Health Legislation Amendment Bill 2019

Explanatory Notes

Short title

The short title of the Bill is the Health Legislation Amendment Bill 2019 (Bill).

Policy objectives and the reasons for them

The Bill amends five health portfolio Acts and two Regulations to implement policy initiatives and to improve the effective operation of the Acts. In particular, the Bill amends:

- the *Hospital and Health Boards Act 2011* to:
  - strengthen networked governance in Queensland's public health system by:
    - requiring Hospital and Health Services and Hospital and Health 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 health services throughout Queensland; and
    - recognising Hospital and Health Services and the Queensland Ambulance Service have mutual obligations to collaborate;
  - strengthen the commitment to health equity for Aboriginal people and Torres Strait Islander people and strengthen the capability and effectiveness of Hospital and Health Boards by:
    - including as a guiding principle a commitment to achieving health equity and delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people;
    - requiring each Hospital and Health Service to have a strategy for achieving health equity for Aboriginal people and Torres Strait Islander people; and
    - requiring each Hospital and Health Board to have one or more Aboriginal persons and/or Torres Strait Islander persons as members;
  - allow the Patient Safety and Quality Improvement Service within Queensland Health to disclose root cause analysis reports about reportable events to quality assurance committees; and
  - make minor technical amendments;
- the *Ambulance Service Act 1991*, to complement the amendment to the Hospital and Health Boards Act, to recognise the Queensland Ambulance Service and Hospital and Health Services have mutual obligations to collaborate;

- the *Public Health Act 2005* to:
  - prohibit the practice of conversion therapy by health service providers in Queensland;
  - repeal redundant provisions for the Queensland Pap Smear Register, which has been replaced by the National Cancer Screening Register; and
  - correct a minor drafting error in the legislative requirements for Water Risk Management Plans;
- the *Public Health Regulation 2018,* to repeal redundant provisions for the Queensland Pap Smear Register;
- the *Private Health Facilities Act 1999*, to align the conditions of licence for private health facilities in Queensland with requirements under the nationally adopted Australian Health Service Safety and Quality Accreditation Scheme;
- the *Private Health Facilities Regulation 2016*, to support amendments to the Private Health Facilities Act to align conditions of licence for private health facilities in Queensland; and
- the *Queensland Mental Health Commission Act 2013*, to clarify the Mental Health Commission's powers to employ staff and to allow the Commissioner to be appointed for a term of up to five years.

Strengthening networked governance in Queensland's public health system

The overarching framework for the delivery of publicly funded health services in Queensland is provided by the Hospital and Health Boards Act. It provides that the public health system comprises the Department of Health and 16 Hospital and Health Services. Under the devolved governance model established by the Hospital and Health Boards Act:

- the Department of Health, through the Director-General, is the system manager, responsible for the overall leadership and management of Queensland's public health system, including statewide planning, managing statewide industrial relations and major capital works, monitoring the performance of Hospital and Health Services and issuing Health Service Directives and Health Employment Directives; and
- the Hospital and Health Services, each governed by a Hospital and Health Board and managed by a Health Service Chief Executive, are the principal providers of public sector health services and are responsible and accountable for the delivery of those services.

In early 2019, the Minister for Health and Minister for Ambulance Services convened an expert panel comprising Mr Jim McGowan AM, Professor Anne Tiernan and Dr Pradeep Philip (Panel) to provide advice on Queensland Health's governance framework as established by the Hospital and Health Boards Act.

The Panel found the devolved governance model provided for in the Hospital and Health Boards Act is generally operating well. However, as the system matures, the Panel considered there is an opportunity to enhance the devolved governance model by emphasising that Queensland Health is a networked system, where each part of the system has mutual and reciprocal obligations to take a statewide perspective. To support this, the Panel recommended amending the Hospital and Health Boards Act to reflect that all component parts of Queensland's public health system are a critical part of, and have responsibilities to, the system.

The Panel also recommended that the Queensland Ambulance Service's role as a critical part of the public sector health system, in particular its interface with Hospital and Health Services, be acknowledged in the Hospital and Health Boards Act and Ambulance Service Act.

Strengthening the commitment to health equity for Aboriginal people and Torres Strait Islander people

In 2008, the Commonwealth and all Australian States and Territories committed to action to 'Closing the Gap' between Aboriginal people and Torres Strait Islander people and other Australians through the National Indigenous Reform Agreement. Successive Queensland Governments have reiterated this commitment and the Queensland Government is working in partnership with the Australian Government and Aboriginal and Torres Strait Islander peak organisations to finalise the Council of Australian Governments' (COAG) *Closing the Gap Refresh*.

In March 2017, Adrian Marrie provided the *Addressing institutional barriers to health equity for Aboriginal and Torres Strait Islander people in Queensland's public hospital and health services report* (the Health Equity Report) to the Anti-Discrimination Commission Queensland. The Health Equity Report identified institutional barriers to health equity for Aboriginal people and Torres Strait Islander people in Queensland's public health system.

The Health Equity Report considered the Hospital and Health Boards Act renders Aboriginal people and Torres Strait Islander people 'legally invisible' by not including, for example:

- a statement of commitment to Closing the Gap in Aboriginal and Torres Strait Islander health in a preamble to the Act, reflecting that 'Aboriginal and Torres Strait Islander health is everyone's business';
- a provision for the delivery of responsive, capable and culturally competent health care to Aboriginal and Torres Strait Islander people in Queensland as an object of the Act; and
- a requirement that Hospital and Health Boards have among their members a person, or persons, with expertise and experience in Aboriginal and Torres Strait Islander health care or health service delivery among the skills, knowledge and experience required for a Hospital and Health Service to perform its functions effectively and efficiently.

The Health Equity Report concluded that, 'the Hospital and Health Boards Act fails to give the necessary legislative force to the COAG national partnership agreements and federal and Queensland policy imperatives to close the Aboriginal and Torres Strait Islander health gap, thus indicating to the Aboriginal and Torres Strait Islander communities that the State is not taking its responsibilities to close the Indigenous Health Gap seriously'.

The Panel considered the findings of the Health Equity Report and recommended the Hospital and Health Boards Act be amended to embed the Queensland Government's commitment to closing the gap in Aboriginal and Torres Strait Islander health. The Panel also recommended the mandating of Aboriginal and Torres Strait Islander representation on Hospital and Health Boards.

Provision of root cause analysis reports to quality assurance committees

The Hospital and Health Boards Act facilitates the use of root cause analysis (RCA) as a quality improvement technique to assess and respond to reportable events that happen while health services are being provided. Reportable events are clinical events resulting in death or likely permanent harm which were not reasonably expected as an outcome of healthcare. The categories of reportable events are prescribed under section 29 of the *Hospital and Health Boards Regulation 2012*.

RCAs are undertaken by a team appointed by a commissioning authority. For public sector health services, the commissioning authority is the Director-General or the chief executive of the Hospital and Health Service that provided the health service which is the subject of the

reportable event. An RCA team must prepare a report stating a description of the event, the factors which contributed to the event and the recommendations for reducing the likelihood of the same type of event happening again.

To facilitate a confidential environment for health professionals to voluntarily disclose information for an RCA, the Hospital and Health Board Act limits the circumstances in which a commissioning authority is required or permitted to disclose an RCA report, or information in the report. These circumstances require commissioning authorities to provide a copy of an RCA report to a prescribed patient safety entity.

Consistent with this requirement, commissioning authorities currently provide copies of RCA reports to the Patient Safety and Quality Improvement Service of Queensland Health. Commonly, Hospital and Health Services also disclose RCA reports to a quality assurance committee which is the prescribed patient safety entity for the Hospital and Health Service.

There are 23 quality assurance committees established under the Hospital and Health Boards Act for specific areas of clinical expertise, for example, paediatrics, cancer control and mental health, or for specific Hospital and Health Services. Quality assurance committees are used to encourage and facilitate the voluntary participation of clinicians in healthcare improvement by providing a confidential and legally privileged environment where practice and data can be examined. Quality assurance committees make recommendations to the Minister about standards and quality improvement initiatives to improve the safety and quality of health services.

In some cases, Hospital and Health Services have difficulty determining which quality assurance committee, beyond the committee relevant to the Hospital and Health Service, have the most relevant expertise to consider individual RCA reports. Hospital and Health Services do not always share copies of these reports and consequently do not fully benefit from the analysis and recommendations that a quality assurance committee can provide.

The Patient Safety and Quality Improvement Service is well positioned to perform this function as it already receives RCA reports for all reportable events and maintains the quality assurance committee register. As the system manager for patient safety and quality improvement for Queensland Health, the Patient Safety and Quality Improvement Service gives advice and information to established committees and knows each committee’s focus and clinical area of expertise. However, the confidentiality provisions of the Hospital and Health Boards Act prevent a patient safety entity, including the Patient Safety and Quality Improvement Service, from providing a copy of an RCA report to anyone else.

Prohibition of conversion therapy

The objective of amendments to the Public Health Act prohibiting conversion therapy is to protect the Queensland LGBTIQ community from the harm caused by conversion therapy, and to send a strong message that being a LGBTIQ person is not a disorder that requires treatment or correction.

Conversion therapy is a term used to describe treatments and practices that attempt to change or suppress a person’s sexual orientation or gender identity. There is no evidence of any benefits from conversion therapy, nor that sexual orientation or gender identity can be changed through therapeutic or other interventions. To the contrary, clinical and social science research has produced overwhelming evidence that conversion therapy is psychologically harmful and correlated with higher rates of suicidality, self-harm and other adverse health outcomes. Many professional and expert bodies, including the Australian Psychological Association, Australian Medical Association and World Health Organization, formally oppose the use of conversion therapy and acknowledge that these practices are harmful and unethical. Despite this strong

consensus and evidence of harm, it is not unlawful for health service providers to perform conversion therapy in Queensland or in any other Australian jurisdiction.

In November 2018, the Minister for Health and Minister for Ambulance Services convened the Ending Sexual Orientation Conversion Therapy Roundtable to consider how to end conversion therapy in Queensland. The roundtable, attended by representatives of the community and government, concluded that the Government should consider legislation making it an offence for health practitioners to perform conversion therapy. The roundtable also recommended that consideration be given to protecting children, young people and vulnerable groups from these practices.

Discontinuation of the Pap Smear Register

The Public Health Act includes a requirement for the chief executive to keep a Pap Smear Register with the cervical screening histories of women. The register was introduced to support women to undergo regular Pap smear tests to detect cancer of the cervix or signs of cancer. The provisions relating to the Pap Smear Register are redundant following commencement of the new National Cancer Screening Register (National Register).

From 30 June 2018, the National Register commenced the functions performed by the Pap Smear Register and at the time, Queensland's data was incorporated into the National Register. The National Register provides a new screening program where cervical screening commences from 25 years of age and a five-yearly test for human papillomavirus is used instead of the two-yearly Pap smear test. Under new arrangements, the Commonwealth has responsibility for notifying women when screening is due and of any action required following a test.

Correction of a drafting error in the requirements for water risk management plans

In response to a Legionnaires disease fatality at the Wesley Hospital in 2016, the *Public Health (Water Risk Management) Amendment Act 2016* inserted a new chapter 2A into the Public Health Act to provide for measures to improve the management and control of health risks associated with the supply and use of water in hospitals and residential aged care facilities.

Chapter 2A provides that a responsible person for a prescribed health facility must ensure that there is a compliant water risk management plan (Plan) for the facility and must ensure the facility operates in a way that complies with the facility's Plan.

Section 61D specifies what a water risk management plan must contain. The intention of section 61D(e) is that hospitals and residential aged care facilities have a water risk management plan that states procedures for responding to: (i) the results of monitoring that indicate the failure of measures to control risks; and (ii) the results of testing that indicated the presence of a hazard in the water distribution system.

As drafted, section 61D sets out the water risk management plan must include the procedures required by either 61D(e)(i) or 61D(e)(ii), but not necessarily both of these. This means that one of these two critical elements may be excluded from the water risk management plan which was not the intention of the policy.

Private Health Facilities Act 1999

The Private Health Facilities Act provides a framework in Queensland for protecting the health and wellbeing of patients receiving health services at private health facilities. The Private Health Facilities Act requires licences for the operation of facilities and establishes licensing conditions. These conditions include that facilities must be certified under a quality assurance program conducted by a quality assurance entity.

In 2006, the Commonwealth, State and Territory governments established the Australian Commission on Safety and Quality in Health Care to lead and coordinate national improvements in safety and quality of health care. In 2011, the *National Health Reform Act 2011* (Cth) established the Commission as a Commonwealth entity. One of the Commission's roles under the Act is to formulate and monitor quality and safety standards.

In November 2010, State and Territory Health Ministers and the Commonwealth Health Minister endorsed the Australian Health Service Safety and Quality Accreditation Scheme (National Accreditation Scheme) as the new national accreditation model in all jurisdictions. From January 2013, it was agreed by all States and Territories that hospitals and day procedure services would be accredited through this scheme in accordance with the National Safety and Quality Health Service Standards (NSQHS Standards).

In Queensland, the *Private Health Facilities Regulation 2016* prescribes the quality assurance program that private health facilities must comply with as a condition of licence under the Private Health Facilities Act. On 5 April 2019, the Private Health Facilities Regulation was amended to establish the NSQHS Standards as the only prescribed quality assurance program. As quality assurance programs have changed over time, the licence conditions under the Private Health Facilities Act require amendment as some are no longer necessary and, in some respects, are inconsistent with the National Accreditation Scheme. For example, although accreditation to the NSQHS Standards is required within 18 months of providing services, the Private Health Facilities Act provides up to three years for a facility to receive accreditation.

Queensland Mental Health Commission Act 2013

On 1 July 2013, the Queensland Mental Health Commission was established to drive ongoing reform towards an integrated, evidence-based, recovery-oriented mental health and substance misuse system. Section 56 of the Queensland Mental Health Commission Act requires the Minister to review the Act's effectiveness after three years of commencement. In 2018, the review was conducted and overseen by a steering committee consisting of the former Queensland Mental Health Commissioner, and representatives from: Queensland Health; the Queensland Mental Health and Drug Advisory Council; and the Department of the Premier and Cabinet.

The review report, which was tabled in the Legislative Assembly on 28 June 2019, makes two recommendations for legislative amendments to address minor issues in relation to the Act.

The Queensland Mental Health Commission Act provides 'the Commission' may employ staff, although the Commission is defined to comprise both the Mental Health Commissioner and other staff of the Commission. The review recommended the Act be amended to ensure the power to employ staff is vested with the Commissioner.

The Act currently provides for the Commissioner to be appointed for three years. The Commissioner can serve more than one appointment term, but there is no scope for the term to be less than, or more than, three years. The review recommended the Act be amended to provide the Commissioner may be appointed for a term of up to five years. This will provide greater continuity in the role and potentially attract a broader pool of applicants when recruitment for the role of the Commissioner is necessary.

Achievement of policy objectives

- ***Strengthening networked governance in Queensland's public health system***

Section 19 of the Hospital and Health Boards Act sets out the functions of Hospital and Health Services including the function to ensure the operations of the Service is carried out efficiently, effectively and economically. The Bill amends section 19 of the Hospital and Health Boards Act to clarify that a Hospital and Health Service, when performing this function, must have regard to:

- the need to ensure that resources of the public sector health system are used effectively and efficiently; and
- the best interests of patients and other users of public sector health services throughout Queensland.

Section 22 of the Hospital and Health Boards Act provides that the role of Hospital and Health Boards is to control the Hospital and Health Service for which it is established. The Bill amends section 22 to provide that Boards, in performing their role must have regard to:

- the need to ensure that resources of the public sector health system are used effectively and efficiently; and
- the best interests of patients and other users of public sector health services throughout Queensland.

The current legislative framework does not specifically recognise the important linkages between the Queensland Ambulance Service and the Hospital and Health Services as providers of health services. The Bill amends the Ambulance Service Act and the Hospital and Health Boards Act to recognise that Hospital and Health Services and the Queensland Ambulance Service have a function to collaborate to manage the interaction between the services provided by the Queensland Ambulance Service and the health services provided by Hospital and Health Services.

- ***Strengthening the commitment to health equity for Aboriginal people and Torres Strait Islander people***

<u>Achieving health equity for Aboriginal people and Torres Strait Islander people</u>

The Bill amends the Hospital and Health Boards Act to include commitments to achieving health equity for, and the delivery of responsive, capable and culturally competent health care to, Aboriginal people and Torres Strait Islander people, as guiding principles of the Act.

In 2017, Hospital and Health Boards and Queensland Health developed and agreed a *Statement of Action towards Closing the Gap in health outcomes*, which commits all areas of Queensland Health and the Hospital and Health Services to undertake organisational, system changes to build sustainable cultural capability across the system. This statement of action identified three action areas to:

- promote opportunities to embed Aboriginal and Torres Strait Islander representation in Queensland Health leadership, governance and workforce;
- improve local engagement and partnerships between Queensland Health and Aboriginal people and Torres Strait Islander people, communities and organisations; and
- improve transparency, reporting and accountability in Closing the Gap progress.

Each Hospital and Health Service has committed to, and is developing and implementing, a Closing the Gap Health Plan responding to these three action areas. Hospital and Health Boards and the Hospital and Health Service's executive team are responsible for implementing and monitoring the plan.

The Bill amends the Hospital and Health Boards Act to require each Hospital and Health Service to have an Aboriginal and Torres Strait Islander Health Strategy (health equity strategy). It is intended a health equity strategy will supersede the existing Closing the Gap Health Plan.

A health equity strategy will set out each Hospital and Health Service's activities towards achieving health equity for Aboriginal people and Torres Strait Islander people. The use of the name 'health equity strategy', rather than 'health plan' as originally recommended by the Panel, is designed to better reflect the strategic content and purpose of the document, as it is not intended the health equity strategy is an operational health service plan.

Aboriginal and/or Torres Strait Islander representation on Hospital and Health Boards

The Queensland Government has committed through the *Queensland Government Reconciliation Action Plan 2018-2021* to increase Aboriginal and Torres Strait Islander representation on Queensland Government Boards and Committees. Consistent with this commitment, and the Panel's recommendation, the Bill will provide that one or more Hospital and Health Board members must be Aboriginal persons or Torres Strait Islander persons. This will provide flexibility for each board to be responsive to the needs of the community within its Hospital and Health Services area.

The Bill provides that the requirement to appoint an Aboriginal person and/or Torres Strait Islander person to the board does not apply until the first time there is a vacancy in the membership, which is not a clinician vacancy. This will ensure that the existing mandatory requirement for boards to have a clinician is not affected and that boards do not have to undertake an additional recruitment process to appoint a board member to meet the legislative requirements until a vacancy occurs.

The Bill also makes clear that skills, knowledge and experience in Aboriginal and Torres Strait Islander health and community issues is relevant expertise required for a Hospital and Health Service to perform its functions effectively and efficiently.

The requirement in the Bill for Aboriginal and/or Torres Strait Islander representation on Hospital and Health Boards does not limit the responsibility for achieving health equity to those members. Achieving health equity will be an overall commitment and responsibility of Hospital and Health Boards, Hospital and Health Services and the Queensland Government.

- ***Efficient provision of root cause analysis reports to quality assurance committees***

The Bill amends the Hospital and Health Boards Act to remove the restriction preventing the Patient Safety and Quality Improvement Service from sharing RCA reports with quality assurance committees. As quality assurance committees are already authorised under the Act to receive RCA reports directly from commissioning authorities, this is not a substantive change of policy, but a process improvement to enable the Patient Safety and Quality Improvement Service to share reports with quality assurance committees. This change will provide committees with timely access to these reports to enable Hospital and Health Services to benefit from the expertise that committees provide, including recommendations for improving the safety and quality of healthcare services.

- ***Prohibition of conversion therapy***

The Bill amends the Public Health Act to prohibit health service providers from performing conversion therapy and makes it an offence for a health service provider to perform conversion therapy. The new offence carries a maximum penalty of 100 penalty units, 12 months imprisonment or both. If the recipient of the conversion therapy is a vulnerable person, such as a child, the maximum penalty increases to 150 penalty units, 18 months imprisonment or both.

The offence is a misdemeanour, which is an indictable offence, and may be heard summarily or on indictment, at the prosecution's election, unless a Magistrates Court is satisfied that the offence should not be heard summarily because of exceptional circumstances.

The creation of the offence will protect the public by prohibiting health service providers from performing conversion therapy. Health service providers who continue to perform conversion therapy will commit an offence carrying substantial penalties. Consistent with the recommendations of the Ending Sexual Orientation Conversion Therapy Roundtable, the increased penalties for conversion therapy performed on a vulnerable person will provide enhanced protections for children, people without legal capacity and people with an intellectual disability. This recognises that these people may be especially susceptible to health service providers offering conversion therapy services and more likely to suffer harm as a result of their treatment.

The Bill defines conversion therapy as a treatment or practice that attempts to change or suppress a person's sexual orientation or gender identity. Gender identity is a broad term that encompasses a person's internal and individual experience of gender, including the person's personal sense of the body and how they express their gender to themselves and others.

The Bill targets practices that are based on the idea that being a LGBTIQ person is a disorder or deviant behaviour that requires correction or suppression. These ideas have long been discredited by the medical community and are not evidence-based. Examples of practices and treatments that are prohibited under the Bill include:

- aversion therapy, which may include administering an electric shock or nausea inducing drugs while showing a person an image of a person of the same sex;
- regression or hypnotherapy to unlock latent heterosexual feelings; and
- counselling sexual identity management which promotes individuals distinguishing between their public and private sexual feelings or gender identity.

In contrast, the Bill does not prohibit treatments or practices that:

- assist individuals who are undergoing or considering a gender transition;
- assist individuals to express their gender identity;
- provide acceptance, support and understanding to these individuals; or
- facilitate an individual's coping, social support or identity exploration and development.

These practices are expressly excluded from the definition of conversion therapy, and will not constitute an offence, because their purpose is to affirm and support, not to change or suppress, a person's sexual orientation or gender identity. Conversion therapy also does not include treatments or medical interventions relating to gender transition.

The Bill also excludes from the definition of conversion therapy treatment decisions and other practices by a health service provider that are reasonably necessary to provide a health service in a safe and appropriate manner or to comply with the provider's legal or professional obligations. This exclusion will not allow health service providers to engage in prohibited practices such as those described above, which have been discredited and would not be performed by a reasonable health service provider. Rather, the exclusion will ensure that the prohibition of conversion therapy does not discourage practitioners from treating LGBTIQ patients out of concern that clinically appropriate decisions could be perceived as not affirming or supporting a patient's sexual orientation or gender identity. The exclusion will protect practitioners who, acting reasonably, in good faith and in accordance with relevant professional standards, treat a patient in a manner that could be subjectively perceived as not affirming or

supporting their sexual orientation or gender identity. For example, a doctor may advise against surgery because a patient has a pre-existing condition that means the surgery is not safe. A doctor may also be required to advise a patient about potential side effects of drugs. In cases such as these, health service providers will be able to rely on the reasonable professional judgment exception to ensure that the health services provided are delivered in a safe and clinically appropriate manner.

The new offence applies to health service providers, as defined in section 8 of the *Health Ombudsman Act 2013*. The Bill is limited to health service providers because, as health professionals, they have ethical obligations not to engage in practices that are harmful and not evidence-based. It would be a violation of the trust that the community places in health service providers to allow these practices to be carried out in the health care system. Prohibiting conversion therapy by health service providers also sends the message that these practices are opposed by the Queensland Government and that being a LGBTIQ person is not a disorder that requires treatment.

The definition of a health service provider is broad, comprising any individual or entity that provides a service that is, or purports to be, for maintaining or improving a person's health or wellbeing. The definition includes registered health practitioners such as doctors, nurses and psychologists and unregistered health practitioners such as counsellors, naturopaths and social workers. The offence will apply regardless of whether the service is paid for or provided for free or the location where the service is provided.

- ***Discontinuation of the Pap Smear Register***

The Bill repeals the redundant provisions in the Public Health Act and Public Health Regulation relating to the Pap Smear Register.

- ***Correction of a drafting error in the provision for water risk management plans***

The Bill corrects section 61D in the Public Health Act to require water risk management plans to state procedures for responding to both: the results of monitoring that indicate the failure of measures to control risks; and the results of testing that indicated the presence of a hazard in the water distribution system.

- ***Private Health Facilities Act 2011***

The Bill amends the Private Health Facilities Act to align the conditions of licence for private health facilities in Queensland with the requirements of the National Accreditation Scheme. The Bill will update the current conditions of licence by removing provisions that refer to specific timeframes and inserting a general requirement to comply with a prescribed safety and quality accreditation scheme. The Bill will also update terminology in the Act to promote consistency with current practice and the National Accreditation Scheme.

The Bill amends the Private Health Facilities Regulation to prescribe the safety and quality accreditation scheme as the Australian Health Service Safety and Quality Accreditation Scheme incorporating the NHQHS standards.

- ***Queensland Mental Health Commission Act 2013***

To implement the recommendations of the review of the Queensland Mental Health Commission Act, the Bill provides the term of the Queensland Mental Health Commissioner can be a term of up to five years.

Section 14 of the Act provides the membership of the commission consists of the commissioner and other staff of the commission. Section 19 prescribes the functions and powers of the

commissioner and section 24 provides the commission may employ the staff it considers appropriate to perform its functions.

To ensure the power to employ staff of the commission is clearly defined, the Bill: amends section 14 to clarify the staff of the commission are employed under the *Public Service Act 2008*; removes section 24 so that the commission may not employ staff; and amends section 19 to provide the commissioner has the function to manage the staff of the commission.

Alternative ways of achieving policy objectives

There are no alternative ways of achieving the policy objectives other than by legislation.

Estimated cost for government implementation

The costs to government associated with the Bill will be met from existing budget allocations.

Consistency with fundamental legislative principles

The Bill has been drafted with regard to the fundamental legislative principles in the *Legislative Standards Act 1992*. Potential breaches of fundamental legislative principles are addressed below.

- *Legislation has sufficient regard to the rights and liberties of individuals*

<u>Clause 16 – Provision of root cause analysis reports to quality assurance committees</u>

The right to privacy, the disclosure of private or confidential information, and privacy and confidentiality issues have generally been identified by the former Scrutiny of Legislation Committee as relevant to consideration of whether legislation has sufficient regard to individuals' rights and liberties.

Section 112(2) of the Hospital and Health Boards Act provides that the commissioning authority of an RCA must give a copy of the RCA report to a prescribed patient safety entity for an authorised purpose for the entity. Consistent with this requirement, the chief executive of Queensland Health has issued a health service directive under section 47 of the Hospital and Health Boards Act requiring the commissioning authority of Hospital and Health Service RCAs to provide copies of RCA reports to the Patient Safety and Quality Improvement Service.

Clause 16 of the Bill inserts new subsection (4A) to section 112 to allow the Patient Safety and Quality Improvement Service, as the administrative unit of Queensland Health responsible for coordinating improvements in the safety and quality of health services, to give RCA reports to a quality assurance committee for an authorised purpose of that committee. Clause 16 may be seen to infringe upon the privacy of individuals as it expands the circumstances in which private or sensitive information may be disclosed.

Quality assurance committees assist Queensland Health and Hospital and Health Services by providing expert insight and recommendations following the completion of an RCA. These committees are already entitled to receive copies of RCA reports for their authorised purposes under section 112(2) of the Act.

The potential breach of fundamental legislative principle is considered justified as quality assurance committees are already authorised to receive RCA reports directly from commissioning authorities. The amendment is not a substantive change of policy, but a process improvement. By providing that the Patient Safety and Quality Improvement Service can provide RCA reports, clause 16 of the Bill will provide quality assurance committees with timely access to reports so that Hospital and Health Services can benefit from the expertise

quality assurance committees may provide, including recommendations for improving the safety and quality of healthcare.

In addition, the Hospital and Health Boards Act provides safeguards to protect confidential information. Section 84 of the Hospital and Health Boards Act places strict requirements, with a maximum penalty of 100 penalty units, on current and former members of quality assurance committees to maintain confidentiality. A committee member may only disclose information if it is:

- for the purpose of exercising their functions;
- to another quality assurance committee for the purpose of that committee performing its functions;
- to a prescribed patient safety entity for an authorised purpose;
- to the Health Ombudsman, if the Committee member is a registered health practitioner and has a reasonable belief that another registered health practitioner has behaved in a way that places the public at risk of substantial harm; or
- to comply with the requirement of an inspector in relation to an offence under part 6, division 1 of the Hospital and Health Boards Act.

Section 84 also imposes strict confidentiality requirements, with a maximum penalty of 100 penalty units, on any person who provides help or assistance to a quality assurance committee in carrying its functions.

- *Legislation has sufficient regard the rights and liberties of individuals*

<u>Clause 27 – Content of water risk management plans – lower threshold for committing offence</u>

The Public Health (Water Risk Management) Amendment Act created a new offence for non-compliance by the responsible person for a hospital or residential aged care facility for ensuring there is a water risk management plan in place that complies with section 61D in the Public Health Act, with a maximum penalty of 500 penalty units. It is also an offence for a responsible person to fail to ensure that the facility operates in a way that complies with the plan or fail to take all reasonable steps to ensure that persons comply with the plan, with a maximum penalty of 200 penalty units.

Section 61D outlines in detail what a water risk management plan must contain. Clause 27 of the Bill makes a correction to section 61D so that water risk management plans must state procedures for responding to both events prescribed by section 61D(e)(i) and 61D(e)(ii), and not, one or the other. This creates a lower threshold for committing the offence which may potentially breach the fundamental legislative principle, according to section 4(2)(a) of the Legislative Standards Act, that legislation must have sufficient regard to individuals' rights and liberties.

The existing offence provisions are necessary to encourage compliance with the requirements relating to water risk management plans, mandatory notification and periodic reporting requirements. The penalty is designed to reflect the significant responsibility hospitals and residential aged care facilities have for proactively managing and controlling the health risks to their patients and residents.

The amendment of section 61D is not intended to create or extend liability. Rather, it clarifies the intent of the legislation that plans should comprehensively cover how facilities will respond to risks to water quality.

The proposed amendments are necessary to manage the potential risks to vulnerable Queenslanders associated with the use of water, and the security of water supply, in Queensland hospitals and residential aged care facilities. Given this, they are justified on the basis that they strike an acceptable balance between the need to adequately protect and promote the health of the public, and the rights and liberties of an individual.

Clause 28 – Prohibition of the practice of conversion therapy by health service providers

Legislating to restrict ordinary activities, without sufficient justification, may be a breach of section(4)(2)(a) of the Legislative Standards Act, which requires legislation to have sufficient regard to the rights and liberties of the individual.

Clause 28 of the Bill provides that a health service provider must not perform conversion therapy on another person in their professional capacity. This may be seen to infringe on the right of health service providers to go about ordinary activities and to conduct business without interference.

The prohibition on conversion therapy is considered justified, as it is necessary to protect people from the harm caused by conversion therapy. Health service providers have an ethical obligation not to engage in practices that cause harm. There is a considerable body of evidence showing that conversion therapy is harmful and does not offer clinical or therapeutic benefits. The United Nations General Assembly states that conversion therapies have been found to be 'unethical, unscientific and ineffective'. This is supported by the 2018 La Trobe University report *Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia*, which found significant negative health outcomes for individuals who have undergone conversion therapy.

Under the *Human Rights Act 2019* and the International Covenant on Civil and Political Rights, a person has the right to protection from torture and cruel, inhuman or degrading treatment. In its 2015 report *Discrimination and Violence Against Individuals Based on Their Sexual Orientation and Gender Identity*, the United Nations General Assembly commented that some forms of conversion therapy may be considered torture and breach the human rights of those subjected to the practices.

It is therefore appropriate to ensure that these practices are not engaged in by health service providers, and that the rights of the LGBTIQ community are protected, even if the prohibition may result in a limitation on the rights of health service providers who perform conversion therapy.

Any further restriction of the religious rights and liberties of individuals is limited by the scope of the prohibition on conversion therapy, which applies only to treatments or practices performed by health service providers. As such, the prohibition applies to conversion therapy that is performed in the course of providing a health service. The right to freedom of thought, conscience, religion and belief is not limited by the Bill. Religious or spiritual practices, such as praying for a person to change their sexual orientation, are not prohibited by the Bill. Further, only the *practice* of conversion therapy is prohibited; holding and expressing views or beliefs on conversion therapy, religious or otherwise, is not prohibited.

To give effect to the prohibition of conversion therapy, clause 28 of the Bill makes it an offence for a health service provider to perform conversion therapy on another person. The offence is subject to a maximum penalty of 150 penalty units, 18 months imprisonment, or both, if the person who is subject to conversion therapy is a vulnerable person. Otherwise the maximum penalty is 100 penalty units, 12 months imprisonment or both.

The offence and penalties are justified as an appropriate response to the harm caused by conversion therapy and the need to ensure these practices are not carried out in a health care

context. A term of imprisonment is necessary to send the message that conversion therapy is not condoned by the Queensland Government and to ensure the offence is a strong deterrent. A term of 12 months imprisonment (or 18 months imprisonment if the treatment is performed on a vulnerable person) is appropriate as, under the Health Practitioner Regulation National Law, registered health practitioners are required to notify the relevant registration body if charged with an offence punishable by 12 months imprisonment or more. This may result in registration consequences for the practitioner, which is a further disincentive for health practitioners to engage in conversion therapy. It is appropriate to impose a higher penalty where the subject of the conversion therapy is a vulnerable person. A higher penalty acknowledges that vulnerable people, including children, people without legal capacity or people with an impairment that may limit their understanding of the treatment, are especially susceptible to these unproven and unethical practices.

A person who commits the offence of performing conversion therapy will commit a misdemeanour. This is an indictable offence, which is appropriate given the serious breach of public trust involved when a health service provider engages in a practice that is known to be harmful and discriminatory and to offer no countervailing benefit to a person's health or wellbeing. Additionally, as an indictable offence, the offence will not be subject to a limitations period for laying charges or bringing prosecutions. Limiting the time during which charges can be laid could frustrate enforcement because claimants are vulnerable, private and unlikely to come forward immediately. In some cases, victims may be underage when the alleged offence occurred and may not be able to make a complaint until several years later.

Proceedings for the offence of performing conversion therapy will be dealt with summarily or on indictment, at the prosecution's election. However, to ensure fairness and protect the rights of defendants, a Magistrates Court must abstain from hearing or deciding the proceeding summarily if the defence demonstrates that this would be inappropriate because of exceptional circumstances, including the need to decide important questions of law or to have a jury consider issues involving contemporary community standards.

<u>Clause 32 – Preservation of offence for disclosing confidential information in the Pap Smear Register</u>

Clause 32 inserts section 496, a saving provision, which preserves the offence provided by section 266, for an offence committed by a person before commencement of section 32. Section 266 provides it is an offence, with a maximum penalty of 50 penalty units, if a relevant person directly or indirectly discloses confidential information in the Pap Smear Register.

New section 496 provides that a proceeding for the offence may be continued or started, and the person may be convicted of and punished for the offence, as if the new Act had not commenced. Preserving this offence is appropriate and justified as women whose information which was held in the register, have a right to expect that their information will remain private and that the safeguards designed to protect privacy should not be removed simply because new information is not being collected.

- *Subordinate legislation to have sufficient regard to the institution of Parliament*

<u>Clause 21 – Condition of licence for private health facilities</u>

Clause 21 of the Bill provides that a condition of licence for private health facilities is that a licensee must comply with an accreditation scheme that relates to safety and quality matters and is prescribed by regulation.

As consequence of this amendment, clause 1 of Schedule 1 amends the Private Health Facilities Regulation to prescribe the accreditation scheme is the Australian Health Service Safety and

Quality Accreditation Scheme incorporating the NSQHS Standards formulated by the Australian Commission on Safety and Quality in Health Care.

Prescribing the accreditation scheme which incorporates an external document, the NSQHS Standards, may be seen to breach section 4(5)(e) of the Legislative Standards Act which requires subordinate legislation to have sufficient regard to the institution of Parliament by allowing the sub-delegation of a power by an Act only in appropriate cases and to appropriate persons and if authorised by an Act.

The potential breach of a fundamental legislative principle is justified by the rigour surrounding the development of the NSQHS Standards, their adoption as part of a national agreement and the requirement for Ministerial approval of any changes to the National Accreditation Scheme or the NSQHS Standards.

In November 2010, Health Ministers endorsed the Australian Health Service Safety and Quality Accreditation Scheme as the new national accreditation model for safety and quality assurance for all jurisdictions. The National Accreditation Scheme consists of the following five inter-related elements to support the application of the NSQHS Standards:

- Health Ministers endorse the NSQHS Standards and receive information about performance against the Standards.
- States and Territories and the Commonwealth Government adopt the NSQHS Standards and require health services to participate in the accreditation process.
- Health service organisations meet the standards and select an approved accrediting agency to assess their compliance in meeting the Standards. Accreditation data is provided to regulators and the national coordination program for reporting and review.
- Approved Accrediting Agencies assess health service organisations against the Standards and regulator-specific requirements.
- A program of national coordination within Australian Commission on Safety and Quality in Health Care.

The NSQHS Standards were developed to provide a nationally consistent level of care consumers can expect from health services. All States and Territories agreed that hospitals and day procedure services would be accredited to the NSQHS Standards from January 2013.

It is considered that the rigour surrounding the development of the NSQHS Standards and their adoption as part of a national agreement, justifies the need to sub-delegate by referring to external documents in the Private Health Facilities Regulation.

The Australian Commission on Safety and Quality in Health Care is responsible for administering the National Accreditation Scheme and the NSQHS Standards and changes to these can only be made with the approval of relevant State and Territory Ministers and Australian Health Minister.

Human Rights

The Human Rights Act was passed by the Queensland Parliament on 27 February 2019 but the obligations on public entities do not commence until 1 January 2020. However, the 23 protected human rights have been considered in the development of the Bill.

- *Commitment to health equity*

The amendments to strengthen the commitment to health equity for Aboriginal and Torres Strait Islander people are compatible with, and support, human rights.

The Preamble to the Human Rights Act reflects the philosophy that underpins the Act. The Preamble recognises that human rights are essential in a democratic and inclusive society that respects the rule of law. It also recognises that human rights must be exercised in a way that respects the human rights of others and should be limited only after careful consideration and only in a way that can be justified.

The Preamble acknowledges that the right to self-determination is of particular significance for Aboriginal peoples and Torres Strait Islander peoples of Queensland.

Section 15 of the Human Rights Act provides that every person has the right to recognition as a person before the law and the right to enjoy human rights without discrimination. The amendments to embed the commitment to health equity may engage this right, as they provide for special recognition of Aboriginal people and Torres Strait Islander people in the Hospital and Health Boards Act which may be seen by some as discrimination in the enjoyment of human rights by other Queenslanders.

Section 15(4) of the Human Rights Act provides a right to equal and effective protection against discrimination and entitles every person to a separate and positive right to be effectively protected against discrimination. Section 15(5) provides that measures taken for the purpose of assisting or advancing persons or groups disadvantaged by discrimination do not constitute discrimination.

The amendments in the Bill support the findings of the Health Equity Report and give effect to the recommendations of the Panel to address barriers to accessing public sector health services by Aboriginal people and Torres Strait Islander people.

The amendments provide special recognition to Aboriginal people and Torres Strait Islander people to embed the Queensland Government's commitment to closing the gap in Aboriginal and Torres Strait Islander health. To the extent that this may constitute discrimination, it is to provide effective protection against discrimination and assist and advance a group that has been disadvantaged by discrimination.

For this reason, the amendments are compatible with the right to recognition and equality before the law.

Section 37 of the Human Rights Act provides that every person has the right to access health services without discrimination. This refers to the right to access a variety of goods, facilities and services necessary for a person to be healthy and recognises that a person's capacity for full health can be limited by biological, environmental and socio-economic factors. This right has been interpreted in international jurisprudence as requiring states to ensure health services are accessible without discrimination and acceptable from a gender, cultural and age perspective.

The Bill supports the right to health services by amending the Hospital and Health Boards Act to support access to non-discriminatory and culturally appropriate health care in the following ways:

- including guiding principles to expressly reflect there is a commitment to achieving health equity for Aboriginal people and Torres Strait Islander people, and a commitment to the delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people;

- putting beyond doubt that skills, knowledge and experience in Aboriginal and Torres Strait Islander health and community issues is relevant expertise required for a Hospital and Health Service to perform its functions effectively and efficiently;
- requiring all Hospital and Health Services to have a health equity strategy that sets out the activities towards achieving health equity for Aboriginal people and Torres Strait Islander people;
- requiring that one or more Hospital and Health Board members must be Aboriginal persons or Torres Strait Islander persons.

By ensuring that the need to provide culturally appropriate health care to Aboriginal people and Torres Strait Islander people is recognised, and legislating measures to support the provision of culturally appropriate health care, the amendments are compatible with the right to access health services.

- *Prohibition of conversion therapy*

The amendments to prohibit conversion therapy may engage the right to freedom of thought, conscience, religion and belief under section 20 of the Human Rights Act. The Bill does not limit this right, as the prohibition applies only to treatments and other practices provided by health service providers. It does not extend to prohibiting a health service provider from holding and expressing views or beliefs on conversion therapy, or from engaging in religious or spiritual practices that are not performed in their capacity as a health service provider, such as praying for a person to change their sexual orientation.

If there is any limitation on the right to freedom of thought, conscience, religion and belief, this must be balanced against the purpose of the limitation and the protection of human rights of those who may be subjected to conversion therapy. The purpose of the limitation is to protect LGBTIQ individuals from the harm caused by conversion therapy. Health service providers have an ethical obligation not to engage in practices that cause harm and there is considerable body of evidence showing that conversion therapy is harmful and does not offer therapeutic benefits. Conversion therapy may also violate the human rights of LGBTIQ people.

Section 17 of the Human Rights Act provides that a person must not be subjected to torture or treated in a cruel, inhuman or degrading way. In its report *Discrimination and Violence Against Individuals Based on Their Sexual Orientation and Gender Identity*, the United Nations General Assembly condemned conversion therapy, stating that conversion therapy may be ‘tantamount to torture’ and that ‘states have an obligation to protect all persons, including LGBT and intersex persons, from torture and other cruel, inhuman or degrading treatment or punishment in custodial, medical and other settings [which includes] conversion therapy’.

Section 37 of the Human Rights Act provides that every person has the right to access health services without discrimination. This right has been interpreted in international jurisprudence as requiring states to ensure health services are accessible without discrimination, accompanied by access to appropriate information, acceptable from a gender, cultural and age perspective, and scientifically and medically appropriate. There is broad scientific consensus that conversion therapy offers no clinical or therapeutic benefits. The United Nations General Assembly states that conversion therapies have been found to be “unethical, unscientific and ineffective”. This is supported by the 2018 La Trobe University report *Preventing harm, promoting justice: Responding to LGBT conversion therapy in Australia*, which found significant negative health outcomes for individuals who have undergone conversion therapy.

Prohibiting conversion therapy by health service providers is a reasonable and appropriate limitation to protect LGBTIQ people from treatments and practices that amount to torture and

ensure they can access appropriate and scientifically supported health care without discrimination.

- *Other health portfolio amendments*

The remaining health portfolio amendments in the Bill are consistent with human rights.

Consultation

- ***Strengthening networked governance in the Queensland public health system***

In preparing its advice, the Panel consulted with non-Government stakeholders including unions representing Queensland Health employees, Australian Medical Association Queensland, Rural Doctors Association of Queensland, Health Consumers Queensland and individual consumer representatives.

Unions representing Queensland Health employees, Australian Medical Association Queensland, Rural Doctors Association of Queensland and Health Consumers Queensland were consulted on the proposed changes to the Hospital and Health Boards Act and the Ambulance Service Act. Stakeholders generally supported the amendments. Some stakeholders raised additional issues relating to Queensland Health governance. These issues will be considered in the context of implementation of the Panel's recommendations.

- ***Strengthening the commitment to health equity for Aboriginal people and Torres Strait Islander people***

Stakeholders including Associate Professor (Adjunct) Adrian Marrie, Queensland Aboriginal and Islander Health Council (QAIHC), Apunipima Cape York Health Council, Institute for Urban Indigenous Health, Australian Medical Association Queensland, Rural Doctors Association of Queensland, Health Consumers Queensland and unions representing Queensland Health employees were consulted on the proposed changes relating to strengthening the commitment to achieving health equity for Aboriginal people and Torres Strait Islander people.

Stakeholders were generally supportive of the changes. Associate Professor (Adjunct) Adrian Marrie, supported the amendments, noting they are broadly in line with the Health Equity Report.

QAIHC and other stakeholders raised concerns that the Aboriginal and Torres Strait Islander board members would be expected to address health equity as a special responsibility, rather than it being addressed by the entire board. The Bill includes achieving health equity as a guiding principle for all Hospital and Health Services. It is not expressed to be a special responsibility of certain board members. Achieving health equity is a commitment of the government and all parts of the health system.

Stakeholders including QAIHC, the Queensland Nurses and Midwives' Union and Health Consumers Queensland noted that consultation is essential when developing Health Equity Strategies. The Bill provides that the stakeholders who must be consulted by Hospital and Health Services when developing and implementing a Health Equity Strategy are to be prescribed by regulation.

- ***Prohibition of conversion therapy***

The amendments to the Public Health Act to prohibit conversion therapy are based on the recommendations of the Ending Sexual Orientation Conversion Therapy Roundtable held in November 2018. The roundtable was convened by the Minister for Health and Minister for Ambulance Services and attended by government and external stakeholders. The external

stakeholders included a person with lived experience of conversion therapy, representatives from the Human Rights Law Centre, Queensland Aboriginal and Islander Health Council, Gar'ban'djee'lum Network, Amnesty International, Queensland University of Technology, Charles Sturt University, Anglican Diocese of Brisbane, Equal Voices, LGBTI Legal Service and clinicians working in this field. The Bill is consistent with the recommendations of the Roundtable, which recommended legislation that banned health practitioners from undertaking conversion therapy and protected children, young people and vulnerable groups should be considered.

On 15 November 2019, members of the roundtable and other interested stakeholders were invited to attend a briefing and provide feedback on a consultation draft of the conversion therapy amendments. The briefing was attended by representatives of the Queensland Nurses and Midwives' Union; Aboriginal and Torres Strait Islander Legal Service; Australian Health Practitioner Regulation Agency; Australian Association of Social Workers; Department of Justice and Attorney-General; LGBTI Legal Service; Office of the Health Ombudsman; Queensland Human Rights Commission; Queensland Law Society; Queensland University of Technology; Stonewall Medical Centre; and Centre for Human Potential. Attendees were broadly supportive of the amendments. Several attendees, including the chair of the roundtable, considered the reforms provide a balanced, well considered and appropriate first step towards addressing conversion therapy practices in Queensland. A general practitioner, who was also a survivor of conversion therapy, stated that he was aware of registered health practitioners who were still providing conversion therapy despite professional standards condemning these practices. Several stakeholders, including the Human Rights Commission, provided advice in relation to definitions in the Bill. The definitions have been updated to incorporate this advice and more clearly communicate concepts related to gender identity and gender expression.

- ***Private Health Facilities Act 1999***

The Private Hospitals Association of Queensland was consulted on the amendments to the Private Health Facilities Act and was supportive of the amendments to remove inconsistencies between the Queensland licence scheme and the National Accreditation Scheme.

Consistency with legislation of other jurisdictions

The amendments relating to the Government's commitment to Closing the Gap align with the 2008 National Indigenous Reform Agreement. Through this agreement, the Commonwealth and all Australian States and Territories committed to action to 'Closing the Gap' between Aboriginal and Torres Strait Islander and other Australians.

The amendments to align the conditions of licence for private health facilities in Queensland with requirements under the National Accreditation Scheme are consistent other Australian States and Territories. In November 2010, State and Territory Health Ministers and the Australian Health Minister endorsed the National Accreditation Scheme as the new national accreditation model in all jurisdictions.

The discontinuation of the Pap Smear Register is also consistent with other Australian States and Territories as part of the renewal of the National Cervical Screening Program to reflect significant advances in science, technology and research. This program was endorsed by all States and Territories at the Australian Health Ministers Advisory Council on 29 July 2009.

No other State or Territory in Australia has introduced legislation prohibiting conversion therapy. In February 2019, the Premier of Victoria announced plans to prohibit conversion therapy after the Victorian Health Complaints Commissioner found 'overwhelming evidence' that conversion therapy does serious and long-term harm to those who receive it. In May 2018,

the Australian Capital Territory Health Minister also announced plans to prohibit conversion therapy.

Several international jurisdictions have enacted legislation banning or restricting conversion therapy. The scope of the restrictions and prohibitions vary. Malta is the only jurisdiction to have enacted legislation banning conversion therapy in all contexts (including religious and spiritual contexts). Ireland has introduced a Bill that would in like manner impose a complete ban on conversion therapy. In New Zealand, a Member's Bill that would prohibit conversion therapy in all contexts has been proposed but not introduced to Parliament. Several jurisdictions, including several states and provinces in the United States and Canada, have prohibited health professionals from performing conversion therapy, in most cases on minors.

Notes on provisions

Part 1 Preliminary

Short Title

Clause 1 provides that, when enacted, the short title of the Act will be the *Health Legislation Amendment Act 2019*.

Commencement

Clause 2 provides for the commencement of the Act.

Clause 2 provides sections 11(3) and (4), 12 to 14, 18 and 19 (to the extent it inserts definition *health equity strategy*) commence on a day to be fixed by proclamation.

Sections 11(3) and (4), 12 and 18 relate to the new requirement that one or more of the members of a Hospital and Health Board must be Aboriginal persons or Torres Strait Islander persons.

Queensland Health carries out recruitment for Hospital and Health Board vacancies annually. The recruitment process is initiated several months prior to vacancies arising and includes validation of the Board's skills requirement by an external independent governance expert, a public expression of interest, panel assessment of applications, probity checks, Ministerial consideration and progression of the appointment to the Governor in Council. Queensland Health's recruitment strategy already proactively encourages applications from suitably qualified persons including Aboriginal persons and Torres Strait Islander persons. However, to ensure that Queensland Health has sufficient time to complete a recruitment process and make appointments, the provisions requiring each Hospital and Health Board to have one or more Aboriginal persons and/or Torres Strait Islander persons on the Board will commence by proclamation.

Sections 13 and 14 require Hospital and Health Services to have a health equity strategy and to consult with persons prescribed by regulation when developing and reviewing the health equity strategy. Section 19 provides a definition for *health equity strategy*. Commencing these provisions by proclamation will enable consultation with relevant stakeholders about these new requirements and planning for the development of the health equity strategies.

Part 2 Amendment of Ambulance Service Act 1991

Act amended

Clause 3 provides that part 2 amends the *Ambulance Service Act 1991*.

Amendment of s 3D (Service's functions)

Clause 4 amends section 3D to give effect to a recommendation of the Panel convened by the Minister for Health and Minister for Ambulance Services to provide advice on Queensland Health's governance framework in the Hospital and Health Boards Act. The Panel recommended the Ambulance Service Act be amended to recognise that the Queensland Ambulance Service and Hospital and Health Services have mutual obligations to collaborate and coordinate their activities in the best interests of the Queensland health system.

Clause 4(1) inserts new paragraph (ja) to section 3D of the Ambulance Service Act to provide that the Queensland Ambulance Service has the function to collaborate with Hospital and

Health Services to manage the interaction between the services provided by the Ambulance Service and health services provided by Hospital and Health Services.

Clause 4(2) renumbers the paragraphs in section 3D due to the insertion of new paragraph (ja).

Clause 4(3) inserts subsection (2) to section 3D to provide a definition for section 3D for a *Hospital and Health Service*.

Part 3 Amendment of Hospital and Health Boards Act 2011

Act amended

Clause 5 provides that part 3 amends the *Hospital and Health Boards Act 2011*.

Amendment of s 4 (Principles and objectives of national health system)

Clause 6 amends section 4 to replace references to 'Indigenous health' with 'Aboriginal and Torres Strait Islander health' and 'Indigenous Australians' with 'Aboriginal people and Torres Strait Islander people'. Section 4 provides that the Act gives effect to the principles and objectives of the national health system agreed by Commonwealth, State and Territory governments. The amendment provides that terminology in section 4 is consistent with the amendments provided by the Bill that strengthen the commitment to health equity for Aboriginal people and Torres Strait Islander people, and the capability and effectiveness of Hospital and Health Boards.

Amendment of s 7 (Establishment of Hospital and Health Services)

Clause 7 amends section 7 which provides for the establishment of Hospital and Health Services.

Clause 7(1) amends the heading of section 7 from 'Establishment of Hospital and Health Services' to 'Role of Hospital and Health Services' to appropriately reflect the purpose of the section. Establishment of Hospital and Health Services is dealt with under section 17.

Clause 7(2) inserts new section 7(5) to give effect to the Panel's recommendation that the Queensland public health system move to a networked governance model by providing that the Hospital and Health Boards Act requires each Hospital and Health Service to have regard to the need to ensure the effective and efficient use of public sector health system resources and the best interests of patients and other users of public sector health services throughout the State.

Amendment of s 13 (Guiding principles)

Clause 8 inserts two new guiding principles of the Act to section 13 to expressly reflect there is a commitment to achieving health equity for Aboriginal people and Torres Strait Islander people, and there is a commitment to the delivery of responsive, capable and culturally competent health care to Aboriginal people and Torres Strait Islander people. For consistency with these new paragraphs, clause 8 amends sections 13(1)(b) and 13(1)(f) by replacing 'there should be a commitment' with 'there is a commitment'. Clause 8 renumbers section 13 due to the insertion of the new paragraphs.

Amendment of s 19 (Functions of Services)

Clause 9 amends section 19 which provides the functions of Hospital and Health Services.

Clause 9(1) inserts paragraph (hb) into section 19(2) to provide a new function of Hospital and Health Services is to collaborate with the Queensland Ambulance Service to manage the interaction between the services provided by the Queensland Ambulance Service and health services provided by the Hospital and Health Service.

Clause 9(1) gives effect to the Panel's recommendation that the Hospital and Health Boards Act be amended to recognise that the Queensland Ambulance Service and Hospital and Health Services have mutual obligations to collaborate and coordinate their activities in the best interests of the Queensland health system.

Clause 9(2) renumbers the paragraphs in section 19(2) due to the insertion of paragraph (hb).

Clause 9(3) inserts subsection (3) to section 19, a direction about performing the functions, to clarify that a Hospital and Health Service, when performing its functions must have regard to: (a) the need to ensure resources of the public sector health system are used effectively and efficiently; and (b) the best interests of patients and other users of public sector health services throughout the State.

Amendment of s 22 (Role of exercising control over Service)

Clause 10 inserts subsection (2) to section 22 to give effect to the Panel's recommendation which aims to drive greater network characteristics in the Queensland health system. New subsection (2) provides that in controlling the Hospital and Health Service for which the Hospital and Health Board is established, a board must have regard to: (a) the need to ensure resources of the public sector health system are used effectively and efficiently; and (b) the best interests of patients and other users of public sector health services throughout the State.

Amendment of s 23 (Membership of boards)

Clause 11 amends section 23 (Membership of boards). The amendment reflects the Queensland Government's commitment to increase Aboriginal and Torres Strait Islander representation on Queensland Government Boards and Committees and implements the Panel's recommendation that each Hospital and Health Board should have one or more Aboriginal persons and/or Torres Strait Islander persons as members.

Section 23 provides that the Minister is to recommend persons for appointment that the Minister considers have the skills, knowledge and experience required for a Hospital and Health Service to perform its functions effectively and efficiently. Relevant skills, knowledge and experience includes the expertise listed in section 23(2). Consistent with the Panel's recommendation, clause 11(1) inserts new paragraph (ea) to section 23(2) to specify that the Minister may recommend persons with the skills, knowledge and experience in Aboriginal and Torres Strait Islander health and community issues relevant to the operation of the Hospital and Health Service. This requirement emphasises that Aboriginal and Torres Strait Islander health is the overall responsibility of the board and Hospital and Health Service and does not rest as a matter only for Aboriginal and/or Torres Strait Islander board members.

Clause 11(2) renumbers section 23(2) due to the insertion of new paragraph (ea).

Clause 11(3) inserts new section 23(3A) to provide that one or more of the members of a Hospital and Health Board must be Aboriginal persons or Torres Strait Islander persons.

Clause 11(4) renumbers sections 23(3A) and (4) due to the insertion of new section 23(3A).

Amendment of s 24A (Temporary members of boards)

Clause 12 inserts a new paragraph (d) to section 24A(1) to provide for the temporary appointment of a member of a Hospital and Health Board if the Minister reasonably believes it is necessary to urgently appoint a member because none of the members of the board are Aboriginal persons or Torres Strait Islander persons. This is consistent with section 24A(1)(c) which provides for the Minister, if the Minister believes it is reasonably necessary, to urgently appoint a member because none of the members of the board are clinicians as section 23(3) requires that one or more of the members of a board must be clinicians.

Clause 12(2) amends section 24A(6) due to the renumbering of section 23 by clause 11.

Amendment of s 40 (Engagement strategies)

Clause 13 amends section 40 (Engagement Strategies).

Clause 13(1) inserts a new paragraph (c) to section 40(1) to require that each Hospital and Health Service must develop and publish a strategy to achieve, and to specify the Hospital and Health Service's activities to achieve, health equity for Aboriginal people and Torres Strait Islander people in the provision of their health services (*health equity strategy*). This amendment implements a recommendation of the Panel and aims to strengthen the Queensland Government's commitment to achieving health equity for Aboriginal people and Torres Strait Islander people.

Section 40(2) requires Hospital and Health Services to consult with particular stakeholders when developing engagement strategies. Clause 13(2) inserts a new paragraph (c) to section 40(2) to provide that a Hospital and Health Service must consult with the persons prescribed by regulation when developing the health equity strategy and when giving effect to the health equity strategy. This will allow Hospital and Health Services to engage with stakeholders to co-design a strategy that is responsive to the community it services.

Clause 13(3) inserts section 40(5) so that when implementing the health equity strategy, Hospital and Health Services must consult with the persons prescribed by regulation and consult in the way prescribed by regulation.

Amendment of s 41 (Review of strategies)

Clause 14 adds a new paragraph (c) to section 41(2) to require Hospital and Health Services to consult with persons prescribed in regulation, as required under section 40(2)(c), when reviewing the health equity strategy. As required by section 41(1) for other strategies, health equity strategies must be reviewed at least once every three years.

Amendment of s 51AA (Consultation on health employment directives)

Clause 15 makes a minor technical amendment to section 51AA to replace the incorrect reference to 'health service directive' with 'health employment directive'. Section 51A provides the chief executive may issue health employment directives about the conditions of employment for health service employees. Section 51AA is about consultation on health employment directives and not health service directives.

Amendment of s 112 (Giving of copy of RCA report – patient safety entity)

Clause 16 inserts new subsection (4A) to section 112, to allow the administrative unit of Queensland Health responsible for coordinating improvements in the safety and quality of

health services to provide root cause analysis reports to another prescribed patient safety entity that is a quality assurance committee for an authorised purpose of the quality assurance committee. A prescribed patient safety entity is defined according to the provisions in the Hospital and Health Boards Regulation. Clause 16(2) renumbers section 112 due to the insertion of the new subsection.

Amendment of s 139 (Meaning of *designated person*)

Clause 17 makes a minor technical amendment to section 139A which defines those persons who are designated persons under the confidentiality provisions of the Act. Section 139A(1)(d) provides that the director of mental health is a designated person. The amendment replaces the term ‘director of mental health’ with ‘chief psychiatrist’ and is necessary as a consequence of the *Mental Health Act 2016.*

Insertion of new pt 13, div 7

Clause 18 inserts new part 13, division 7, which is a transitional provision for the *Health Legislation Amendment Act 2019*. The transitional provision is new section 329 (Aboriginal and Torres Strait Islander board membership). It applies to new section 23 which requires that one or more of the members of a Hospital and Health Board must be Aboriginal persons or Torres Strait Islander persons.

The Bill includes a transitional provision that the requirement to appoint an Aboriginal person and/or Torres Strait Islander person to the board will apply the first time at which there is a vacancy in the membership and a clinician is on the board. This will ensure that the existing mandatory requirement for boards to have a clinician is not affected and that boards do not have to undertake an additional recruitment process to appoint a board member to meet the legislative requirements until such a vacancy occurs.

Recruitment for all Hospital and Health Boards is currently undertaken collectively once a year in May. The purpose of the transitional provision is to ensure that Hospital and Health Boards are not required to appoint an additional member if on commencement the board does not meet the new requirement and does not have a vacancy.

Amendment of sch 2 (Dictionary)

Clause 19 inserts new definitions in schedule 2.

Clause 19 inserts a definition for *Queensland Ambulance Service* as a consequence of clause 9 and a definition for *health equity strategy* as a consequence of clause 13.

Part 4 Amendment of Private Health Facilities Act 1999

Act amended

Clause 20 provides that part 4 amends the *Private Health Facilities Act 1999.*

Amendment of s 48 (Conditions of licence)

Clause 21 amends section 48 to provide that a condition for the issue of a licence for the operation of private health facilities is that the licensee must comply with an accreditation scheme relating to safety and quality matters prescribed by regulation.

Clause 21(1) replaces the licence conditions under sections 48(1)(b), (c) and (d). These sections set out the requirements for the licensee to start a quality assurance program conducted by a quality assurance entity, and the requirements for receiving certification that the facility operates under a quality assurance system. Clause 21(3) omits section 48(2) and (3) as these conditions are no longer necessary due to the adoption of the Australian Health Service Safety and Quality Accreditation Scheme by all Australian jurisdictions. Clause 21(2) renumbers section 48 due to the amendments.

Amendment of s 50 (Term of licences)

Clause 22 amends section 50(2)(a) to replace the term ‘a quality assurance system’ with ‘an accreditation scheme prescribed under section 48(1)(b)’.

Amendment of pt 12 hdg (Saving and transitional provisions)

Clause 23 amends the heading for part 12 which are saving and transitional provisions. Clause 23 provides the heading is ‘Saving and transitional provision for Act No. 60 of 1999’ to distinguish the existing transitional provisions in the Act from the new transitional provision for the *Health Legislation Amendment Act 2019*.

Insertion of new pt 15

Clause 24 inserts new part 15 (Transitional provision for the Health Legislation Amendment Act 2019). The transitional provision is new section 169 (Conditions of existing licences) for amended section 48 regarding conditions of licences. The transitional provision provides that licences in force before commencement of amended section 48 are to be subject to the new licence conditions in new section 48(1)(b).

Amendment of sch 3 (Dictionary)

Clause 25 removes the definitions for *quality assurance entity* and *quality assurance program* from schedule 3 (Dictionary) because the terms are now redundant due to the amendments.

Part 5 Amendment of Public Health Act 2005

Act amendment

Clause 26 provides that part 5 amends the *Public Health Act 2005*.

Amendment of s 61D (Content of water risk management plans)

Clause 27 amends section 61D to replace ‘or’ with ‘and’. This is so that water risk management plans for prescribed facilities must state procedures for responding to both events prescribed by section 61D(e)(i) and 61D(e)(ii), and not one or the other.

Insertion of new ch 5B

Clause 28 inserts a new chapter 5B (Conversion therapies) in the Public Health Act.

New section 213E inserts definitions for the new chapter 5B. The term *sexual orientation* is defined broadly to mean a person’s capacity for emotional, affectional and sexual attraction to, and intimate and sexual relations with, persons of a different gender, the same gender or more than one gender. The terms *conversion therapy* and *gender identity* are defined in new sections

213F and 213G respectively, as discussed below. The term *health service provider* is defined by incorporating the definition provided in section 8 of the *Health Ombudsman Act 2013*.

New section 213F defines *conversion therapy*. The definition provides non-exhaustive examples of some of the treatments and other practices that fall under the definition of conversion therapy. The definition lists several practices that are not considered conversion therapy for the purposes of part 5B. These are practices that assist a person who is considering or undergoing a gender transition; assist a person to express their gender identity; provide acceptance, support and understanding of a person; or facilitate a person's coping, social support and identity exploration and development. The definition provides non-exhaustive examples of these practices.

The definition also specifies that conversion therapy does not include a practice by a health service provider that, in the provider's reasonable professional judgment, is necessary to provide a health service in a manner that is safe and appropriate or to comply with the provider's legal or professional obligations. The purpose of this exclusion from the definition of conversion therapy is to clarify that a health service provider does not commit an offence if they provide a health service in a manner that, while not affirming or supportive of a person's sexual orientation or gender identity, is justified by reasonably held concerns about the safety or appropriateness of a treatment or practice. This is an objective standard and, as such, will only immunise actions by a health service provider that are evidence-based or consistent with professional standards.

New section 213G defines *gender identity*. Gender identity is defined as a person's internal and individual experience of gender, whether or not it corresponds with the sex assigned to the person at birth. This is a broad concept that includes the person's personal sense of the body and expressions of the person's gender, including name, dress, speech and behaviour. It also includes, if freely chosen, modification of the person's bodily appearance or functions by medical, surgical or other means.

New section 213H creates a new offence that prohibits a health service provider from performing conversion therapy on another person. The offence is a misdemeanour and carries a maximum penalty of 100 penalty units, 12 months imprisonment or both. The maximum penalty increases to 150 penalty units, 18 months imprisonment or both if the person on whom the conversion therapy was performed is a vulnerable person. A *vulnerable person* is defined as a child, a person who has impaired capacity within the meaning of the *Guardianship and Administration Act 2000* for making decisions about a particular treatment, or a person with an impairment that is likely to significantly limit the person's ability to understand a particular treatment.

New section 213I provides that a proceeding for an offence may be taken summarily or on indictment. The decision how to proceed will be at the prosecution's election. However, a Magistrates Court is required to abstain from hearing or deciding the proceeding for the offence summarily if, on application made by the defence, the court is satisfied that the offence should not be dealt with summarily because of exceptional circumstances.

Omission of s 250 (Arrangements about transfer of information)

Clause 29 removes section 250 which provides the chief executive may arrange for the transfer of information in the Queensland Cancer Register for inclusion in the Pap Smear Register. This amendment is a consequence of the discontinuation of the Pap Smear Register.

Omission of ch 6, pt 3 (Pap Smear Register)

Clause 30 removes chapter 6, part 3, which establishes the Pap Smear Register and governs its management and operation. The Pap Smear Register has been permanently discontinued as a result of the National Cancer Screening Register and no longer requires legislative authorisation.

Amendment of s 441 (Summary offences)

Clause 31 amends section 441, which specifies that proceedings for offences under the Public Health Act are to be taken summarily. The amendment clarifies that section 441 only applies to an offence against new section 213H if the proceeding for the offence is taken summarily under section 213I.

Insertion of new ch 12, pt 5

Clause 32 inserts new chapter 12, part 5, saving provision for the Health Legislation Amendment Act 2019. Part 5 contains new section 496 which applies in relation to an offence, for disclosing confidential information of registered screening histories of women, against section 266 committed by a person before the commencement.

Without limiting section 20 of the *Acts Interpretation Act 1954*, section 496 provides that for a proceeding for the offence may be continued or started, and the person may be convicted of and punished for the offence, as if the new Act had not commenced. It is necessary to preserve this offence as it is a safeguard designed to protect privacy and should not be removed simply because new information is not being collected for the Pap Smear Register.

Amendment of sch 2 (Dictionary)

Clause 33 amends schedule 2 (Dictionary).

Clause 33(1) removes a number of definitions relating to the Pap Smear Register from schedule 2 (Dictionary).

Clause 33(2) inserts definitions in schedule 2 for the following terms for new chapter 5B (conversion therapies): *conversion therapy*; *gender identity*; *health service provider*; and *sexual orientation*.

Clause 33(3) to (8) removes definitions for the provisions relating to the Pap Smear Register from schedule 2 dictionary and renumbers the schedule due to the removal of these definitions.

Part 6 Amendment of Queensland Mental Health Commission Act 2013

Act amended

Clause 34 provides part 6 amends the *Queensland Mental Health Commission Act 2013*.

Amendment of s 14 (Membership of commission)

Clause 35 amends section 14, which provides for the membership of the commission, to give effect to a recommendation of the review undertaken by the Minister, pursuant to section 56, of the effectiveness of the Queensland Mental Health Commission Act, to make it clear the commissioner has the function to employ the staff of the commission and not the commission.

Section 14 provides the commission consists of the commissioner and the other staff of the commission. Clause 35(1) removes the word ‘other’ from section 14(b) ‘the other staff of the commission’. This is to clarify that the staff of the commission does not include the commissioner.

Clause 35(2) inserts new subsection (2) to section 14 to clarify the staff of the commission are employed under the *Public Service Act 2008*. The clause inserts a note to section 14 to refer to section 17 for provisions about the employment of the commissioner. Clause 35 is necessary because clause 40 removes the provisions which relate to the staff of the commission from division 4.

Replacement of pt 2, div 4 hdg (Staff of the commission)

Clause 36 amends the heading for part 2, division 4 (Staff of the commission) to replace it with ‘Division 4 Commissioner’ This is necessary as division 4 no longer deals with staff of the commission. Provisions related to staff of the commission will be dealt with in section 14, as amended by clause 35, and section 19, as amended by clause 39.

Omission of pt 2, div 4, sdiv 1 hdg (Commissioner)

Clause 37 removes the unnecessary subdivision 1 heading (Commissioner) from division 4.

Replacement of s 18 (Term of office)

Clause 38 amends section 18, which provides the commissioner holds office for a term of 3 years, to provide the term of the commissioner is for a period of not more than 5 years decided by the Governor in Council. Clause 38 gives effect to the recommendation of the review undertaken by the Minister, pursuant to section 56, of the effectiveness of the Queensland Mental Health Commission Act. This will provide greater continuity in the role and potentially attract a broader pool of applicants when recruitment for the position of the commissioner is necessary.

Amendment of s 19 (Functions and powers of commissioner)

Clause 39 inserts paragraph (c) to section 19(1) to provide the functions and powers of the commissioner include the management of the staff of the commission in accordance with the requirements of this Act and the *Public Service Act 2008*. This is a technical amendment which gives effect to a recommendation of the review of the effectiveness of the Act to amend the Act to clarify the power to employ staff of the commission by the commissioner is clearly defined.

Omission of pt 2, div 4, sdiv 2 (Staff)

Clause 40 removes part 2, division 4, subdivision 2 (Staff), which is redundant as a consequence of clauses 35 and 39.

Part 7 Minor and consequential amendments

Legislation amended

Clause 41 provides part 7 makes minor and consequential amendments to the regulations mentioned in schedule 1.

Schedule 1 Minor and consequential amendments of regulations

Private Health Facilities Regulation 2016

Clause 1 replaces sections 8 and 9 with section 8. Part 4 of the Bill amends the Private Health Facilities Act to provide as a condition of licence, a licensee must comply with an accreditation scheme that relates to safety and quality matters and is prescribed by regulation. The Bill removes terminology ‘quality assurance entity’ and ‘quality assurance program’ from the Act.

Clause 1 inserts section 8(1) to prescribe the safety and quality accreditation scheme for section 48(1)(b) of the Act is the AHSSQAS. Clause 1 inserts section 8(2) to define the *AHSSQAS* to mean the Australian Health Service Safety and Quality Accreditation Scheme formulated by the Commission under the *National Health Reform Act 2011* (Cwlth), section 9(1)(l) incorporating the NHQHS standards.

Clause 1 clarifies that the *Commission* means the Australian Commission on Safety and Quality in Health Care established under the *National Health Reform Act 2011* (Cwlth), section 8.

Clause 1 defines the NSQHS Standards to mean the National Safety and Quality Health Service Standards, 2nd edition.

Public Health Regulation 2018

Clause 1 removes part 8, division 4, which relates to the Pap Smear Register. This is a consequential amendment due to the amendments to the Public Health Act which remove the provisions for the Pap Smear Register, which has been discontinued due to the commencement of the National Cancer Screening Register.

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