, attempt to ensure that the approaches of the differing boards remain consistent. On the other hand, if this model adopts a more collaborative approach, the boards will also be able to act to inform the Health Rights Commission of issues relating to the maintenance of professional standards and any case that arises.

For disciplinary proceedings, if the board decides following consultation with the Health Rights Commission to proceed further, the next step will depend upon the severity of the alleged misconduct. A registrant can, however, elect to have the matter dealt with directly by the health practitioner's tribunal.

Turning to the history of the Health Rights Commission, it is said that the failure of existing institutions and structures to deal with Ward 10B at Townsville General Hospital was the reason for the establishment of the Health Rights Commission. It was argued that the rights of patients in that case were not adequately protected by the Health Department, the health professions, the Registration Board or the Ombudsman.

Public submissions were called for and there was universal support for the creation of a new statutory mechanism to deal with health complaints, with only one professional association dissenting. Submissions favoured the Victorian model with its emphasis on conciliation. The medical profession, in particular, was strongly opposed to the New South Wales model whereby a complaints unit, now the Independent Health Care Complaints Commission, had carried the prosecution of professional disciplinary matters.

Medical defence organisations made it clear that they were seeking an alternate dispute resolution model. At the eleventh hour in the development of the legislation it became apparent that there were some significant issues regarding the Victorian model which had not been adequately considered. These were: the focus on dispute resolution rather than the broader public interest; the balance of independent and accountability mechanisms; and the lack of clarity regarding the respective roles of the Health Rights Commissioner and the boards.

While that Government—the Goss Government in 1991—remained committed to the creation of an agency to accept the public complaints, after careful review of the Victorian model the policy direction of the then Bill was substantially refined to focus on the public interest. If honourable members look at the Minister's second-reading speech on the Health Rights Commission Bill, together with the debate on that Bill at the time, they will see that it was contended that 97% of matters would be conciliated, but in fact less than 5% of complaints are dealt with in this way. Experience has shown that it is more likely to be handled and resolved at a local level.

During the debate on the Health Rights Commission Bill in 1991, the commission's investigation powers were questioned by the Opposition and, in particular, the member for Toowoomba South, Mike Horan, a backbencher at the time. He said that the Health Rights Commission has the potential to become a Big Brother organisation because of the enormous power that will be vested in the Minister and the commissioner. He has been proved to be totally wrong. He criticised the duplication of investigatory powers conferred on the registration boards. However, he was only half right, as only the Medical Board has proper investigative powers.

History has shown that, whilst the Health Rights Commission was set up as an independent body to resolve health complaints, problems have arisen in its operation. The cause of the operational problems have at their root the fact that the disciplinary provisions of the current registration Acts do not dovetail with the Health Rights Commission Act 1991 and this has created the potential for delay and has increased the risk that professional standards issues would be overlooked.

Of particular concern are, firstly, the absence of a parallel jurisdiction to accept complaints. Secondly, doubts have arisen about the admissibility of the commission's investigation report in board disciplinary proceedings and the inadequate powers of the boards to investigate disciplinary matters. Currently the commissioner may refer a complaint only where he or she is satisfied that the board has adequate functions and powers of investigation. Thirdly, deficiencies in the statutory consultation

requirements have been revealed. For example, the commissioner is not required to consult a board before making an assessment decision and a board is not required to advise the commissioner when disciplinary proceedings are being commenced.

As I pointed out previously, there are also inflexible referral requirements. Lastly, the commissioner cannot refer complaints to a board without assessment, which causes unnecessary delays in matters being addressed. The operational problems with the current Health Rights Commission Act are addressed by this Bill. This Bill addresses: the inefficiency related to the receipt and consideration and assessment phases of the Act; the lack of power to refer complaints to other bodies at the conclusion of assessment; the inability to take more than one action on a complaint; and the inability to split complaints involving multiple issues or respondents into component parts.

In relation to disciplinary proceedings, it is usually health complaints which provide the main trigger for disciplinary proceedings against registrants. Given that disciplinary proceedings are the principal strategy for protecting the public and upholding professional standards, this Bill establishes processes to facilitate complaints and provides increased flexibility for the handling of complaints by the boards and the Health Rights Commission.

The Bill also incorporates strategies to ensure that the professional standards issues arising out of complaints are given statutory priority and are not inadvertently overlooked. Specifically, the Bill facilitates complaints by providing the boards and the commission with the function of receiving complaints. Some complainants, particularly third parties, have indicated that they would prefer to make complaints directly to the board. The Bill also facilitates complaints by removing the requirement for third party complaints to be referred immediately to the commission; by providing statutory protection to persons who honestly and on reasonable grounds make complaints to boards; by incorporation of the various rights of complainants and witnesses, for example, to be given notice of a disciplinary proceeding, to attend the proceedings, to be accompanied and advised of the outcome of the proceedings, and to have their identity suppressed if mentioned in the proceedings; by providing for increased public involvement in the discipline of registrants, for example, all adjudicate bodies must include at least one public member; and by requiring that all disciplinary bodies are constituted by at least one person of the same gender as the complainant.

In addition, increased flexibility and complaint handling is achieved by reducing the circumstances under which a board must immediately refer a complaint to the commission. This allows a board to retain a complaint if the board and the commissioner agree that it is in the public interest of the board to do so. It also enables the commissioner and a board to agree that it is in the public interest for the commissioner to refer a complaint directly to a board without assessment and also flexibility by enabling the commissioner to take multiple action from complaints and split complaints with multiple issues or multiple respondents.

As I have said before, the Bill ensures that professional standards issues arising out of complaints are not overlooked by requiring the most significant statutory decisions under the Bill and the Health Rights Commission Act to be informed by the view of both the boards and the commissioner. This is achieved by requiring the boards and the commission to give each other copies of all complaints, enabling boards to make submissions on complaints being assessed by the commission, requiring consultation between the commission and the boards at the conclusion of assessment and preventing the rejection of a complaint where a board considers that it should be investigated. It is also achieved by requiring boards to provide the commissioner with a report at the conclusion of all investigations and to have regard to any comments, information or recommendations provided by the commissioner in determining the action to be taken. It is also achieved by requiring the commissioner to be notified when a matter is referred for disciplinary proceedings as the commissioner retains the power to intervene in disciplinary proceedings and be advised of the decision of the disciplinary body and the reasons for the decision.

This Bill ensures that priority will be given to professional standards issues, that is, the public interest issues, because of the consultation and decision-making processes that I have described already. In addition, where the commissioner and a board cannot agree on the action to be taken at the conclusion of the assessment of a complaint about a registrant, the Minister will determine if a matter should be referred to a board for investigation or other action. The key considerations for the Minister will be the statutory purposes of the disciplinary proceedings and disciplinary action, and the grounds for disciplinary action under the Bill.

To those who are critical of the changes proposed by this legislation or to those who are uncertain that the provisions of this Bill are an improvement on the current system, I would like to make the following points. The provisions are an improvement, because they increase public protection; they provide a fairer process than the one we have at present; they make the complaint process and the disciplinary process more accountable than it is at the moment; they make the system much more flexible; and they make the process an integrated process, which is sorely missing and is currently causing many problems.

In conclusion, for all of these reasons, I once again endorse the view that this is the most significant health consumer protection law ever introduced into the Queensland Parliament. I commend the Minister for her hard work in bringing together six years of consultation into what I believe will give greater public protection and enhance consumer confidence in our health system.