# *HEALTH AND COMMUNITY SERVICES COMMITTEE*

**Members present:**

Mr TJ Ruthenberg MP (Chair)
Dr AR Douglas MP
Mr JD Hathaway MP
Mr DE Shuttleworth MP

**Staff present:**

Mr K Holden (Acting Research Director)
Ms K Dalladay (Principal Research Officer)

## PUBLIC BRIEFING—HEALTH LEGISLATION AMENDMENT BILL 2014

### TRANSCRIPT OF PROCEEDINGS

**WEDNESDAY, 10 SEPTEMBER 2014**

**Brisbane**

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**Committee met at 10.28 am**

**CHAIR:** Good morning and welcome. I declare open the hearing of the Health and Community Services Committee public briefing on the Health Legislation Amendment Bill 2014. Today our purpose is to receive a briefing on the bill from the officials from the Department of Health. My name is Trevor Ruthenberg. I am the chair of the committee and the member for Kallangur. With me today are Dr Alex Douglas, the member for Gaven; Mr John Hathaway, the member for Townsville; Mr Jon Krause, the member for Beaudesert, is an apology today; and Mr Dale Shuttleworth, the member for Ferny Grove. I also have apologies from Ms Ros Bates, the member for Mudgeeraba, and Mrs Jo-Ann Miller, the member for Bundamba.

Our official guests at the table are Dr Michael Cleary, the Chief Operations Officer and Deputy Director-General of Health Services Clinical Innovation Division; Ms Loretta Carr, Manager, Regulatory Policy Unit, Policy and Clinician Engagement; Ms Sophie Dwyer, Executive Director, Health Protection Directorate, Chief Health Officer Branch; and Mr Mark West, Director, Preventive Health Unit, Chief Health Officer Branch. For the purposes of Hansard, I recognise that we have a fair few of the departmental staff here with us. Welcome to you all.

Mobile phones should be turned off or switched to silent, please. I remind those present that these proceedings are similar to parliament and are subject to the Legislative Assembly's standing rules and orders. Hansard is making a transcript of the proceedings. The committee intends to publish the transcript of today's proceedings unless there is good reason not to. The bill was introduced by the Minister for Health and referred to the committee on 9 September 2014. The committee is required to report to parliament by 17 November. Submissions will be invited on the bill. Subject to the submissions, the committee may hold a public hearing.

## CARR, Ms Loretta, Manager, Regulatory Policy Unit, Policy and Clinician Engagement, Department of Health

## CLEARY, Dr Michael, Deputy Director-General, Health Service and Clinical Innovation, Department of Health

## DWYER, Ms Sophie, Executive Director, Health Protection Directorate, Chief Health Officer Branch, Department of Health

## WEST, Mr Mark, Director, Preventative Health Unit, Chief Health Officer Branch, Department of Health

**CHAIR:** Before I invite you to make a comment, Dr Cleary, I wish to thank you for being available at such short notice and for accommodating our requirements. If we had had to hold this off, as you know we do not sit again for four weeks and it would have been very difficult to coordinate diaries. Therefore, we truly appreciate your attending this morning. I invite you to make some statements and brief us on the bill. Depending on how well you brief us, we may ask you some questions. Please commence.

**Dr Cleary:** Thank you very much, Chair, for your introductory comments and for recognising the team with us today. Again, I thank the committee for taking the time to meet with the Department of Health around the legislation and the legislative reform program that we have been putting into play. If the chair is happy, I might talk a little about some of the future activities at the end of our formal presentation, followed by questions. As you say, depending on how well I brief the committee that could take either a short or a longer period.

Today's presentation relates to the Health Legislation Amendment Bill, which is an omnibus bill that will amend eight of the Health portfolio acts, give effect to policy initiatives of government and improve the efficiency with which those acts operate. The acts that will be amended include the Ambulance Services Act, the Health Ombudsman Act, the Hospital and Health Boards Act, the Mental Health Act, the Public Health Act, the Radiation Safety Act, the Tobacco and Other Smoking

Products Act and the Transplantation and Anatomy Act. Through the presentation I will run through the various components, but for the purposes of the presentation I thought I would start with the most important policy initiatives and work through to those that are still important but perhaps are not as key to the government reform agenda.

Firstly, in relation to the Tobacco and Other Smoking Products Act, the Chief Health Officer will formally release updated smoking figures in November of this year. They will show that in 2014 Queensland adults' daily smoking rate has reduced to 14 per cent. I note that in 2001 it was 22 per cent, so I think that represents a significant and remarkable reduction in the number of people smoking in the state. That is great news for the health of Queenslanders, because I know that smoking related disease contributes to death and has a significant impact on families, the economy and healthcare costs more generally. The fundamental driver in the reduction of the smoking rates has been the strong legislation that has been put in place to protect children, eliminate retail products being displayed and create smoke-free zones. The legislation is really the key plank in driving that change. This has been a stepped approach with the community leading the way and wanting more protection from the hazards of smoking.

Three changes in the Queensland tobacco laws are included in the bill. The first of those relates to electronic cigarettes, and I note that the Minister has made some public comments on those already; the expansion of smoking bans at schools and hospitals; and the expansion of smoking bans in prisons. The changes for the electronic cigarettes, or e-cigarettes, are about taking early action now to protect the health of Queenslanders. E-cigarettes are products designed to simulate smoking. However, they do not contain tobacco leaf. They typically heat a form of liquid that contains nicotine into a fine vapour that is then inhaled into a person's lungs by sucking on a mouthpiece or triggering a switch. The public health concerns about those devices include concerns that existing laws for smoke-free zones do not capture e-cigarette use. People, and in particular children, may be exposed to the second-hand—and I use the word in inverted commas—'smoke' from the e-cigarettes.

The short- and long-term effects of e-cigarettes are still unclear. However, the World Health Organisation recently found that there is sufficient evidence to warn children and pregnant women not to use them and, given the potential for nicotine exposure to have long-term consequences on brain development, I think this is one of the key drivers for the WHO recommendation. The WHO has also called for strong regulation in relation to the devices. Therefore, the changes today are clearly in keeping with the international perspective on e-cigarettes.

The safety, quality and effectiveness of e-cigarettes as quit-smoking aids remain unproven. I think that is important to note. There is no benefit in the devices to assist people to stop smoking. There are, however, six types of TGA approved nicotine replacement devices or products that are available, including patches, gum, lozenges, inhalers, mouth sprays, mouth strips et cetera. They are already available and they are available for people to access should they wish to quit smoking. The regulation of those devices means that the same rules will apply in terms of the approach taken to e-cigarettes as to ordinary cigarettes. Again, that is an important issue, I think, for us in terms of treating these in an equivalent way—not a unique or special way—but they are equivalent to regular cigarettes.

While these cigarettes have been available for some time, interest and uptake in their use has risen recently in line with the promotion of some of the devices, and some of that promotion has been on the internet. Because e-cigarettes do not contain tobacco leaf, they are not currently captured as smoking products under the tobacco act and are not currently subject to any restrictions regarding their sale or supply. The bill amends the tobacco act to capture personal vaporisers and associated products such as liquids, cartridges and mouthpieces as smoking products. The amendment will enable existing restrictions regarding supply, promotion, use and enforcement of smoking products to apply to these personal vaporisers. Medical devices approved by the TGA will not be captured by this proposed amendment, for example ventolin puffers. The committee should also be aware that the possession of liquid for use in e-cigarettes is prohibited in Queensland at this point in time.

Moving on to the second area, which relates to schools and hospitals: total smoking bans at schools and hospitals, including a five-metre buffer from the perimeter, will continue the legislative reform agenda by strengthening the smoking laws to further protect the health of Queenslanders. It also addresses many concerns from parents, schools and hospital patients and visitors about walking through congested areas at the front of those facilities where smokers sometimes congregate. Smoke-free schools, hospitals and related facilities reinforce the message that those institutions have an important place for learning, care and the promotion of healthy living. Currently,

46 per cent of Queensland public hospitals are non-smoking. The experience from those facilities, along with extra quit-smoking support for staff and patients, is being used to support the transition to the new smoke-free requirements and the buffer zones around hospitals and schools.

The third area to talk through relates to prisons. The bill also removes the exemption that previously enabled smoking in correctional facilities. Total smoking bans commenced at all Queensland prisons on 5 May 2014. Those bans were part of a major collaborative effort between Corrective Services and the Department of Health, and included extra quit-smoking support, nicotine replacement therapy and staff quit-smoking programs. The transition to smoke-free prisons went very smoothly. Over 80 per cent of offenders who smoke access nicotine replacement therapy to help reduce their craving and potential irritability. For Corrective Services staff who joined the quit-smoking program, success rates were as high as 70 per cent of people moving to a non-smoking regime after 16 weeks. That is a real achievement for an organisation. Corrective Services should be commended for the work that they have been doing with their staff to achieve such a high level of discontinuation of smoking. The legislative reforms for e-cigarettes, smoking bans in schools and hospitals and prisons reaffirm Queensland as the leader in public health in this area and our smoking legislation will remain the strongest of any legislation of this type in Australia.

The next policy initiative in the bill is the amendment to the Public Health Act to transfer civil liability for asbestos related matters from local government to the state. This initiative responds to a key recommendation accepted by government under the Queensland Ombudsman's report on an investigation into the regulation of asbestos in Queensland. This recommendation sought to resolve the existing arrangements between the state and councils in responding to asbestos risks under the Public Health Act. The Ombudsman provided 36 recommendations that sought to improve the management of asbestos matters across agencies in Queensland. Of the 36 recommendations, five relate solely to the Department of Health, with another seven being jointly managed by Health and other agencies. While the bill addresses one of the health related recommendations, the department has made significant progress on the remaining recommendations. These recommendations are generally of a technical nature or relate to communications. They are on track and in accordance with the action plan. Having said that, one of the key recommendations is this legislative change and some of the other actions that will be taken are contingent upon this legislative change being put into play.

When the Public Health Act provisions relating to asbestos commenced in 2007, it provided that the management of asbestos related public health risks in the workplace setting were the responsibility of local government. Workplace asbestos risks are managed under the *Workplace Health and Safety Act 2011*. Local governments subsequently raised concerns regarding their ability to obtain insurance to cover this work and the cost involved, and so relied on provisions in the act to refer this work, by mutual agreement, to the state to take action. The arrangement had relied on the state accepting case-by-case referrals for asbestos matters from local government and managing them on behalf of local government.

Queensland Health undertakes asbestos work on behalf of the local government organisations and has been involved in managing up to 120 complaints each year across the state. In some instances, the department has funded remediation works in terms of asbestos contamination and it has cost us in the order of $100,000 in total to manage those works. Referrals to the department have been an issue for us and they generally relate to do-it-yourself home renovators who clean asbestos cement roofs with high-pressure hoses, causing asbestos contamination in their yards and perhaps in the surrounding yards. An incident such as that can be further complicated if a home handyman who is employed by the owner of the property is used to clean the private residence. Workplace health and safety laws may apply to some aspects of that. However, the Ombudsman identified that the arrangements were not well coordinated and that the intent of the legislation was not being met with the current arrangements.

The department has been working with the Local Government Association of Queensland to address this issue and, in particular, the local government's lack of protection from civil liability for asbestos related matters. A whole-of-government strategy now provides for a streamlined and collaborative approach to seamlessly address the risks across all of those agencies. The proposed amendment to the Public Health Act resolves the arrangement and further supports the *Statewide Strategic Plan for Safe Management of Asbestos in Queensland 2014-2019*, which was prepared by the Queensland Government in response to the Ombudsman's report.

The bill gives effect to a key recommendation of the Ombudsman and initiatives under the strategic plan by providing indemnity for local governments against civil liability for the management of asbestos related matters in non-workplace settings. The protection only applies to local

government officers acting in an administration or an enforcement capacity under the Public Health Act. The indemnity is continued upon compliance by local governments with a number of conditions such as compliance with relevant laws, record keeping and retention, and appropriately training staff.

If a civil claim is brought against a local government and they have complied with the conditions of the indemnity, the claim will be attached to the state to manage accordingly. As the risk will be insured, any claim will be managed by the Queensland Government insurance fund. A process for annual compliance certification will allow local governments to certify contemporaneously that they have complied with the conditions. This may relieve them of the burden of proving compliance at a later date, particularly as asbestos claims may not arise for some 30 or 40 years after an event has occurred.

If a local government has not reasonably complied with the conditions, the claim may be declined by the state and will then be managed by the local government. The state may also seek contributions from the local government if the local government organisation or its officers have not acted in good faith or if there had been gross negligence. In order to ensure the seamless transition of this work to local governments, an implementation plan has been developed by the relevant government departments. This includes the provision of training for local government officers, ongoing support and mentoring, and assistance where necessary. There has been and will continue to be a 24-hour government call centre 13QGOV, which is available to support local governments in responding to any asbestos complaints.

The proposed amendment presents a low risk to the state. The risk assessment is based on scientific evidence that suggests a low exposure is likely to be associated with a low level of risk. Most complaints are about low-risk situations. Greater investment and public awareness will allow a reduction in the number of incidents. We also note there have been no claims under the Public Health Act or the Workplace Health and Safety Act in relation to this activity or these kinds of activities to date. So overall we think that the amendment, although the state takes on the risk, is likely to be small and that the strategies that we are putting in place will mitigate that risk even further.

Moving on to the area related to root cause analysis, the bill amends the Hospital and Health Boards Act and the Ambulance Service Act to address recommendations arising out of a review of root cause analysis legislation. Root cause analysis, or RCA, is a quality improvement technique that is used to assess and respond to reportable events that occur during the provision of health care such as those resulting in unexpected serious injury. During an RCA, a multidisciplinary team is appointed to retrospectively analyse the consequences of the event leading to the clinical incident. The team identifies any contributing factors and makes recommendations on how similar matters can be avoided in the future.

Approximately 150 RCAs are undertaken each year by hospital and health services across Queensland in order to examine and learn from unexpected patient events. The current provisions relating to RCAs in the Hospital and Health Boards Act and the Ambulance Service Act require a review to be undertaken to ensure there are continued and adequate procedural arrangements in place to meet the expectations of the community. Queensland Health led a review of the RCA provisions, which commenced in March 2010, in consultation with the Queensland Ambulance Service. Broad consultation was undertaken in the course of the review of the RCA provisions. The majority of feedback acknowledged the positive contribution of RCAs to the broader approach to patient safety and patient care improvement, and no submissions were received requesting that the legislation be abolished, for example. There was some consumer feedback advocating extension of the legislation to mandate RCAs for certain types of adverse events. However, consistent with the majority of submissions received, the report recommends continuing the current approach of enabling but not requiring an RCA for an adverse event.

An enabling approach is consistent with the position of the majority of Australian states that have significant legislation provisions in place relating to root cause analysis, those being Queensland, New South Wales and South Australia. Only New South Wales mandates RCAs for certain reportable events. An enabling approach is also consistent with the department's policy of facilitating the hospital and health services' management of the local health service and not to be directing in terms of the service provision or management of those services.

The report recommended minor legislative amendments to the act. They included treating the chain of events documentation as part of the RCA report, opening up the availability of the chain of events while maintaining it not being able to be presented in legal proceedings. This will assist in how the RCA team's recommendations are arrived at and will in turn provide better feedback to

patients, families and staff. It included mandatory reporting by the RCA team member as an explicit ground for stopping an RCA. Conduct in this case is conduct that is serious enough to require mandatory reporting to AHPRA as a public notification and that would be privileged by the committee. Of course, in Queensland now that reporting would go through to the Health Ombudsman. The RCA team members are to provide the commissioning authority with the grounds upon which the RCA was stopped. Up until this time the RCA team members are not required to explain the rationale for ceasing the RCA, only that they are going to cease it. I think that will provide a better explanation of the rationale and also allow the chief executive or the commissioning authority to take action where appropriate.

Expanding the scope of the legislation to include non-government organisations prescribed under regulation will also be an element of the change. This would include services such as the Royal Flying Doctor Service, who have approached us because on occasions we jointly undertake root cause analyses in relation to the care and treatment of patients who are provided with care and are supported by both Queensland Health and the Royal Flying Doctor Service. The potential for us to improve our patient safety and quality through working with the organisation such as the RFDS will be an important part of our work going forward.

The review report also recommends a number of other areas of further guidance and education on provisions in the existing legislation that appear not to be well understood. The department's Patient Safety Unit has recently released a comprehensive guide on clinical incident management and a series of associated fact sheets that we believe will assist greatly in communicating that information. The department's Patient Safety Unit has also recently run two workshops, one which was over a week, to provide support for staff working in a Hospital and Health Service and improve their understanding of the legislation and the procedural requirements. We also ran a workshop with the chairs of the new hospital and health boards' quality and safety committees to ensure they were well briefed on the legislation as well. Both of those have been well received by staff. I think those types of activities will further allow us to improve the communication and respond to some of the issues raised in the report. I do not have with me today a copy of those materials, but we would be very pleased to provide those to the committee for your perusal.

The next piece of legislation that is being modified is the *Transplantation and Anatomy Act 1979*. The Transplantation and Anatomy Act was introduced 35 years ago and has not been comprehensively reviewed since that time. A review of the act is in its initial stages and it is progressing well. In the meantime, however, there are a number of operational issues that we believe require addressing in the short term.

The bill amends the Transplantation and Anatomy Act to facilitate the supply of blood products and tissue products based on the needs of Queensland patients. The current controls in the Transplantation and Anatomy Act on buying, selling and advertising human tissue based products have been effective in restricting the commercial trade in human tissues. However, there have been extensive progressions in scientific research and medical practice in this area and these provisions really now need to be modified from the way they were drafted some many years ago. The controls are potentially obstructive in that they may restrict the efficient supply of blood and blood products under the national blood supply arrangements that are currently in place and the supply of tissue based therapeutic products approved by the Commonwealth Therapeutic Goods Administration.

The department is aware of 12 human tissue based products that are currently available in most other Australian jurisdictions but are not easily available in Queensland. This is because the act prohibits the buying and selling of human tissue and includes human tissue based products. Currently, these products may be made available. A buyer has to know about them when a seller is not able to advertise the product. This can be difficult. A buyer has to apply to the Minister for a permit to buy the products and the permit application has to be assessed and considered by the Minister on a case-by-case basis. That is, you cannot provide approval for a generic product or a specific product across the state; it has to be for the provision of a particular product to a particular hospital.

There are 12 tissue products that are currently used and would fall under this arrangement. They include products that are used to control bleeding in situations where sutures are not able to be placed to control the bleeding, and Surgiflo is an example of that. They are tissues or products that are used for burns and there are a range of orthopaedic products that come under this arrangement such as a recently released putty. These products are in demand following the significant expansion in this area in that the technologies have advanced over recent years.

Recently the department has received a number of requests for permits for these products. As I have indicated, they have to be considered on a case-by-case basis by the Minister, and that can be a somewhat complex process given that they are fairly straightforward applications.

The amendments will ensure the act is able to keep up with the evolving human tissue based health technologies. The amendment in the bill will also clarify that third-party suppliers of blood and blood products who are contracted by the Commonwealth or by Queensland to supply human tissue products are able to buy and sell and advertise those products in Queensland. These amendments will also apply to cord blood, which is sometimes used in the treatment of patients with malignancies.

The bill goes on to clarify that process tissue products that are included in the Australian Register of Therapeutic Goods as registered goods, medical devices or biological are exempt from prohibition on buying, selling and advertising of tissue. This requirement will ensure that only those tissue based goods which have been evaluated by the TGA for safety, quality and effectiveness are exempt from the restrictions of the Transplantation and Anatomy Act. There are other registers held by the TGA where the level of scrutiny of those products is less, and that is why there is the higher level of scrutiny by only having those devices that are registered in this way being those that will be considered.

The bill also amends the Transplantation and Anatomy Act to provide that a prescribed tissue bank can hold itself out to sell or inquire as to whether a person is willing to buy tissue products. The amendment ensures prescribed tissue banks are not unduly disadvantaged by the amendment that enables exempt entities to buy and sell products in Queensland. In this regard there are some products, for example, that the Bone Bank in Queensland would provide, which are very similar to the products that I have just described, such as the putty used in some orthopaedic procedures, and to provide for a level playing field. That amendment should ensure that both the private sector organisations and the Bone Bank would be able to promote their products in a manner equally to clinicians so that clinicians can make an appropriately informed choice of which product is best for their patient.

The bill also includes an express power of delegation for the Minister. Having express functions under the Transplantation and Anatomy Act, the Minister does not have the power to delegate and must, therefore, personally exercise these functions regardless of the relative importance, risk or impact of a particular matter. These functions relate specifically to authorising the buying of human tissue in special circumstances and approving advertising relating to the buying of tissue. The bill provides a power for the Minister to delegate his or her powers or functions under the act to an appropriately qualified Public Service employee such as the Chief Health Officer or the chief executive for the department or other appropriate employee. The delegation power is policy neutral and is subject to the provisions of the *Acts Interpretation Act 1953*.

The final amendment to the Transplantation and Anatomy Act is a machinery amendment to clarify the operation of the act. Both the Transplantation and Anatomy Act and the Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act provide for commercial trade in human eggs and human sperm. Reimbursement for reasonable expenses incurred by persons in connection with the supply of eggs, sperm and embryo is permitted by the Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act but is prohibited by the Transplantation and Anatomy Act. The bill clarifies that if the Transplantation and Anatomy Act is inconsistent with the Research Involving Human Embryos and Prohibition of Human Cloning for Reproduction Act the latter act prevails to the degree of that inconsistency.

Moving on to the next area, which is principally related to confidentiality, as you would be aware the Blueprint for Better Healthcare in Queensland has four principal themes, one of which is to provide health services that are focused on patients and people. One of the key ways to deliver on this theme is to optimise the opportunity for collaboration and partnerships and to make healthcare systems more accessible. For this reason Queensland Health delivers public health services particularly in regional areas and remote areas as a partnership with external providers. In Cape York, for example, chronic disease care for maternal and child health services is delivered by the Torres and Cape Hospital and Health Service in partnership with the Royal Flying Doctor Service and Apunipima Cape York Health Council.

Under these types of service agreements, staff of external services need to access Queensland Health information in order for clinicians and administrators to be able to provide appropriate care and to ensure the continuity of that care. A barrier to Queensland Health sharing patient information with external providers is the duty of confidentiality and the Hospital and Health Boards Act, which prohibits the disclosure of patient information except in specific circumstances.

The bill addresses this barrier by creating a new exemption to the duty of confidentiality to enable external service providers to access Queensland Health information systems. These systems may be electronic, paper or in other forms.

In recognising the need to protect privacy of persons and patients who are receiving or have received public health services, the new exception builds on a number of safeguards that are already within the system. These include that there must be an agreement between the external service provider and the chief executive of the Hospital and Health Service; the access to the information system must be authorised by the chief executive and only if the chief executive is satisfied that the access is necessary to enable the external service provider to provide health care under the agreement; and the chief executive's authorisation must be in writing and describe the information system or systems that the provider is authorised to access and the conditions for use. While the chief executive is permitted to delegate this function, in most cases the function will not be delegated because the chief executive is the primary signatory for contracts. As a further safeguard, the new exemption states that external service providers are to be bound by the contract service provisions under the Information Privacy Act. This ensures that the national privacy principles in the privacy act apply to the external service provider. This requirement will help manage the risk relating to further disclosure, use, security et cetera of confidential material.

Moving on to the last major area for our discussion today relating to the Radiation Safety Act, the Radiation Safety Act currently allows a holder of a renewable instrument, such as a licence or approval to acquire a radiation source, to apply to the chief executive for renewal within 60 days before the instrument expires. There were 7,618 instruments of renewal applied for between 1 July 2013 and 30 June 2014. Ninety-three per cent of these renewals were received before the expiry date; seven per cent or 533 of these renewals were received after the expiry date of the current licence; and 86 per cent of these were received 30 days or less from the expiry date.

The difficulty that we have is that the renewal cannot be accepted by the Department of Health if it is received after the licence's expiry date. This is the case even if renewal is received just one day after expiry. In these circumstances, the holder of the instrument must complete a complete fresh application and incur the costs of a new application as if they were processing the application for the first time. This framework is considered overly bureaucratic and imposes both regulatory and financial burdens on stakeholders and an administrative burden on government.

The bill proposes to amend the Radiation Safety Act to allow a recently expired act instrument—that is, a licence—to be renewed, and the limitation on that would be that they would need to be received within 30 days of the expiration of the instrument. The Radiation Safety Act is also amended to clarify that a person cannot be in possession of a licence or approval to acquire a banned radiation source, the removal of redundant definitions and provides that documentation held by the former Radiation Advisory Council of Queensland transitions to the Radiation Advisory Council.

There are a number of other amendments which are of an operational nature and we believe will improve the operation of the act. Of these, in the Health Ombudsman Act a reference to a Privacy Commissioner being appointed under the *Right to Information Act 2009* is corrected to state that the Privacy Commissioner is appointed under the *Information Privacy Act 2009*. That is a technical correction. In the Mental Health Act the definition of psychiatrist' is amended to capture a new category of registrant with limited registration to undertake postgraduate training or supervised practice. That is to make us consistent with the new definition that the Australian Health Practitioner Regulation Agency has put in place. The amendment will also avoid workforce and service delivery implications in areas of need to enable suitably qualified medical practitioners from countries such as Canada and the United Kingdom to undertake functions under the Mental Health Act, in particular in regional and remote Queensland.

That really draws to a conclusion a summary of the changes in the legislation and I might pause there and see if there are any questions. Thank you.

**CHAIR:** Thank you, Dr Cleary. It seems to be fairly straightforward, some fairly technical type stuff, some good stuff clearing up and helping our medical staff around the state do their job. I will open it up to any committee members if there are any questions. Mr Hathaway?

**Mr HATHAWAY:** Thank you very much, Dr Cleary, for that presentation. I have a few questions to clear up my own mind. I take it the original intent of the *Transplantation and Anatomy Act 1979* was really to stop the commercialisation of trade in tissue. Do any of the changes that you are proposing here enable that? I think somewhere it talks about having a list price for the cost of recovery, storage and packaging and that is a recoverable cost. None of these changes are likely to create a competitive marketplace?

**Dr Cleary:** Thank you. No. The changes in the legislation have obviously been thought through very carefully to make sure that the international agreements that Australia and other countries have signed up to in terms of the trade in human tissues are maintained. The big issue for healthcare providers is that technology has moved on considerably from when the act was originally written. It was never envisaged that there would be commercially-available products which included tissue. Bone putty is a good example of that, where it does include tissue that was obtained and then incorporated into the product. Those types of products—as I said, there are about 12 that we are aware of now in the market—are in common use. They are appropriate products for use. It would seem appropriate to streamline the approval process for those products. Again, they were never envisaged when the act was originally drafted because the concept of having those types of products, which included human tissue, was not there.

These arrangements will, I think, safeguard the policy around the trade in human tissues while allowing for appropriate medical devices and technologies to be used. The big safeguard, I believe, is the fact that the TGA will provide the highest level of supervision of those products and will ensure they are appropriately regulated and oversighted at the national level. For products to be approved by the TGA at the level that we are recommending in the legislation will, I think, be the safety net because if it is not a product recommended and approved by the TGA, which will have undertaken a whole range of safety and quality assessments, then it will not be able to be considered in Queensland.

**Mr HATHAWAY:** My next question was on electronic cigarettes. Are we the first jurisdiction or have other jurisdictions in Australia moved ahead of us?

**Dr Cleary:** This will be a first for Queensland and Australia. It is certainly an area that has been on the mind of the Minister, I am aware, and his policy guidance in this area has been very important. In the past we have been able to restrict the use of the solutions that are used in the e-cigarettes, but that has not really proven to be effective when you think that those devices can be displayed, they can be purchased and they can be purchased by people under-age in shops. We have quite strong regulations around the display and sale of smoking products, so there is a clear inconsistency between the two types of products—those with tobacco leaf in them and those without. This really brings us into harmony in some respects by saying that both of these products should be regulated at the same level because they are very similar products. Again, I think it gives Queensland the opportunity to bring into play legislative provisions that will regulate e-cigarette products before the market grows and we are then looking at putting arrangements in place after the market has expanded. So I think it is a timing issue. That is a long answer to your question. Yes, Queensland is taking the lead and this will be the first jurisdiction to implement this type of legislation.

**Mr HATHAWAY:** While I support that fully, I am wondering: is the supply, control or holding of liquid nicotine or smoking oil banned in New South Wales?

**Dr Cleary:** The products are similarly regulated in Queensland and all other states. If we become aware that people have those products then we can seize them. The same provisions apply across Australia.

**CHAIR:** In terms of the regulation around the control of the sale of that liquid nicotine, is its sale prohibited or restricted right now?

**Dr Cleary:** Thank you for the question. I might hand over to Sophie Dwyer to respond to that, because it is a technical issue around national and state laws. It is regulated under the state laws, but there is national harmony.

**Ms Dwyer:** Nicotine is scheduled under the Standard for Uniform Scheduling of Medicines and Poisons. As such, that specifies across the country that it is a substance that should only be in the possession of people with appropriate approvals. These products fall outside of that, and so therefore they are not allowed to be possessed and we therefore can seize them. It requires us to determine that it does contain nicotine.

**CHAIR:** But under the current legislation they cannot be sold in a service station or a store, for example. Who is an 'authorised seller'?

**Ms Dwyer:** Not all products claim to contain nicotine, and that is one of the challenges.

**CHAIR:** I understand. Thank you.

**Mr HATHAWAY:** With regard to smoking on educational premises, I fully support that. In clause 59, section 26ZGB talks about education facilities as listed in schedule 4 of the Education (General Provisions) Act. Does that include TAFEs?

**Mr West:** No, it does not. The definition is most definitely schools, so that is P-12.

**Mr HATHAWAY:** So TAFEs and universities do not fall under it?

**Mr West:** That is correct. They do not apply.

**CHAIR:** Is liquid nicotine regulated under medicines or poisons?

**Ms Dwyer:** It is currently regulated under our poisons regulations.

**Mr HATHAWAY:** On page 7 of the explanatory notes it talks about radiation sources and a source that has been banned. How is a particular device banned and where is that listed?

**Dr Cleary:** At this moment the device that falls under that provision is the solaria, and they obviously are going to be banned from 1 January next year. That is the provision that covers the banning of solaria. There are no other devices to my knowledge at this point in time.

**Mr HATHAWAY:** Does that include any of the laser devices at all?

**Dr Cleary:** No, that will be prohibited from 1 January as a device.

**Mr HATHAWAY:** With regard to the definition of psychiatrist, we are now talking about potentially broadening the scope of that definition so that a medical officer who is undertaking his training or residency in psychiatry is also included until he is accepted by the college?

**Dr Cleary:** The change is really to allow us to keep up to date with what the national arrangements are. Within the national arrangements there used to be a provision to allow for an area of need for a doctor to practise in a particular field. With the harmonisation of medical registration across Australia, that area-of-need arrangement has been abolished and doctors who may well be specialists in psychiatry, having trained in the UK or Canada, come in to Australia to work now under a new provision which tends to relate to the training and professional development area and it is used now more commonly. We used to have a provision that allowed these doctors to enter under an area of need. That provision has been abolished and the new provision relates to people coming in under this new category. In effect, it is just us recognising that the category has changed. On the ground it will not mean any change to the way that doctors are recognised to practise in Queensland. There will be no effect on the ground. What we are really seeing is that, to comply with the new national arrangements, we need to make this change to our act.

**Dr DOUGLAS:** I do not want this to sound like it is overlapping a question earlier, but does this legislation mirror other states' legislation, particularly in the issues of root cause analysis, transplantation laws, e-cigarettes, radiation and asbestos?

**Dr Cleary:** The Queensland legislation is consistent with the legislation in other states, but because of the legislative framework that is in place in Queensland there will be differences from state to state. Queensland, for example, has a very strong Hospital and Health Boards Act, and that is a significant piece of legislation in providing guidance in how the health system operates. If you consider that that is the key driving piece of legislation, many of our other legislative provisions are either regulatory, which needs to have strong provisions in place, or facilitatory in that we facilitate the operation of the hospital and health boards to provide services. The regulatory ones clearly apply to both the public and the private sector, whereas the facilitatory ones I am referring to principally relate to our hospital and health boards.

In terms of the legislation, the root cause analysis legislation is very similar across all the states and territories. The one difference I think, as we alluded to, is principally with New South Wales, where they stipulate to a degree where a root cause analysis is required to be undertaken whereas in Queensland it is at the discretion of the chief executive. Having been in those situations, I think that is an appropriate way for us to operate because there are more mechanisms to review a matter in Queensland than perhaps are in place in other states. For example, there may be an incident which has occurred where a HEAPS analysis is more appropriate. A HEAPS analysis is a similar process to a root cause analysis. It does not come with the same legislative protection, and it is usually used where you know exactly what has happened and why it has happened, and really you want to determine how you can mitigate it occurring again in the future. The root cause analysis is often used in circumstances where it is not clear what led to this event and there needs to be a very clear and detailed understanding of the circumstances that led up to the event.

In my role previously as a commissioner of RCAs I would often look at the circumstances. If an event was clearly a complex one, and many of them are, you would always elect to undertake a root cause analysis. If, on the other hand, it was very clear what had happened—there may have been a medication error or it was clearly an error where the problem could be identified—then I would often elect to use a HEAPS analysis because that allowed you to hone in on what the problem was and how to fix it. For example, if someone received the wrong medication, what extra processes do we need to put in place to make sure that does not happen again?

I think giving the Hospital and Health Service chief executives the opportunity to determine whether something needs to be investigated formally through a health service investigation or to use a root cause analysis or to use a HEAPS analysis is very important. Overall I think in Queensland we have 16 million patient interactions a year, and a small number of those result in significant adverse events. In those circumstances I think it is good process to have the people who are close to the clinical workplace consider what is the best way to investigate and resolve those things going forward.

In terms of the other legislation, we are currently working on the Transplantation and Anatomy Act. Whilst doing that we have also looked at interstate legislation to see if there are opportunities for us to draw on the provisions that they have. With the Hospital and Health Boards Act I think we probably have the most up-to-date legislation around Hospital and Health Service management. The Mental Health Act is a body of work that, as you would be aware, we are working on at the moment. Although the act is 10 years old, a reform of the way that legislation operates is appropriate, so we are working on those areas as well.

As a general rule whenever legislative change is being considered, one of the core activities that we undertake is to compare and contrast the proposed legislation in Queensland with what legislative arrangements are available in other states and territories and look very hard at that to make sure that we have the appropriate legislative provisions. Our legislative policy team always provides a very detailed summary of legislation in other states before there is any policy consideration by the department.

**Dr DOUGLAS:** Is there any national transfer template legislation coming in for transplantation and radiation? They are very contentious areas with regard to discussions, particularly transplantation and human tissue. There have always been calls for seamlessness across our borders. Is there template legislation that you are aware of?

**Dr Cleary:** I might hand over to Ms Dwyer to speak about the radiation area, given that that is an area of great interest to us all.

**Ms Dwyer:** While the acts may not be identical across the country, they operate within a policy framework referred to as the national directory which comes to health ministers. There is a national framework for discussing controls on radiation sources, and each state may have slight nuances on how they give effect to that or there may be different stages, but essentially that is discussed at the national level and we try to streamline our work consistently with those national requirements.

**Dr DOUGLAS:** Essentially, these changes will be in line with what exists in most other states in Australia currently and what the best practice guidelines are. Can I just ask one further question with regards to transplantation and radiation? What interactions have you had with the major providers of the services? It is not all public; it is private care as well, and they are very large and commercialised organisations now, as people would know with IVF for example.

**Dr Cleary:** We have had considerable interaction with the private sector. As Dr Douglas has indicated, the area that relates to reproductive technology is certainly in scope. We have had meetings and more detailed discussions with some of those providers, especially the larger ones, and they are supportive of these types of changes. I think the major consultation process will be undertaken in terms of looking at the act overall to determine the best way to take forward any government policy change around organ and tissue transplantation.

In terms of the radiation safety issues, there was again extensive consultation with the providers of solaria, for example, before government policy decisions were made. There were variable views expressed at that time, as you would be aware. But the overwhelming evidence was that ultraviolet radiation is so harmful that regulation in this space was appropriate. Again, it is an area where consultation with both the public and private sector is a key feature of any legislative change that we consider, and I know that in terms of government policy it is one of the key things that governments consider before they make any policy recommendations.

**Mr SHUTTLEWORTH:** If I can just come back to the RCAs for a moment—and it is maybe just a point of clarification for myself. In terms of the last bullet point there, where it says that the legislation will prevent information obtained during the course of an RCA from being tendered as evidence, what would happen in a situation where an HHS or an HHB decided that as a result of a death they would undertake an RCA and then some period down the track a family member subsequently made a complaint to the Health Ombudsman, for example? How would that scenario play out? Would that evidence that was then uncovered as a result of the RCA be inadmissible and so how would a claim be brought by a family member?

**Dr Cleary:** In terms of the arrangements that are put in place, the reason there is such a high level of confidentiality associated with the documentation and discussions that occur within that multidisciplinary team is that it allows for full and frank conversations to occur and for the documentation to be developed so that you can identify what the root cause of the incident was.

In terms of the release of documentation, the RCA legislation allows for the release of documentation under certain provisions to persons that have a direct involvement or to other agencies that it is relevant to. So there is the provision to release information to persons or other agencies such as the Health Ombudsman or the coroner. The requirement for the protection of the information that is contained or obtained through that process is principally differentiated from the information that may be used in a civil action, where independent sourcing of that information would be required rather than relying on information collected as part of a root cause analysis.

So the confidentiality provisions are there for a number of purposes. One is to ensure that any of the discussions that occur around these very difficult circumstances can be maintained and the second is to ensure that the information that is provided is provided in a safe and appropriate environment. The provisions I think, therefore, are appropriate. I might seek a little bit of further advice for the committee around the circumstances where information is released and the process by which that information is released so that we give you a more technical answer to that question which I do not have with me at the moment.

**Mr SHUTTLEWORTH:** Thank you.

**CHAIR:** Dr Cleary, just before we wind up, there is a bill that is potentially going to be coming this way that I think has already been made available on the internet for consultation. Do you want to give us a quick synopsis of where that is at or what that is?

**Dr Cleary:** The Public Health Act governs the use of medicines in Queensland and it is a 2005 act. Again, to recognise the changes that are occurring in Queensland and across the world with the use of drugs and medications, we have taken forward a review of that particular act and the provisions that relate to drugs and poisons. The exposure draft of the legislation has been provided on the government website for consultation. That has been provided, together with some discussion papers relevant to specific fields of endeavour such as farming, people who regulate poisons and health professionals so that they can identify the area of interest that they have and go straight to the provisions of the act that relate to them. But the Medicines, Poisons and Therapeutic Goods Bill in its draft form is available on the internet. I would envisage that it will be a piece of legislation that will eventually come through to the committee for consideration.

For me, I think it is a really important piece of legislation because it also allows us to reduce the red tape associated with some of the regulatory arrangements in that legislation which again are matters that have been established before the current systems and processes were put in place in hospital and health services.

**CHAIR:** Very good. We appreciate that. Just before we close, it is fantastic to have the folks who usually we do not see sitting here with us. Just know that even though we do not see you very often we appreciate what you do. We know the work that you do. While Dr Cleary comes here and looks like an oracle of wisdom, in fact we understand that there are many people behind him who provide that advice to him. We appreciate the work that you do. Thank you very much. Thank you to our officials. Thank you, Dr Cleary, for attending today at such short notice. We do appreciate it very much. I declare the hearing closed.

**Committee adjourned at 11.36 am**