

# **Health and Other Legislation Amendment Bill 2016**

**Report No. 38, 55<sup>th</sup> Parliament**

**Legal Affairs and Community Safety Committee**

**September 2016**

## Legal Affairs and Community Safety Committee

|                                       |   |
|---------------------------------------|---|
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## Chair's foreword

This report details the examination by the Legal Affairs and Community Safety Committee of the Health and Other Legislation Amendment Bill 2016.

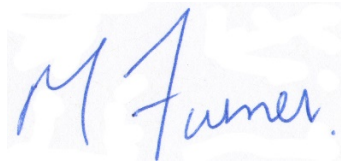
The committee's task was to consider the policy outcomes to be achieved by the legislation, as well as the application of fundamental legislative principles – that is, to consider whether the Bill had sufficient regard to the rights and liberties of individuals, and to the institution of Parliament in accordance with section 4 of the *Legislative Standards Act 1991*.

The committee recommends the Bill be passed.

On behalf of the committee, I thank those who lodged written submissions on this Bill or appeared before the committee. I also thank Queensland Health and the Department of Justice and Attorney-General for their assistance during the inquiry.

I thank all members of the committee for their work on the inquiry and the committee's staff for the support they provided.

I commend this report to the House.



Mark Furner MP  
**Chair**



## **Recommendation**

### **Recommendation 1**

**4**

The committee recommends the Health and Other Legislation Amendment Bill 2016 be passed.





## 1. Introduction

### 1.1 Role of the committee

The Legal Affairs and Community Safety Committee is a portfolio committee of the Legislative Assembly.<sup>1</sup> The committee's primary areas of responsibility include:

- Justice and Attorney-General
- Police Service
- Fire and Emergency Services
- Training and Skills.

A portfolio committee is responsible for examining each bill and item of subordinate legislation in its portfolio areas to consider:<sup>2</sup>

- the policy to be given effect by the legislation
- the application of fundamental legislative principles
- for subordinate legislation – its lawfulness.

### 1.2 Inquiry process

The Health and Other Legislation Amendment Bill 2016 was introduced by the Minister for Health and Minister for Ambulance Services, Hon. Cameron Dick MP, on 16 June 2016. The Bill was referred to the committee for detailed consideration, with the committee to report by 6 September 2016.

The committee invited submissions from the public and from identified stakeholders, to be received by 22 July 2016. Twenty-one submissions were received (see Appendix A for a list of submitters).<sup>3</sup>

The committee received an oral briefing on the Bill from Queensland Health and the Department of Justice and Attorney-General (DJAG) on 11 July 2016, and also received written advices from those departments on issues raised in the submissions. The committee held a hearing on the Bill on 17 August 2016.

### 1.3 Policy objectives of the Health and Other Legislation Amendment Bill 2016

The Bill has a number of policy objectives to be effected by amending a number of different Acts. It proposes to amend:

- the *Criminal Code* to standardise the age of consent for sexual intercourse to 16 years and to replace references to 'sodomy' with 'anal intercourse'
- the *Hospital and Health Boards Act 2011* to facilitate general practitioners having access to the Queensland Health database *The Viewer* and to enable more efficient disclosure of confidential patient information for research purposes
- the *Public Health Act 2005* to:
  - allow health information relating to deceased patients to be disclosed for research purposes
  - enable schools to share student information with school immunisation and oral health service providers, to improve the uptake of the School Immunisation Program and School Dental Program

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<sup>1</sup> *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

<sup>2</sup> *Parliament of Queensland Act 2001*, section 93(1).

<sup>3</sup> View submissions at:

<http://www.parliament.qld.gov.au/work-of-committees/committees/LACSC/inquiries/current-inquiries/17-CounterTerrorismAB16>

- make consequential amendments to reflect changes to the Australian Childhood Immunisation Register
- the *Queensland Institute of Medical Research Act 1945* to facilitate the payment of bonuses to successful discoverers or inventors.

### **Amendments to the Criminal Code**

The Bill proposes to amend the Criminal Code to:

- standardise the age of consent for sexual intercourse to 16 years (currently 18 years for anal intercourse and 16 years for all other sexual activity)
- replace references to 'sodomy' with 'anal intercourse'.

The Bill implements the recommendations of a recent expert panel and is intended to support the release of the *Queensland Sexual Health Strategy 2016–2021* (SHS) later in 2016. According to the explanatory notes, in practice, the current law discriminates against young same-sex attracted men under 18 years.

The Bill proposes to:

- remove the offence of unlawful sodomy (section 208 of the Criminal Code)
- amend the offences of unlawful carnal knowledge (sections 215 and 216 of the Criminal Code) to extend the definition of *carnal knowledge* in those provisions to include anal intercourse
- make consequential amendments to a range of other Acts to support these amendments.

### **Amendments to the *Hospital and Health Boards Act 2011***

#### **Access by general practitioners to *The Viewer***

These amendments are aimed at facilitating general practitioners having access to the Queensland Health database *The Viewer* and 'to enable more efficient disclosure of confidential patient information for research purposes.' *The Viewer* is currently available to authorised Queensland Health staff. Access activity is recorded and audited.

A general practitioner would be able to access *The Viewer* to see a patient's information, such as public hospital medical records, including for example pathology and radiology tests reports. The explanatory notes state this would improve collaboration between different parts of the health system and would assist timely and more co-ordinated patient care. The explanatory notes state it is understood that Queensland would be the first jurisdiction in the country to do this.

The Office of the Information Commissioner (OIC) was consulted on privacy aspects and supports the policy intent, however the OIC noted that it will create a new 'privacy vulnerability'. The OIC supports the proposed privacy safeguards.<sup>4</sup>

#### **Disclosure of patient data for research purposes**

These amendments aim to enable a more efficient process for disclosure of patient information, by removing the need for researchers to follow an application process under this Act in certain circumstances, where a patient does not have capacity to provide express consent. (The current process is set out in more detail at page 4 of the explanatory notes.)

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<sup>4</sup> Explanatory notes, page 14.

## Amendments to the *Public Health Act 2005*

### Deceased patient data

This amendment also concerns the application process for accessing confidential information. The current provisions allowing disclosure refer to 'health information held by a health agency' under the Act. In turn, the definition of that term refers to a 'person'. It is currently unclear whether, in referring to a 'person' the relevant definition extends to deceased persons. The proposed amendment would clarify that in this context the information held by a health agency extends to both living and deceased persons.

### Disclosure of student information

According to the explanatory notes, a 'substantial number' of the parental consent forms required to authorise student vaccination are not being returned.<sup>5</sup> Vaccination rates are below the target. Also, consent levels for participation in the school dental scheme are declining. The amendment would allow school principals (and delegates) to disclose student information to immunisation or oral health service providers to allow providers to:

- follow up with parents where consent forms are not returned
- reconcile returned forms against all eligible students
- make informed decisions on future strategies to improve consent rates from certain cohorts (for example, students from Indigenous or culturally or linguistically diverse backgrounds) if need be.

### Consequential amendments

The Bill would also make some minor consequential amendments to the *Public Health Act* in light of changes to the *Australian Immunisation Register Act 2015* (Cwlth).

## Amendments to the *Queensland Institute of Medical Research Act 1945*

Currently, the *Queensland Institute of Medical Research Act 1945* provides (in section 19) that the Council of the Queensland Institute of Medical Research may pay to successful discoverers or inventors working as officers and employees or under the auspices of the Council such bonuses as the Governor in Council determines.

Part 5 of the Bill would replace section 19 with a new provision which, in paraphrase, removes the requirement for a Governor in Council determination, unless the total paid in any one financial year exceeds \$10 million. In that event, the Council would require Governor in Council approval.

The new provision also changes the description slightly to cover a discoverer or inventor working, or who has worked, as officers and employees or under the auspices of the Council.

### 1.4 Should the bill be passed?

Standing Order 132(1)(a) requires the committee to determine whether or not to recommend that the Bill be passed.

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<sup>5</sup> Explanatory notes, page 5.

Committee comment

After examination of the bill, including the policy objectives it seeks to achieve and consideration of the information provided by submitters, government agencies and stakeholders, the committee recommends that the bill be passed.

**Recommendation 1**

The committee recommends the Health and Other Legislation Amendment Bill 2016 be passed.

## 2. Examination of the Health and Other Legislation Amendment Bill 2016

### 2.1 Amendments to the Criminal Code

The Bill proposes to amend the Criminal Code to:

- standardise the age of consent for sexual intercourse to 16 years
- replace references to *sodomy* with *anal intercourse*.

The government established a panel of key health experts and relevant organisations, which convened in May 2016. The panel noted that young people in same sex relationships may feel compelled to withhold information about their sexual history from their health practitioner for fear of the possible legal consequences, whether for themselves or their partner. The panel:

- recommended the age of consent for all forms of lawful sexual intercourse be standardised to 16 years
- recommended that the Criminal Code be amended to replace references to ‘sodomy’ with ‘anal intercourse’, considering that using the term sodomy may stigmatise this form of intercourse, and homosexual relationships in particular.

The Bill implements the recommendations of the expert panel and is also intended to support the release of the *Queensland Sexual Health Strategy 2016–2021* later in 2016. A draft of the strategy, released for public consultation in May 2016, aims to:

- support healthy and safe sexual experiences based on respect and consent
- provide Queenslanders with the knowledge required to maintain optimal sexual and reproductive health.

#### Consultation

The government consulted on the draft amendments to the Criminal Code with: Legal Aid Queensland, the Public Defender, the Queensland Law Society, the Bar Association of Queensland, the Aboriginal and Torres Strait Islander Legal Service, the Lesbian Gay Bisexual Trans Intersex Legal Service Inc, the Director of Public Prosecutions, the Chief Magistrate, the Chief Judge of the District Court, the Chief Justice of the Supreme Court and the President of Court of Appeal. No issues were raised.<sup>6</sup>

#### 2.1.1 Standardising the age of consent

Currently in Queensland, the age of consent for anal intercourse is 18 years, while the age of consent for all other sexual activity is 16 years.

Whilst the current provisions in the Criminal Code do not by their express terms discriminate on the grounds of sexual orientation, in practical effect they do discriminate against same-sex attracted men under 18. It is also argued that the current law:

- is a barrier to young people accessing safe sex education regarding anal intercourse
- denies gay and bisexual youth peer acceptance and community support.

The Bill proposes to standardise the age of consent, by:

- removing the offence of unlawful sodomy (section 208 of the Criminal Code)
- amending the offences of unlawful carnal knowledge (sections 215 and 216 of the Criminal Code) to extend the definition of *carnal knowledge* in those provisions to include anal intercourse
- making consequential amendments to a range of other Acts to support these amendments.

<sup>6</sup> Explanatory notes, page 14.

## Other Australian jurisdictions

In New South Wales, Victoria, Western Australia, the Northern Territory and the Australian Capital Territory, the age of consent for all sexual activity is 16 years. The standard age of consent for sexual activity in Tasmania and South Australia is 17. Thus, as observed in the explanatory notes, all other Australian states and territories provide an equal age of consent for all sexual activity.<sup>7</sup> In most jurisdictions, this happened many years ago.

The Department advised the committee it understood that the years in which other States standardised their ages of consent were South Australia – 1976, Australian Capital Territory – 1985, Victoria – 1991, Tasmania – 1997, Western Australia 2002, with New South Wales and the Northern Territory being the most recent – in 2003.<sup>8</sup>

### 2.1.2 Removing references to ‘sodomy’

The Bill proposes to replace references in the Criminal Code to ‘sodomy’ with ‘anal intercourse’. The explanatory notes record that the expert panel considered that using the term sodomy may stigmatise this form of intercourse, and homosexual relationships in particular. The panel therefore recommended the Criminal Code be amended to replace references to sodomy with anal intercourse.<sup>9</sup>

### 2.1.3 Issues raised by stakeholders

As noted above, the explanatory notes state that no issues were raised in the government’s consultation on the proposed provisions. Of the 21 submissions received on the Bill, 14 addressed the proposed amendments to the Criminal Code. Of those, all but one expressed support for standardising the age of consent.

The committee heard from medical practitioners experienced in sexual health. Succinctly, Dr Neil Simmons stated:<sup>10</sup>

*Young people will not approach health practitioners to discuss their sexual health if they believe what they are doing is illegal.*

In opposing the provisions, Dr David van Gend saw the current provisions as protecting young males, stating:

*This Bill is negligent in failing to protect the vulnerable. It would, for the first time in our legal history, permit older homosexual men to sodomise schoolboys with impunity.*

*Schoolboys are vulnerable and often sexually confused. Multiple lines of research confirm that around two thirds of schoolboys aged 16 who identify as homosexual will no longer identify as homosexual within a few years. Their sexual identity is immature; the situation is fluid.*

*Permitting older, established homosexual men access to schoolboys who are in a stage of uncertainty and sexual fluidity is likely to have the effect of establishing those schoolboys in a homosexual identity and subculture which they might otherwise have avoided. Look at the evidence on the next page, where half of 16 year olds who identify as gay no longer identify as gay by age 18! That’s why the law must wait until they are 18.*

Others saw the current statutory provision as presenting a danger to young males, on the basis that the current illegality presents a barrier to young gay males seeking appropriate sexual health advice

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<sup>7</sup> Explanatory notes, page 1.

<sup>8</sup> DJAG response to questions on notice.

<sup>9</sup> Explanatory notes, page 1.

<sup>10</sup> Submission 5.

and tests. The Queensland AIDS Council referred to the Queensland Gay Community Periodic Survey (GCPS) as providing guidance on the sexual activity of young men who have sex with men in Queensland. It advised:<sup>11</sup>

*In 2015, 1.7% of participants were 16-17 years of age. Within this age group, only 32% had ever been tested for HIV, and only 22% had been tested for HIV in the past 12 months. Of this group, nearly 10% had sex with more than 5 men in the past 6 months, whilst 35% had sex with 2-5 men. 80% of the 16-17 year olds had sex with at least one man in the past six months.*

*The GCPS shows us that sexual health is an issue for young gay men, and that without equality of age of consent, the barriers to HIV testing, and avoiding disclosure to health care providers on sexual activity will continue.*

The Queensland AIDS Council went on to express concern:<sup>12</sup>

*... that with the current inequality of age of consent, young people who are sexually active are reluctant to access sexual health services including HIV and other STI testing and preventative health education for fear of being prosecuted.*

*One of the significant barriers to accessing healthcare for LGBTI people is disclosure of gender identity or sexuality. Clinicians, healthcare workers, youth workers and health promotion officers spend a lot of time developing rapport with young LGBTI people, and it is only through this rapport being built that disclosure of complex issues relating to sexuality or gender identity is possible.*

*The barrier placed by unequal age of consent, the barrier of "fear of prosecution", significantly reduces rapport between health care workers and community, and therefore reduces the ability to provide appropriate healthcare for LGBTI community.*

The Council raised another area in which the current law can have adverse health impacts – regarding mental health:

*In addition to placing a barrier to accessing sexual health care, the unequal age of consent significantly damages the mental health of LGBTI young people. The inequality of age of consent signals to young people that engaging in anal sex is dirty, taboo, or dangerous and should only be practised by people older than themselves. It signals therefore that young LGBTI people engaging in anal sex themselves are dirty, the behaviour should be kept a secret, and that sexual health should not be discussed until the young person reaches the age of consent.*

In supporting the proposed amendment, the LGBTI Legal Service Inc. advised:<sup>13</sup>

*We agree that the proposed amendments appropriately omit or amend all references to section 208 of the Criminal Code, which has the consequential effect of abolishing unequal age of consent laws in Queensland. As such, we support the proposed drafting. We also consider that all necessary amendments to associated legislation have been appropriately identified and addressed in the Bill.*

The Queensland AIDS Council made identical statements regarding the sufficiency of the drafting.<sup>14</sup>

### **Terminology – removing references to ‘sodomy’**

As noted above, the expert panel considered that using the term ‘sodomy’ may stigmatise anal intercourse, and homosexual relationships in particular. The panel therefore recommended the

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<sup>11</sup> Submission 9.

<sup>12</sup> Submission 9.

<sup>13</sup> Submission 17.

<sup>14</sup> Submission 9.

Criminal Code be amended to replace references to 'sodomy' with 'anal intercourse'. The Bill aims to give effect to this recommendation

The committee received no submissions opposed to the amendment that would remove references to 'sodomy' in the Criminal Code. A number of submissions supported the amendment.

The LGBTI Legal Service Inc. noted that language within legislation plays an important role in defining social values and community acceptance of LGBTI people, and stated:<sup>15</sup>

*.... the word 'sodomy' has overtones of moral condemnation and carries negative connotations. As such, we strongly support the Parliament's proposed amendments to remove all references to 'sodomy' in Queensland's law, and agree that any necessary references to anal intercourse should be made using more appropriate and specific language. As such, the LGBTI Legal Service fully supports the proposed replacement of the word 'sodomy' with 'anal intercourse' within the legislation.*

Similarly, the Queensland AIDS Council submitted that the term 'sodomy' had:<sup>16</sup>

*... connotations of outdated laws and moral standards that Queenslanders have moved from many years ago. It reinforces negative connotations around anal sex – suggesting that anal sex is taboo or dirty. Instead the use of the term "anal intercourse" provides an opportunity to discuss anal sex in a way that is not stigmatized, particularly where anal sex is consensual, enjoyable, and a form of expression of love between adults.*

### **Committee comment**

The proposed amendments to standardise the age of consent will bring Queensland into line with all other Australian jurisdictions. The current position is discriminatory in practice. The committee also believes the change will remove potential barriers to young gay men seeking health advice, and will remove a stigmatising effect. There is some anecdotal evidence that the current law is not enforced.<sup>17</sup>

The committee supports standardising the age of consent. The committee also supports the proposed amendments to remove references to 'sodomy' in the Criminal Code.

## **2.2 Hospitals and Health Boards Act 2011**

### **2.2.1 Proposed amendments – access to *The Viewer***

These amendments are aimed at facilitating general practitioners having access to the Queensland Health database *The Viewer* and 'to enable more efficient disclosure of confidential patient information for research purposes.'<sup>18</sup>

*The Viewer* is a Queensland Health database where information about patients is stored on a read-only, web-based platform. The information includes the patient's name, address and demographic information, admission and discharge history, pathology and medical imaging reports, and other information relating to their medical history. *The Viewer* is currently available to authorised Queensland Health clinical and support staff. Each user has individual user logins and access activity is recorded and audited.<sup>19</sup>

Currently, the confidentiality provisions in section 142 and ancillary provisions of the *Hospitals and Health Boards Act 2011* restrict access to *The Viewer*. The Bill (clauses 17 to 24) proposes amendments to the Act to allow access by general practitioners.

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<sup>15</sup> Submission 17.

<sup>16</sup> Submission 9.

<sup>17</sup> LGBTI Legal Service, public hearing transcript, page 17.

<sup>18</sup> Explanatory notes, page 5.

<sup>19</sup> Explanatory notes, page 2.



## Consultation

The explanatory notes state that the proposal to provide GPs with access to *The Viewer* was considered as part of a summit held on 29 April 2015 and 7 October 2015 to address the issue of patient wait times. Summit participants included representatives from Health Consumers Queensland, The Royal Australian College of General Practitioners – Queensland Faculty, the Australian Medical Association Queensland and various Primary Health Networks including Greater Metro South Primary Health Network and Brisbane North Primary Health Network. Summit participants endorsed the recommendation to provide GP access to *The Viewer*. The Queensland Clinical Senate was consulted further in relation to this proposal and was strongly supportive. Hospital and Health Services were consulted in relation to this proposal. The feedback received was supportive of the amendments.<sup>20</sup>

The OIC was consulted in relation to the privacy aspects of the proposal. OIC supports the policy intent of the proposal, while noting that it will create a privacy vulnerability that did not exist previously. OIC supports the proposed safeguards to ensure patients' personal information is protected.<sup>21</sup>

## The amendments

The proposed amendments would allow a general practitioner to access *The Viewer* to see a patient's information, such as public hospital medical records, including for example pathology and radiology tests reports.

The explanatory notes state this would improve collaboration between different parts of the health system and would assist consistent, timely and more coordinated patient care, and give an example:<sup>22</sup>

*... where a patient attends an emergency department after hours and is instructed to follow up with their GP for further treatment or care, the GP will be able to access the relevant admission and discharge, pathology and imaging reports to ensure appropriate care is provided and only appropriate outpatient referrals are made. GPs will be able to see the results of pathology and other tests already performed at the hospital and avoid unnecessarily repeating tests.*

According to the explanatory notes, it is understood that Queensland would be the first jurisdiction in the country to do this.<sup>23</sup>

This approach was supported by a number of submitters. The Australian Medical Association Queensland advised the committee of its support:<sup>24</sup>

*AMA Queensland welcomes moves that would allow a General Practitioners (GP) to access the Queensland Health Viewer database. Continuity of care is an important principle in the delivery of health in Australia and these amendments will help reduce fragmentation of care.*

Medical defence organisation and medical indemnity insurer, Medical Insurance Group Australia (MIGA) observed:<sup>25</sup>

*MIGA sees the crucial importance of clear and timely clinical information being available to a patient's treating practitioners. This ensures a continuity of care which is as seamless as possible, minimising the risk of important clinical information, which could impact advice and decisions relating to a patient's clinical condition, not being known by key practitioners involved in their care.*

<sup>20</sup> Explanatory notes, page 14.

<sup>21</sup> Explanatory notes, page 14.

<sup>22</sup> Explanatory notes, page 3.

<sup>23</sup> Explanatory notes, page 16.

<sup>24</sup> Submission16.

<sup>25</sup> Submission 6.

*MIGA supports sensible approaches, like this proposal, towards ensuring an appropriate flow of clinical information, particularly electronically, amongst health professionals.*

Palliative Care Queensland also supported the proposal, noting that the current use of hard copy documentation, and outdated methods of communication from tertiary providers, such as faxing can be problematic and can lead to delays in treatment and care.<sup>26</sup>

#### **Possible privacy concerns, the need for education**

As mentioned earlier, the OIC was consulted on privacy aspects and supported the policy intent, however noted that it will create a new 'privacy vulnerability'. The OIC supports the proposed privacy safeguards.

In introducing the Bill, the Minister for Health and Minister for Ambulance Services, the Hon. Cameron Dick MP, stated:<sup>27</sup>

*Appropriate safeguards will be in place to ensure the privacy of patient information. It is intended the system will require the health practitioner to search by a unique identifier such as the patient's Medicare number. The system will involve regular monitoring and audits.*

It will be an offence to access information unless access is for the purpose of providing care or treatment to a patient or incidental to that purpose. It will also be an offence to disclose information obtained by accessing the database, unless authorised under the *Hospital and Health Boards Act*. Both offences carry a penalty of 600 penalty units, currently equivalent to \$73,140.

As alluded to by the Minister, safeguards will be built into *The Viewer* itself. The system will require health practitioners to provide a combination of unique identifiers before accessing a patient's information, such as a patient's healthcare identifier through the validation of their Medicare number along with their date of birth. Requiring this combination of detail will help to prevent unauthorised access. Access to the system is logged and Queensland Health will undertake regular monitoring and auditing.<sup>28</sup>

The committee explored issues of privacy during the public briefing with departmental representatives. The committee was advised by Queensland Health:<sup>29</sup>

*... aside from the offence provision ... there are other potential serious consequences of misuse. GPs are subject to the Health Practitioner National Regulation Law. Under that national law, a GP could also be subject to disciplinary action. GPs are also subject to the Australian privacy principles under the Commonwealth Privacy Act, so potentially a privacy complaint could also be made under that act. We have considered the penalty units in our own act that would work in concert with the existing regulatory arrangements for the profession.*

Arising at least in part from privacy issues, some submitters noted the importance of education in using the system. MIGA noted:<sup>30</sup>

*... it would be important for participating general practitioners to be educated about their obligations. This could be achieved via guidelines or other information made available to them before they commence using the system.*

Health Consumers Queensland urged that there be targeted education and training of all health professionals (including registrars in hospitals) to ensure important information is uploaded.<sup>31</sup>

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<sup>26</sup> Submission 15.

<sup>27</sup> Explanatory speech, Hansard 16 June 2016, page 2420.

<sup>28</sup> Queensland Health, public briefing 11 July 2016, transcript, page 2.

<sup>29</sup> Queensland Health, public briefing 11 July 2016, transcript, page 3.

<sup>30</sup> Submission 6.

<sup>31</sup> Submission 6.

Queensland Health acknowledged the importance of education on using *The Viewer*. It advised that when a practitioner is registered to use *The Viewer*, they would be provided with guidelines and instructions on how to use the system. In addition, awareness and education will be extended to Hospital and Health Services, Primary Health Networks, GPs, the general public and other appropriate stakeholders.<sup>32</sup> Regarding privacy aspects, users are advised of the potential penalties for misuse and the terms and conditions of use. The terms and conditions are also presented on each occasion, before a user can enter the system.

During the committee's inquiry, we heard suggestions for a broadening of the scope of the access in a number of respects, including to:

- allow practitioners to upload data to the database
- extend access to health practitioners other than general practitioners
- allow disclosure to professional indemnity insurers and lawyers.

### **Uploading of data**

The Australian Medical Association Queensland advised that it believed it is important that GPs be given the ability to upload data to the system, in addition to having access to read data:<sup>33</sup>

*One area where we believe this is particularly important is in end-of-life care. If a patient has an advanced health directive, or has completed a Statement of Choices, it is important that health practitioners working in the public hospital system have access to the most up-to-date version of that document, particularly given statistics that show only 14 percent of Australians die at home. If a patient updates this document at a GPs office, currently there is a convoluted [and] slow process that must be followed to ensure this information is reflected in the Viewer.*

*If a GP was able to update this information directly, this would obviously simplify the process significantly and would ensure that a patient's wishes are followed.*

*We appreciate that this is currently out of the scope of the proposed legislation but we would like to ensure the Government understands the importance of working towards this goal.*

In response, Queensland Health advised that, as *The Viewer* is a read-only, web-based application that displays patient information consolidated from other information systems, its initial focus is providing general practitioners with read-only access. Queensland Health noted that the system could be extended in the future to allow general practitioners and other health practitioners to upload their patient information into the system.<sup>34</sup>

### **Extending access to other health practitioners**

Health Consumers Queensland advocated for access to *The Viewer* to be extended to nurses, midwives and allied health professionals. It argued that:<sup>35</sup>

*An up-to-date and accurate shared health record ensures more connected health care, reduces the unnecessary duplication of tests and procedures and ensures important information such as test results, allergies, conditions, medications can be seen by all relevant health professionals.*

Palliative Care Queensland also urged extending access to other providers, making particular reference to the fact that there can be a range of different physical settings for palliative care:<sup>36</sup>

<sup>32</sup> Queensland Health, response to submissions, page 18.

<sup>33</sup> Submission 16.

<sup>34</sup> Queensland Health, response to submissions, page 14.

<sup>35</sup> Submission 21.

<sup>36</sup> Submission 15.

*.... providing access to The Viewer, will provide accurate and timelier access to information, and will result in improved communication and care.*

*Palliative care in Queensland occurs in all settings of care, including hospitals (public and private), community and residential aged care. The care of patients in the last twelve months of life is often shared across several settings. For example a patient with a diagnosis of advanced cancer may be receiving palliative chemotherapy in a private hospital setting, have specialist palliative care outpatient appointments at a public hospital setting, whilst having home visits by the General Practitioner and a non-Government primary care nursing service in order to meet their needs. PCQ recommends the Government consider extending access to The Viewer to private hospitals with shared care agreements, primary care providers and residential aged care facilities (with appropriate safeguards in place).*

In response, Queensland Health noted that nurses, midwives and allied health practitioners who are employed by Queensland Health to provide clinical care may already have access to *The Viewer*.<sup>37</sup> Under the proposal in the Bill, access would not be dependent on the type of facility, but rather the type of practitioner – a general practitioner could access *The Viewer*, regardless of where they worked. Other categories of health practitioners may also be able to access *The Viewer*, if prescribed in the future:

*The Bill will enable prescribed health practitioners—that is, a health practitioner registered under the Health Practitioner Regulation National Law (the National Law)—to access prescribed information systems such as The Viewer. It is initially intended to prescribe GPs for the purposes of accessing The Viewer. As nurses, midwives and a range of allied health professionals are registered health practitioners under the National Law, these categories of health practitioners could be prescribed under a regulation. Consideration will be given to whether these further categories of health practitioners should be prescribed in future.*

#### **Other issues**

Health Consumers Queensland suggested that data in *The Viewer* could be added to the individual patient's My Health Record:<sup>38</sup>

*We recognise that the structure of My Health Record does not lie with the Queensland Health department, but we always encourage sharing and collaboration so we can move forward and end up with an electronic health record for all Australians which is actually meaningful and is going to contribute to the safety and quality of our care.*

Queensland Health advised that it supported consideration being given to mechanisms to increase the uploading of information to a patient's My Health Record, noting that My Health record is a matter for the Federal government.<sup>39</sup>

MIGA urged an amendment to allow disclosure of information to professional indemnity insurers and lawyers, on the basis that:<sup>40</sup>

*There may be claims, complaints or other circumstances which could arise from, or otherwise relate to, use of the new system, that require health practitioners to either notify, or seek advice from, their professional indemnity insurer or another independent lawyer.*

MIGA proposed that section 158 of the Act be amended:

*to provide that any relevant health practitioner, whether a designated person or prescribed health practitioner, can disclose confidential information to their professional indemnity*

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<sup>37</sup> Queensland Health, response to submissions, pages 12 and 17.

<sup>38</sup> Public hearing transcript, page 14, and see submission 21.

<sup>39</sup> Queensland Health, response to submissions, page 18.

<sup>40</sup> Submission 6, page 2.

*insurer or a lawyer in relation to a matter for the purposes of notifying a potential claim or complaint, or for seeking legal advice.*

Section 158 deals with disclosure to lawyers and currently provides:

*A relevant chief executive may disclose confidential information if—*

- (a) the disclosure is to a lawyer in relation to a matter; and*
- (b) the lawyer is representing the State or a Service in relation to the matter.*

In responding to this concern, Queensland Health stated:<sup>41</sup>

*.... the issue of enabling prescribed health practitioners and designated persons to disclose confidential information to a professional indemnity insurer or lawyer is beyond the scope of the Bill.*

*Further consideration will be given to the issues raised by MIGA.*

### **2.2.2 Committee comment**

The committee supports the proposed amendment. Appropriate education in effective and permissible use of the system is vitally important, particularly noting the sensitive and personal nature of much of the information and the privacy concerns involved. The committee notes the response from Queensland Health to the concerns raised regarding privacy.

The suggested extensions of the scheme to allow access by other health practitioners and to permit practitioners to have more than read-only access have merit, and the committee notes there is provision for future expansion in these respects.

### **2.2.3 Proposed amendments – data for research purposes**

According to the explanatory notes, these amendments have been progressed at the request of the Australian Medical Association Queensland, which identified a legislative barrier to researchers' ability to efficiently gain access to patient information for research purposes where patients do not have capacity to consent.

A complex legislative framework currently exists for gaining access to patient information in these circumstances. The duty of confidentiality in section 142 of the *Hospital and Health Boards Act* prohibits *designated persons* from disclosing patient information to another person, except in prescribed circumstances. The circumstances currently prescribed under part 7 do not specifically include disclosing patient information for research purposes.

### **Consultation**

As well as the Australian Medical Association Queensland, researchers have been consulted and their feedback has been reflected in the Bill. Hospital and Health Services were consulted in relation to this proposal. The feedback received was supportive of the amendments. OIC was consulted in relation to the privacy aspects of the proposal. No significant privacy implications were identified.<sup>42</sup>

According to the explanatory notes, this application process is an unnecessary burden in instances where a patient is unable to provide consent for researchers to access their information but the research project has met a number of other requirements, including that:

- the research has ethics approval
- commencement of the project has been authorised by the relevant chief executive in accordance with administrative requirements within Queensland Health, and

<sup>41</sup> Queensland Health, response to submissions, page 3.

<sup>42</sup> Explanatory notes, page 15.

- the patient's participation in the research has been approved under a substitute decision-making framework.

The Australian Medical Association Queensland raised concerns that the current *Public Health Act* application process may delay or temporarily suspend research projects. The explanatory notes set out the current process:<sup>43</sup>

*To undertake medical research, researchers are required to meet a number of requirements, including that the research project is submitted for review by a Human Research Ethics Committee or, in the case of low and negligible risk research, a Human Research Ethics Committee or another review body. Once the project is approved, a research governance review is undertaken within the Department of Health or Hospital and Health Service where the project is to be carried out. This ensures the regulatory, budgetary, and contractual requirements have been addressed, that the appropriate head of department and heads of supporting departments have indicated their awareness of and support of the project, and that any other site specific issue are dealt with. Once the research governance review is complete, the research project is authorised to commence at that site by the relevant chief executive.*

The Bill amends the *Hospital and Health Boards Act* to enable more efficient disclosure of patient information for research purposes. The amendments remove the need for researchers to undertake the *Public Health Act* application process to obtain a patient's confidential information in the above circumstances, while ensuring other appropriate approvals and authorisations in relation to the research have been obtained.

#### **Issues raised in the inquiry**

The Australian Medical Association Queensland advised the committee of its support for the amendment:<sup>44</sup>

*It is our understanding that the process outlined under s150A(1) is reflective of the current procedure for granting research approval after going through ethics and the research governance process. AMA Queensland has no concerns with this part of the Health and Other Legislation Amendment Bill 2016.*

*In regards to the example listed after 150A(2)(c), AMA Queensland is also pleased with this amendment. As this amendment was required due to issues arising as a result of next of kin not being able to consent to research on behalf of a person with impaired capacity, the direct reference to the Statutory Health Attorney should help clarify and simplify the matter in future cases.*

Palliative Care Queensland opposed the amendment:<sup>45</sup>

*PCQ does not support streamlining the existing process relating to disclosure of confidential information for research purposes where the adult patient is unable to consent to the disclosure of information.*

*PCQ understands the following:*

*The proposed amendments permit "designated persons" and "prescribed health practitioners" to disclose what would otherwise be strictly confidential health information about patients within prescribed guidelines and to access a database containing such information where such information is necessary for the treatment of a patient.*

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<sup>43</sup> Explanatory notes, page 4.

<sup>44</sup> Submission 16.

<sup>45</sup> Submission 15.

*Disclosure can occur where the CEO authorises such disclosure, where such disclosure is necessary to protect a child or where the CEO otherwise authorises it in writing. Disclosure can also occur where the CEO gives written approval to a researcher to carry out research. A designated person can also disclose such information to a researcher.*

*At this stage, PCQ is concerned that the Regulations which will accompany the Act are not available for review, specifically whether the Regulations provide more stringent guidelines on the use of the confidential information or indeed who can become a designated person. Whilst the Bill lists a long list of people who can become designated persons, there is no detail available regarding how the process of selecting a designated person will be carried out, and what persons are (or should be) excluded from being selected. This is an important detail, as the magnitude of the potential for patient harm (via the disclosure of personal health information) is high and whilst the Minister talks about “appropriate safeguards”, the details are lacking.*

*From PCQ’s point of view, the amendments of the Act which relate to the disclosure of information where patients are unable to consent to such disclosure is an important feature. This amendment is likely to intersect and potentially come into conflict with elderly patients who have General Powers of Attorney. Whilst the Bill addresses this issue by requiring that the “substituted decision maker” must consent to such disclosure of information, there is potential there for practical conflicts to arise between the health practitioner and the substituted decision maker.*

*PCQ recommends that the Government publish further detail in relation to the above prior to amending the Hospital and Health Boards Act 2011*

Regarding these issues, Queensland Health observed:<sup>46</sup>

- *The amendment to enable disclosure of patient information for research purposes will not increase access to any particular Queensland Health database. The amendment removes the need for a researcher to obtain an additional approval under the Public Health Act for disclosure of patient information where a patient is unable to provide consent, and the research project has met a number of other requirements.*
- *The ability for the chief executive to authorise disclosure of information to protect a child is not linked to the research amendment. The Hospital and Health Boards Act already enables a designated person to disclose confidential information where it is necessary to protect a child. The Bill extends this provision to enable prescribed health practitioners (for example, GPs) to disclose confidential information where it is necessary to protect a child and the chief executive has authorised the disclosure.*
- *The Bill enables designated persons to disclose confidential information about a person for the purpose of conducting research, where a number of conditions are met. Designated person is defined in new section 139A of the Act and includes public service employee, a health service employee or volunteer. No further categories of designated persons are prescribed under the Hospital and Health Boards Regulation 2012.*

In its written submission, Health Consumers Queensland opposed the amendment, on the basis that:

*The rights of consumers, particularly those who are most vulnerable (who may not have capacity to consent) ... need more consideration than just ethics approval and approval for commencement of a research project.’*

<sup>46</sup> Queensland Health, response to submissions, page 13.

Subsequently, Health Consumers Queensland advised that, having received further information, it supported the proposed amendment:<sup>47</sup>

*.... we are now supportive of this moving forward. We understand that Queensland is the only jurisdiction in Australia that does not have this ease of access to all patient information and we would support that happening within the existing protections that exist.*

**Committee comment**

The committee supports the amendment.

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<sup>47</sup> Public hearing transcript, page 14.



## 2.3 Public Health Act 2005

### 2.3.1 Proposed amendments – deceased patient data

#### Proposed amendments

This amendment to the *Public Health Act 2005* also concerns applications for accessing confidential information. Researchers seek access to historical patient information, including information relating to deceased patients for research purposes including, for example, studies requiring information relating to factors contributing to causes of death. The current confidentiality constraints apply where a patient is deceased.

Section 142(3) of the *Hospital and Health Boards Act* provides that the duty of confidentiality in relation to patient information applies even if the patient is deceased. However, the definition of *health information held by a health agency* under the *Public Health Act* does not clearly relate to both living and deceased patients as it refers to ‘a person’. It is currently unclear whether, in referring to a ‘person’ the relevant definition extends to deceased persons.<sup>48</sup> As a result, it is unclear whether a researcher is able to obtain information relating to deceased patients through the *Public Health Act* application process outlined above.<sup>49</sup>

The proposal is to make a minor amendment to the *Public Health Act* to clarify that the definition of *health information held by a health agency* includes the information of both living and deceased persons. This supports the above amendment to the *Hospital and Health Boards Act* to enable more efficient disclosure of patient information for research purposes.

#### Consultation

Hospital and Health Services were consulted in relation to this proposal. No feedback was received. The explanatory notes advise that when consulted on privacy aspects of the proposed amendment, the OIC noted that care should be taken when handling the information of a deceased person, as it ‘may also be the personal information of the living, for example, a family member.’ The explanatory notes record that disclosure of this information will be subject to the stringent requirements of the Act, including privacy considerations.<sup>50</sup>

#### Committee comment

This proposed amendment was not addressed in any detail in submissions to the inquiry, though some submitters briefly indicated their support. (None were opposed.) The committee supports the amendment.

### 2.3.2 Proposed amendments – dental and vaccination records

#### Proposed amendments

According to the explanatory notes, a ‘substantial number’ of the parental consent forms required to authorise student vaccination are not being returned. Vaccination rates are below the target. Also, consent levels for participation in the school dental scheme are declining. The amendment would allow school principals (and delegates) to disclose student information to immunisation or oral health service providers to allow providers to:

- follow up with parents where consent forms are not returned
- reconcile returned forms against all eligible students

<sup>48</sup> *Person* is defined in the *Acts Interpretation Act 1954* to include an individual and corporation, with an *individual* defined to mean a natural person. The term natural person is generally understood to relate only to living persons.

<sup>49</sup> Explanatory notes, page 5.

<sup>50</sup> Explanatory notes, page 15.

- make informed decisions on future strategies to improve consent rates from certain cohorts (for example, Indigenous or CALD students) if need be.

The OIC was consulted on privacy aspects and ‘no significant privacy concerns’ were identified.<sup>51</sup>

### **Consultation**

Targeted consultation was undertaken with Independent Schools Queensland, the Queensland Catholic Education Commission and state school principal and school administrator associations. No feedback was received from the state school sector. Independent Schools Queensland and the Queensland Catholic Education Commission support the proposal in-principle, but explained that disclosure of student information would be a shift in practice for school principals. Hospital and Health Services were consulted and the feedback received was supportive of the amendments.

OIC was consulted in relation to the privacy aspects of the proposal. No significant privacy concerns were identified.<sup>52</sup>

### **Position in other jurisdictions**

According to the explanatory notes, it is understood a number of other jurisdictions allow immunisation and oral health providers to access student information, as follows:<sup>53</sup>

- In 2013, Victoria amended the Public Health and Wellbeing Regulations 2009 to enable secondary school principals to share student information with school immunisation providers which, in Victoria, is undertaken by local councils. Information able to be disclosed includes the student’s name, the name of their parent or guardian and the parent or guardian’s telephone number, email address and postal address.
- In Tasmania, local councils deliver school based immunisation programs under the *Public Health Act 1997*, which provides that a local council may require a person to provide information relating to public health which is reasonably needed for the purposes of the Act. This enables local councils to require schools to provide student information for the purposes of a school based immunisation program.
- In Western Australia, the Department of Health and Department of Education share the information of state school students for the purposes of providing school immunisation services and for the purposes of the school dental program.
- The Northern Territory has administrative arrangements in place for the sharing of student information for the school immunisation program. Schools share student information with school nurses, who are employed by the Department of Health to work in schools.
- New South Wales, South Australia and the Australian Capital Territory have no legislation in place to provide for sharing of student information to support immunisation or school dental programs.

The Australian Medical Association Queensland expressed support for the amendments which allow schools to share student information with school immunisation providers.<sup>54</sup>

Health Consumers Queensland supported the proposals.<sup>55</sup>

*Particularly in any public health campaign that seeks to increase immunisation rates, it is important that all parents (including those from an Aboriginal and/or Torres Strait Islander or culturally and linguistically diverse background) can have open discussions with health care providers, their*

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<sup>51</sup> Explanatory notes, page 15.

<sup>52</sup> Explanatory notes, page 15.

<sup>53</sup> Explanatory notes, page 16.

<sup>54</sup> Australian Medical Association Queensland, submission 16.

<sup>55</sup> Submission 21.

*concerns listened to, they be given evidence based information and then supported to make informed decisions.*

Both the Queensland Catholic Education Commission and Independent Schools Queensland expressed broad support for the intent of the amendments, but raised a number of concerns going to issues of privacy and administrative burdens. Independent Schools Queensland described it as adding an additional administrative burden on schools on top of what is already a very laborious task. It raised concerns regarding some specific aspects:<sup>56</sup>

- the need for the delivery and format of the data to accommodate a range of different data management systems across different schools.
- clarification of how discrepancies in the data will be managed due to the time lag between the initial transfer of data and delivery of the program.
- the need to resolve uncertainty as to how the data is to be stored and destroyed during and after its use.

The Queensland Catholic Education Commission raised similar concerns regarding the impost being placed on schools, and suggested that a review of the impact of the changes be mandated.<sup>57</sup>

In response, Queensland Health advised that such issues would be addressed in supporting resources and communication materials.<sup>58</sup> It acknowledged that, given the number of schools and service providers involved, a one size fits all approach would not work, and providers would need to work with schools to determine an acceptable format. Student information may be transferred to the providers in a format convenient to the schools. Ideally, this will be in electronic form. If the format is unusable, the providers will work with the schools to achieve a mutually agreeable format. In addition, in relation to concerns regarding the administrative burden on schools, there will be a phased implementation, with disclosure of student information for the immunisation program being required in 2017 (year 7 cohort only) and disclosure for the School Dental Program being required from 2018.<sup>59</sup>

For the latter, the preferred model will link providers directly with parents and guardians once the demographic information has been provided, minimising the role of schools in the provision of services, and reducing their administrative burden.

Independent Schools Queensland advised:<sup>60</sup>

*These concerns include the initial disclosure of information and the continued storage and destruction of the disclosed information. This will be the first time independent schools have been required to provide identified data, without explicit consent from parents and caregivers, to an external agency. This ... will require appropriate supporting documentation to evidence the requirement and ample notification time to advise the parent body.*

Responding to concerns regarding storage and destruction of data, Queensland Health advised:<sup>61</sup>

*All providers will be bound to comply with either the National Privacy Principles or Information Privacy Principles in the Information Privacy Act. School health providers must store and dispose of disclosed student information in accordance with the Queensland State Archive guidelines. School health providers will be required to securely dispose of disclosed student information when the information is no longer required. It is anticipated that no disclosed data would be required for the School Immunisation Program beyond the end of a school year. For the school dental program, the*

<sup>56</sup> Submission 19.

<sup>57</sup> Submission 8.

<sup>58</sup> Queensland Health, response to submissions, page 14.

<sup>59</sup> Queensland Health, response to submissions, page 15-16.

<sup>60</sup> Submission 19.

<sup>61</sup> Queensland Health, response to submissions, page 16.

*information would be required until school dental services have completed delivery of care to the school cohort.*

Queensland Health responded that its understanding was that disclosure of student information relating to Indigenous status would be an authorised disclosure for the purposes of the Australian Privacy Principles as Australian Privacy Principles 6.2(b) provides that an Australian Privacy Principle entity may use or disclose information for a secondary purpose if the use or disclosure is required or authorised by or under an Australian law, which would include the *Public Health Act*.

At the public hearing, Independent Schools Queensland described this response from Queensland Health as providing ‘some level of reassurance’. At the same time it observed that the response: <sup>62</sup>

*... does highlight the complexity of the issues involved here and the complexity of those intended actions... Queensland Health response should give the committee an insight into the significant administrative burden that will be placed on schools through this legislation.*

*... it would be great if we were able to advise schools that we have looked at all possible alternative strategies rather than the proposed legislation. In this regard I hope the committee will give consideration to our concerns and perhaps give an assurance that alternative strategies have been considered.*

Independent Schools Queensland raised a specific concern regarding records of Indigenous students:

*Particular concern is given to the disclosure of Indigenous status under 213AD (1)c and the exemptions that may safeguard this provision. ISQ represents a number of Indigenous boarding schools that house students from very isolated and remote communities. The communication with parents and guardians is often difficult due the constraints of geography and technology. It is with this in mind that ISQ frames its concern about the disclosure of Indigenous status.*

*Indigenous status is considered ‘sensitive Information’ under the Privacy Act 1988 (Cth). ISQ recognises the disclosure of sensitive information without consent is allowed where required or authorised by law (APP 6.2(b)). However, the disclosure of Indigenous status from parents on behalf of students is often provided with specific instructions around the purposes of use. This permission may or may not be given for cultural purposes. Identified disclosure of Indigenous status without consent is highly culturally sensitive and could unduly place principals in a problematic position. Under 213AD(3), exemptions are outlined where disclosure would not be in the best interests of the child. ISQ is of the belief that the prescribed exemption does not give sufficient scope to an independent school principal to allow an exception to this requirement based on cultural reasons or parental/guardian choice.*

At the public hearing, Independent Schools Queensland stated:<sup>63</sup>

*one of the issues we were raising here is the difficulty for our Indigenous schools in particular around communicating with parents. Many of the Indigenous students at our main Indigenous schools actually come from the cape, so they are either boarding or homestayng or whatever. Without making any reflections, some Indigenous communities are difficult in terms of communicating with from a school perspective.*

According to Queensland Health, whilst disclosure of a student’s indigenous status is not a requirement under the Bill, it is anticipated that information to be prescribed under a regulation may include indigenous status. Disclosure of indigenous status would allow the Department to make informed decisions about future strategies to improve consent form return rates, for example, consider the impact of cultural or language issues.<sup>64</sup>

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<sup>62</sup> Public hearing transcript, page 7.

<sup>63</sup> Public hearing transcript, page 9.

<sup>64</sup> Queensland Health, response to submissions, page 15.

### Committee comment

The committee notes the concerns raised by Independent Schools Queensland and Queensland Catholic Education Commission. The committee is encouraged by the response from Queensland Health and its reference to providing supporting resources and communication and marketing materials. The committee sees the administrative burden on schools as not insignificant and it is important that there be close collaboration to minimise this burden as much as possible. It is critical that the department ensures it works closely with schools on communication and implementation to ensure an optimal outcome as effectively as possible.

The committee supports the amendment.

## 2.4 Amendments to the *Queensland Institute of Medical Research Act 1945*

### Proposed amendments

The *Queensland Institute of Medical Research Act 1945* establishes the Queensland Institute of Medical Research (QIMR). Currently, that Act provides (in section 19) that the Council (of QIMR) may pay to successful discoverers or inventors working as officers and employees or under the auspices of the Council 'such bonuses 'as the Governor in Council determines'.

Part 5 of the Bill would replace section 19 with a new provision which, in effect removes the requirement for a determination by Governor in Council for the payment of a bonus, unless the total paid in any one financial year exceeds \$10 million. Prior Governor in Council approval will be required once the annual limit exceed \$10 million.

The new provision also changes the description slightly to cover a discoverer or inventor working, *or who has worked*, as officers and employees or under the auspices of the Council. [Emphasis added]

According to the explanatory notes, the current provision impedes QIMR's ability to remunerate discoverers in a timely manner and to attract high-performing discoverers, that QIMR is committed to improving the translation of medical research discoveries into treatment, diagnosis and prevention strategies and to do so, QIMR must be able to attract and retain world leaders in medical research.<sup>65</sup> The amendment would give QIMR autonomy to manage bonuses as it determines up to the \$10 million cap, providing QIMR with a competitive edge for attracting and remunerating discoverers or inventors.<sup>66</sup>

The explanatory notes state that research institutes in other states can make distributions to inventors without needing to obtain Governor in Council approval, and specific mention is made of the position in:<sup>67</sup>

- New South Wales - where, under the *Garvan Institute of Medical Research Act 1984* (NSW), Board approval is not required, irrespective of the size of the payment to inventors. Any distributions that do occur are reported to the Finance, Risk and Audit Committee for noting.
- Victoria - where the Walter and Eliza Hall Medical Research Institute has an internal royalty policy that mandates the distributions to inventors. Distributions are uncapped. Any distribution to staff requires board approval and the Walter and Eliza Hall Medical Research Institute has a commercialisation committee to oversee key activities.

<sup>65</sup> Explanatory notes, page 6.

<sup>66</sup> Explanatory notes, page 6.

<sup>67</sup> Explanatory notes, page 17.

According to the explanatory notes, QIMR was consulted and supports the amendment.<sup>68</sup> Two submissions to the committee supported this amendment, with Health Consumers Queensland stating:<sup>69</sup>

*We support the motivation behind the proposed change ... in order [to] more easily attract and retain world-class researchers who can produce the best outcomes for Queensland research dollars. We would support bonuses being awarded within a clinical governance framework similar to that of the Walter and Eliza Hall Medical Research Institute, as cited in the Explanatory Notes to this Bill (Board approval and a commercialisation committee).*

**Committee comment**

The committee supports the proposed amendment.

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<sup>68</sup> Explanatory notes, page 15.

<sup>69</sup> Health Consumers Queensland, submission 21, page 8. Support for this amendment also came from the Public Health Association Australia (submission 18).

### 3. Compliance with the *Legislative Standards Act 1992*

Section 4 of the *Legislative Standards Act 1992* (LSA) states that ‘fundamental legislative principles’ are the ‘principles relating to legislation that underlie a parliamentary democracy based on the rule of law’. The principles include that legislation has sufficient regard to:

- the rights and liberties of individuals<sup>70</sup>
- the institution of parliament.<sup>71</sup>

The committee has examined the application of the fundamental legislative principles (FLPs) to the Bill. There are potential FLP issues in relation to clauses 25, 31 and 36. These are considered below.

Each clause raises the issue whether sufficient regard is had to the right and liberties of individuals. These three clauses could be considered to have insufficient regard to the rights and liberties of individuals as they facilitate or permit the disclosure of personal and confidential information in certain circumstances.

All of these clauses, the possible concerns regarding privacy, and views of submitters on those aspects have all been canvassed in some detail already in this report. The clauses contain various safeguards around access to, and use of, confidential or private information, as outlined above.

#### Summary of provisions

**Clause 25** inserts new section 150A into the *Hospital and Health Boards Act 2011* to allow for the disclosure of confidential information about a person for research purposes.

Various safeguards attach to section 150A, including that the ‘researcher’ has to have the written approval of the chief executive to conduct the research (150A(1)); the disclosure must be by a designated person to the researcher and only where the person/‘participant’ is an adult with impaired capacity for consenting to participate in the research and the tribunal under the *Guardianship and Administration Act 2000* or another person who is authorised to make decisions for the participant consents to the participant’s participation in the research.

**Clause 31** inserts new section 161C into the *Hospital and Health Boards Act 2011* to permit a prescribed health practitioner to access information (including confidential information) contained in a prescribed information system, where accessing such information is necessary for the health practitioner to facilitate the care or treatment of an individual, or such information is accessed incidentally whilst accessing information required for the care or treatment of the individual.

Conditions for accessing the information and information systems will be prescribed by regulation and general practitioner activity in *The Viewer* will be recorded and audited to ensure these conditions are met.

The Bill also provides that it is an offence for prescribed health practitioners to disclose confidential information, either directly or indirectly, unless the disclosure is required or permitted under the *Hospital and Health Boards Act 2011* (new section 142A(1)).

**Clause 36** inserts new chapter 5, part 4 into the *Public Health Act 2005* to allow for the disclosure of confidential information for school health programs such as immunisation and dental treatment programs. New section 213AD under part 4 will permit a school health program provider to ask a school principal for specified identifying information about students and their parent/guardian. The principal must disclose the information unless the principal considers the disclosure is not in the best interests of the student.

<sup>70</sup> *Legislative Standards Act 1992*, s 4(2)(a).

<sup>71</sup> *Legislative Standards Act 1992*, s 4(2)(b).

**Committee comment**

The explanatory notes advise in relation to clause 36 and the application of the Information Privacy Principles:<sup>72</sup>

*The type of information being disclosed under the provision is, for the most part, the same information included on the consent form, which the provider would have access to. Hospital and Health Services who deliver the programs directly are considered a health agency under the Information Privacy Act and are therefore bound to comply with the National Privacy Principles in discharging their obligations in relation to disclosure of information by schools. Some external immunisation providers, such as Brisbane City Council, may be an agency under the Information Privacy Act, and therefore bound to comply with the Information Privacy Principles. Others may be bound to comply with the Information Privacy Act by virtue of their contract with the Hospital and Health Services. However, to ensure that all external providers, as contracting agencies to Hospital and Health Services, are bound to comply with the privacy principles in discharging their obligations, the Information Privacy Act will be deemed to apply to a school health program provider that is not an agency under section 18 of the Information Privacy Act or a health agency under schedule 5 of the Information Privacy Act.*

On balance, and noting the various safeguards in place, the committee is of the view that the various public benefit considerations underpinning these clauses, outweigh concerns regarding potential risks arising from the inappropriate accessing or use of confidential information.

**New offence provisions**

The Bill contains the following new offence provisions:

| Clause | Offence   | Proposed maximum penalty |
|--------|---|--------------------------|
| 18     | <p><b>Amendment of <i>Hospital and Health Boards Act 2011</i>, new s 142A</b></p> <p><b>142A Confidential information must not be disclosed by prescribed health practitioners</b></p> <p>(1) A prescribed health practitioner must not disclose, directly or indirectly, confidential information to another person unless the disclosure is required or permitted under this Act.</p>   | 600 penalty units        |
| 31     | <p><b>Amendment of <i>Hospital and Health Boards Act 2011</i>, new s 161C</b></p> <p><b>161C Prescribed health practitioner may access prescribed information system and particular information</b></p> <p>(1) A prescribed health practitioner may access a prescribed information system.</p> <p>(2) A prescribed health practitioner must not access information contained in a prescribed information system unless –</p> <p>(a) the information is necessary for the prescribed health practitioner to facilitate the care or treatment of an individual; or</p> <p>(b) the prescribed health practitioner accesses the information incidentally while accessing information mentioned in paragraph (a).</p> |                          |

<sup>72</sup> Explanatory notes, page 12.



|  |   |  |
|--|---|--|
|  | (3) A prescribed health practitioner must comply with all conditions prescribed by regulation in relation to accessing a prescribed information system and any information contained in the system. | 600 penalty units<br><br>600 penalty units |
|--|---|--|

**Explanatory notes**

Part 4 of the *Legislative Standards Act 1992* relates to explanatory notes. It requires that an explanatory note be circulated when a Bill is introduced into the Legislative Assembly and sets out the information an explanatory note should contain.

Explanatory notes were tabled upon the introduction of the Bill. Explanatory notes were tabled with the introduction of the Bill. The notes are fairly detailed and contain the information required by Part 4 and a reasonable level of background information and commentary to facilitate understanding of the Bill's aims and origins.



**Appendix A – list of submissions**

| Number | Submitter   |
|--------|---|
| 01     | Queensland Nurses' Union                                      |
| 02     | John Frame  |
| 03     | Protect All Children Today Inc                                |
| 04     | Dr Wendell Rosevear   |
| 05     | Dr Neil Simmons   |
| 06     | Medical Insurance Group Australia                             |
| 07     | Queensland Family and Child Commission                        |
| 08     | Queensland Catholic Education Commission                      |
| 09     | Queensland Aids Council                                       |
| 10     | Dr David van Gend   |
| 11     | Anti-Discrimination Commission Queensland                     |
| 12     | Australian Law Reform Commission                              |
| 13     | Peter Black   |
| 14     | Alastair Lawrie   |
| 15     | Palliative Care Queensland                                    |
| 16     | Australian Medical Association Queensland                     |
| 17     | Lesbian Gay Bisexual Trans Intersex (LGBTI) Legal Service Inc |
| 18     | Public Health Association of Australia                        |
| 19     | Independent Schools Queensland                                |
| 20     | Caxton Legal Centre Incorporated                              |
| 21     | Health Consumers Queensland                                   |

## **Appendix B – witnesses**

### **Public Briefing – Brisbane, 11 July 2016**

#### *Queensland Health*

Forrester, Ms Kathleen, Deputy Director-General; Strategy, Policy and Planning Division; Department of Health

Harmer, Mr David, Acting Executive Director, Strategic Policy and Legislation Branch, Department of Health

Law, Ms Kirsten, Acting Director, Legislative Policy Unit, Department of Health

#### *Department of Justice and Attorney-General*

Hughes, Ms Jo, Acting Principal Legal Officer, Strategic Policy, Department of Justice and Attorney-General

Shephard, Ms Louise, Director, Strategic Policy, Department of Justice and Attorney-General

### **Public Hearing – Brisbane, 17 August 2016**

Dr Wendell Rosevear

Dr Neil Simmons

Ms Mandy Anderson, Director of Education, Queensland Catholic Education Commission

Mr David Robertson, Executive Director, Independent Schools Queensland

Dr David van Gend

Ms Melissa Fox, General Manager, Health Consumers Queensland

Ms Matilda Alexander, LGBTI Legal Service

Mr Michael Scott, Executive Director, Queensland AIDS Council