Parliamentary Committees



Health and Other Legislation Amendment Bill 2018

Report No. 18, 56th Parliament
Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
February 2019

Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee

Chair	Mr Aaron Harper MP, Member for Thuringowa
	Mr Joe Kelly MP, Member for Greenslopes (Acting Chair, 31 January to 8 February 2019)
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Members	Mr Michael Berkman MP, Member for Maiwar
	Mr Martin Hunt MP, Member for Nicklin
	Mr Barry O'Rourke MP, Member for Rockhampton
	Ms Joan Pease MP, Member for Lytton

Committee Secretariat

Telephone	+61 7 3553 6626
Fax	+61 7 3553 6699
Email	health@parliament.qld.gov.au
Technical Scrutiny Secretariat	+61 7 3553 6601
Committee Web Page	www.parliament.qld.gov.au/Health

Acknowledgements

The committee acknowledges the assistance provided by Queensland Health and the Department of Housing and Public Works.

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Abbreviations

ACRRM	Australian College of Rural and Remote Medicine
ADAQ	Australian Dental Association, Queensland Branch
AFOEM	Australasian Faculty of Occupational and Environmental Medicine
AMA Queensland	Australian Medical Association, Queensland Branch
BDMR Act	*Births, Deaths and Marriages Registration Act 2003*
Bill	Health and Other Legislation Amendment Bill 2018
CMDLD	Coal mine dust lung disease
committee	Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee
Coroners Act	*Coroners Act 2003*
Cremations Act	*Cremations Act 2003*
CWP	Coal workers' pneumoconiosis
department	Queensland Health
DHPW	Department of Housing and Public Works
DNRME	Department of Natural Resources, Mines and Energy
DRA	Domain Residents Association Inc
Draft Regulation	Draft Health and Other Legislation Amendment Regulation 2018
FLP	Fundamental legislative principles
HCQ	Health Consumers Queensland
Health Act	*Health Act 1937*
HDPR	Health (Drugs and Poisons) Regulation 1996
HHB Act	*Hospital and Health Boards Act 2011*
Lambert Initiative	Lambert Initiative for Cannabinoid Therapeutics, The University of Sydney
LFA	Lung Foundation Australia
LGAQ	Local Government Association of Queensland
LSA	*Legislative Standards Act 1992*

MCUA	Medical Cannabis Users Association of Australia Inc
Medicinal Cannabis Act	*Public Health (Medicinal Cannabis) Act 2016*
Medicinal Cannabis Bill	Public Health (Medicinal Cannabis) Bill 2016
MS	Multiple Sclerosis
OQPC	Office of the Queensland Parliamentary Counsel
PCA	Property Council of Australia
Poisons Standard	*Standard for the Uniform Scheduling of Medicines and Poisons* (Cth)
POQA	*Parliament of Queensland Act 2001*
Public Health Act	*Public Health Act 2005*
QCAT	Queensland Civil and Administrative Tribunal
QCCL	Queensland Council for Civil Liberties
QLS	Queensland Law Society
QUT	Queensland University of Technology
Radiation Safety Act	*Radiation Safety Act 1999*
RCPAQAP	Royal College of Pathologists of Australasia Quality Assurance Programs Pty Ltd
Retirement Villages Act	*Retirement Villages Act 1999*
RIS	Regulatory Impact Statement
Select Committee	Coal Workers' Pneumoconiosis Select Committee, 55th Parliament
TGA	Therapeutic Goods Administration
Transport Code	Code for the Safe Transport of Radioactive Material

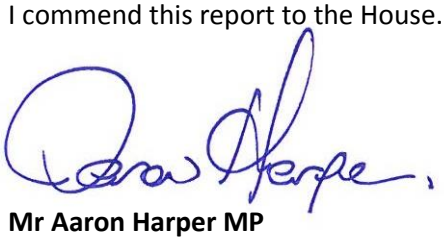
Chair's foreword

This report presents a summary of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee's examination of the Health and Other Legislation Amendment Bill 2018.

The committee's task was to consider the policy to be achieved by the legislation and the application of fundamental legislative principles – that is, to consider whether the Bill has sufficient regard to the rights and liberties of individuals, and to the institution of Parliament.

On behalf of the committee, I thank those individuals and organisations who made written submissions on the Bill and who gave evidence at the committee's public hearing on 24 January 2019

I commend this report to the House.



Mr Aaron Harper MP

Chair

Recommendations

The committee recommends the Health and Other Legislation Amendment Bill 2018 be passed.

1 Introduction

1.1 Role of the committee

The Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee (the committee) is a portfolio committee of the Legislative Assembly which commenced on 15 February 2018 under the *Parliament of Queensland Act 2001* (POQA) and the Standing Rules and Orders of the Legislative Assembly.[1]

The committee's primary areas of responsibility include:

- Health and Ambulance Services
- Communities, Women, Youth and Child Safety
- Domestic and Family Violence Prevention, and
- Disability Services and Seniors.

Section 93(1) of the POQA provides that a portfolio committee is responsible for examining each Bill in its portfolio areas to consider:

- the policy to be given effect by the legislation, and
- the application of fundamental legislative principles.[2]

Further information about the committee can be found on its webpage.[3]

1.2 Bill referral

The Health and Other Legislation Amendment Bill 2018 (Bill) was introduced into the Legislative Assembly and referred to the committee on 13 November 2018. The committee was required to report to the Legislative Assembly by 14 February 2019.

1.3 Inquiry process

On 14 November 2018, the committee issued a call for written submissions on the Bill. Submissions closed on 7 January 2018. The committee received 42 submissions and received 82 copies of a form submission.[4] A list of public submissions is provided at **Appendix A**.

Queensland Health (the department) provided a written briefing on the Bill, ahead of a public briefing on 5 December 2018 from the officers from that department and from the Department of Housing and Public Works (DHPW).

On 24 January 2019, the committee held a public hearing and received a second departmental briefing.

The departmental officers and witnesses who appeared at the briefings and hearing are listed in **Appendices B and C**.

The submissions, correspondence from Queensland Health and DHPW, and transcripts of the briefings and hearing are available on the inquiry webpage.[5]

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1 *Parliament of Queensland Act 2001*, section 88 and Standing Order 194.

2 Schedule 6, Standing Rules and Orders of the Legislative Assembly.

3 https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC.

4 Where the committee receives a number of submissions with substantially uniform content based on a template document or wording, these submissions are treated by the committee as a 'form submission'.

5 https://www.parliament.qld.gov.au/work-of-committees/committees/HCDSDFVPC/inquiries/current-inquiries/HealthOLAB18.

1.4 Policy objectives of the Bill

The Bill proposes to amend health and other portfolio Acts to implement a number of policy initiatives and improve the operation of the legislation. Its objectives include:

- repealing the *Public Health (Medicinal Cannabis) Act 2016* and making consequential amendments to the Health Act 1937, to streamline the regulatory framework for prescribing medicinal cannabis in Queensland
- amending the *Public Health Act 2005* to:
  - establish the Notifiable Lung Disease register and require prescribed medical practitioners to notify the chief executive of Queensland Health about cases of notifiable dust lung disease
  - enable the chief executive to require a person responsible for causing a pollution event to establish a pollution notice, to inform the public of potential risks to public health, and
  - enable the standard that a person must comply with when manufacturing, selling, supplying or using paint to be prescribed by regulation rather than in the Act
- amending the *Radiation Safety Act 1999* to provide that certain persons are deemed to have a use license or a transport license in relation to a radioactive substances
- amending the *Transplantation and Anatomy Act 1979* to:
  - clarify provisions about research that involves removing tissue from adults and children
  - ensure pathology laboratories can access tissue-based products that are necessary for diagnostic and quality control purposes, and
  - remove the requirement that a post-mortem examination of a body conducted in a hospital only be held in the hospital mortuary
- amending the *Births, Deaths and Marriages Registration Act 2003,* the *Coroners Act 2003* and the *Cremations Act 2003*, to enable human body parts used at a school of anatomy for the study and practice of anatomy to be lawfully cremated without a corresponding death certificate or the approval of an independent doctor, and
- amending the *Retirement Villages Act 1999* to clarify a recent amendment in relation to the timely payment of exit entitlements at retirement villages, and make associated amendments to the *Duties Act 2001*.[6]

1.5 Government consultation on the Bill

As set out in the explanatory notes, general consultation on the proposed amendments was undertaken with:

> *... the chief executives of Queensland's Hospital and Health Services, Royal Australasian College of Physicians, Royal Australian College of General Practitioners (RACGP), Medical Association Queensland, Australian College of Rural and Remote Medicine and Health Consumers Queensland.*[7]

In addition, targeted consultation was undertaken with key stakeholder groups in relation to each of the Bill's sets of amendments.[8]

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6 Health and Other legislation Amendment Bill 2018 (Bill), explanatory notes, p 1.

7 Explanatory notes, pp 17-18.

8 Explanatory notes, pp 17-20.

The explanatory notes advise that feedback on the amendments was generally supportive.[9] However, the explanatory notes also acknowledged concerns expressed by the Local Government Association of Queensland (LGAQ) in relation to amendments dealing with pollution notices; and by various industry representatives with respect to the proposed amendments to the *Retirement Villages Act 1999.*[10]

1.6 Should the Bill be passed?

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

After examination of the Bill, including consideration of the policy objectives to be implemented, stakeholders' views, and information provided by Queensland Health and the Department of Housing and Public Works, the committee recommends that the Bill be passed.

Recommendation 1

The committee recommends the Health and Other Legislation Amendment Bill 2018 be passed.

9 Explanatory notes, pp 18-20.

10 Explanatory notes, pp 18-20.

2 Examination of the Bill

This section discusses issues raised during the committee's examination of the Bill.

2.1 Streamlining the regulatory framework for prescribing medicinal cannabis

In Queensland, the prescription of medicinal cannabis is currently regulated under parallel state and Commonwealth approval processes.

At the Federal level, the *Standard for the Uniform Scheduling of Medicines and Poisons* (Poisons Standard) classifies medicines and poisons into schedules that determine how they are made available to the public. The Poisons Standard is maintained by the Therapeutic Goods Administration (TGA).[11]

State legislation adopts the schedules of the Poisons Standard and imposes controls on various medicines, based on their scheduling. This enables restrictions to be placed on the supply of scheduled substances to the public, according to their degree of risk and the degree of control over their availability, in the interest of public health and safety. Schedules range from schedule 2 (pharmacy medicine), through to schedule 10 (substances of such danger to health as to warrant the prohibition of sale, supply and use).[12]

In Queensland, controls on medicines are primarily contained in the Health (Drugs and Poisons) Regulation 1996 (HDPR), made under the *Health Act 1937* (Health Act).

Up until 31 August 2016, medicinal cannabis was classed as a schedule 9 prohibited substance, alongside other substances such as heroin and the hallucinogenic drug LSD. This scheduling served to prohibit its use for therapeutic purposes.[13]

Queensland legislated separately to enable the therapeutic use of medicinal cannabis in certain circumstances, first by amending the HDPR in December 2015, to enable the chief executive of Queensland Health to approve a doctor to prescribe medicinal cannabis on a case-by-case basis;[14] and later by introducing and passing the Public Health (Medicinal Cannabis) Bill 2016 (Medicinal Cannabis Bill),[15] to establish a more comprehensive, state-based regime for patients to access medicinal cannabis products, while also preventing their unauthorised use.[16]

The explanatory notes advise that the regime established by the resulting *Public Health (Medicinal Cannabis) Act 2016* (Medicinal Cannabis Act), provided for 'a robust system of approvals… and other controls to ensure medicinal cannabis is only prescribed by suitable medical practitioners with conditions where there is evidence of its efficacy', and was designed to operate 'in the absence of any other controls on access to medicinal cannabis at the Commonwealth level'.[17]

However, by the time the Medicinal Cannabis Bill was passed (in October 2016) and the Medicinal Cannabis Act commenced (in March 2017), the TGA had rescheduled medicinal cannabis as a schedule 8 or schedule 4 substance, depending on its composition.[18] This meant that medicinal cannabis products had joined a range of other medicines[19] that can be accessed for therapeutic use

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11 Queensland Health, correspondence, 27 November 2018, p 1.

12 Queensland Health, correspondence, 27 November 2018, p 1.

13 Queensland Health, correspondence, 27 November 2018, p 2.

14 Queensland Health, correspondence, 27 November 2018, p 1.

15 Public Health (Medicinal Cannabis) Bill 2016, explanatory notes, p 1.

16 Public Health (Medicinal Cannabis) Bill 2016, explanatory notes, p 1.

17 Bill, explanatory notes, p 2.

18 Queensland Health, correspondence, 27 November 2018, p 1.

19 Other schedule 8 drugs include methadone, morphine and fentanyl. Other schedule 4 drugs, also referred to as prescription only medicines, include insulins, erythromycin and penicillins. See: Queensland Health, correspondence, 27 November 2018, p 2.

under existing Commonwealth regulatory frameworks with their own well-established access pathways and controls.[20]

According to the explanatory notes, these changes to the regulation of medicinal cannabis at the Federal level meant that:

> *… in practice, Queensland's medicinal cannabis approval process now duplicates the TGA approval process for access to medicinal cannabis. Queensland and the TGA run the same checks on:*
>
> - *the doctor – for example, checking the doctor's registration with the Australian Health Practitioner Regulation Agency, ensuring there are no conditions on the registration and that they are a suitable specialist in the relevant field to prescribe or support the prescribing by a general practitioner;*
> - *the condition – for example, considering if there is scientific evidence for the use of medicinal cannabis to treat the condition and whether the patient has already used conventional treatments for the condition; and*
> - *the proposed product – for example, whether the proposed product and dose comply with the Guidance for the use of medicinal cannabis in Australia and the Standard for medicinal cannabis, published by the TGA.*[21]

Further, although Queensland was the first state to legalise the use of restricted medicinal cannabis products on 11 December 2015; the shift in the Commonwealth regulatory landscape means that Queensland is now the only state that requires the following additional state-based approvals for access, as stipulated under the Medicinal Cannabis Act:

- state approvals for doctors seeking to prescribe schedule 4 medicinal cannabis products (e.g. cannabidiol, the non-psychoactive component of cannabis, which is classified alongside other 'prescription only' schedule 4 drugs, including insulins, erythromycin and penicillins)
- state dispensing approvals for pharmacists who dispense medicinal cannabis
- state approvals to allow researchers to conduct clinical trials involving medicinal cannabis, and
- state-based approvals for patients from other jurisdictions and overseas.[22]

As well as posing an administrative burden, the explanatory notes state that having two approval processes assessing the same matters:

> *… introduces the potential for Queensland and the TGA to reach different conclusions about applications, which may weaken confidence in the regulatory framework. The current TGA approval for access to medicinal cannabis is considered adequate to assess these matters.*[23]

2.1.1 The proposed amendments

The Bill would repeal the Medicinal Cannabis Act[24] to remove the 'unnecessary duplication' of Commonwealth regulatory requirements for access to medicinal cannabis, 'streamlining processes for patients, health professionals and researchers'.[25]

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20 Explanatory notes, p 2.

21 Queensland Health, correspondence, 27 November 2018, p 3.

22 Explanatory notes, p 20.

23 Explanatory notes, p 2.

24 Bill, clause 57.

25 Hon Dr Steven Miles MP, Minister for Health and Minister for Ambulance Services, Explanatory Speech, *Record of Proceedings,* 13 November 2018, pp 3392-3393.

Medical practitioners 'will no longer need to navigate two legislative frameworks when they are prescribing different medicines', with the regulation of medicinal cannabis returning to the HDPR, and thereby once more falling subject to the Commonwealth regulatory framework.[26]

To ensure that medicinal cannabis can be regulated under the Health Act and the HDPR, the Bill amends the definitions of *article, drug*, and *poison* in the Health Act so that medicinal cannabis is captured by these definitions.[27]

Subject to accompanying changes to the HDPR, as proposed in a draft Health and Other Legislation Amendment Regulation 2018 (Draft Regulation) that was tabled with the Bill,[28] this means that medicinal cannabis products will be treated in the same manner as other schedule 8 or schedule 4 medicines (depending on their composition).

As a further consequence, as is the case with other schedule 8 medicines:

> *… specialist medical practitioners will be able to prescribe medicinal cannabis for any medical condition. Currently, under the medicinal cannabis regulation specialists can prescribe medicinal cannabis for particular patients—that is, patients with chemotherapy induced nausea or vomiting, terminally ill persons, children with drug resistant epilepsy, persons with multiple sclerosis and persons experiencing chronic non-cancer pain. Once the act is repealed, specialists will be able to prescribe any medicinal cannabis product for any condition they consider would benefit… and that includes specialist general practitioners and members of the rural and remote college, so ACRRM [Australian College of Rural and Remote Medicine] specialists as well as any other specialist... The only people who will not be able to prescribe would be, for instance, a medical officer perhaps within a hospital who has not yet undertaken any type of speciality training.*[29]

It will remain illegal for members of the Queensland public to grow cannabis for medicinal purposes.[30]

2.1.2 Stakeholder views and the department's response

The amendments to streamline the framework for prescribing medicinal cannabis were a major focus of the submissions received on the Bill, having been addressed in close to half of all submissions, and in many cases exclusively so.

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[26] Ms Kirsten Law, Director, Legislative Policy Unit, Strategy, Policy and Planning Division, Queensland Health, public briefing transcript, Brisbane, 5 December 2018, p 4.

[27] Bill, clauses 11 and 12.

[28] Health Legislation Amendment Regulation, draft, tabled 13 November 2018, https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2018/5618T1869.pdf. See also Health Legislation Amendment Regulation, explanatory notes, tabled 13 November 2018, https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2018/5618T1870.pdf.

[29] Dr Sonya Bennett, Acting Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, and Dr Sue Ballantyne, Senior Medical Adviser, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 5 December 2018, p 4.

[30] Hon Dr Steven Miles MP, Minister for Health and Minister for Ambulance Services, explanatory speech, *Record of Proceedings,* 13 November 2018, p 3392.

Support for the amendments

For the most part, the amendments were supported.[31] The Queensland Council for Civil Liberties (QCCL) described the Bill's 'final abandonment of state duplication of the federal application process' as 'a welcome development';[32] while the Queensland Branch of the Australian Medical Association (AMA Queensland) submitted that, given the changes to the way medicinal cannabis is regulated by the TGA, 'AMA Queensland agrees that a separate Act specific to Queensland is no longer needed'.[33]

Multiple Sclerosis (MS) Australia and MS Research Australia similarly expressed their support for the removal of the duplicate requirements, not only 'in the interest of patients having more straightforward access to medicinal cannabis products', but also 'to eliminate the possibility of contradictory approval outcomes at different levels of government weakening the process'.[34] Further, the Lambert Initiative for Cannabinoid Therapeutics (Lambert Initiative) submitted that it supported 'any attempts to simplify and streamline access to medical cannabis products where clinically appropriate', including 'the repeal of the *Public Health (Medicinal Cannabis) Act 2016* and subsequent amendments to the *Health Act 1937*'.[35] The Lambert Initiative singled out the capacity for all specialist doctors to request a prescription of an unapproved medicinal cannabis product as a result of the amendments, as 'a significant improvement on the current framework'.[36]

Health Consumers Queensland (HCQ) advised that 'from an organisational perspective' it supported the amendments, and outlined the results of a survey in which it asked 'consumers, carers and family members' the general question: 'Do you agree with removing the barriers for patients and doctors seeking access to medical cannabis treatment?'. HCQ reported that 86.11 per cent of 73 respondents answered 'yes' and 2.78 per cent answered 'not sure'.[37]

The Medical Cannabis Users Association of Australia Inc (MCUA) also reported a consensus among its Queensland members that repealing the Medicinal Cannabis Act 'is a very good thing', given the current 'obstructive' framework 'has contributed to ongoing delays and frustrations experienced by patients trying to acquire *legal* access to cannabis medicine'.[38]

A number of individual submitters detailed their own significant difficulties accessing medicinal cannabis for their personal therapeutic treatment, or for that of an ailing family member, under the current system. This included accounts of 'extreme hardship and harm to patients and their families' as a result of current barriers to accessing medicinal cannabis,[39] often with significant implications for

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31 The Lambert Initiative for Cannabinoid Therapeutics, submission 1; Confidential submission 5; Multiple Sclerosis Australia and MS Research Australia, submission 7; Health Consumers Queensland, submission 11; Australian College of Nursing, submission 12; MIGA, submission 15; MEDIFARM, submission 17; Name suppressed, submission 20; Name suppressed, submission 24; Ms Tricia Simpson, submission 26; Confidential submission 27; Australian Medical Association Queensland, submission 29, Medical Cannabis Users Association of Australia Inc, submission 30; Ms Lanai Carter, submission 34; Queensland Council for Civil Liberties, submission 37; Confidential submission 39; Mr John Ransley, submission 40; and Confidential submission 42.

32 QCCL, submission 37, p 2.

33 AMA Queensland, submission 29, p 1.

34 MS Australia and MS Research Australia, submission 7, p 5. See also MIGA, submission 15, p 1. MIGA, a medical defence organisation/professional indemnity insurer submitted that it believes the schedule 4 and schedule 8 regimes, coupled with TGA applications and oversight, provide appropriate regulation of medicinal cannabis use.

35 Lambert Initiative, submission 1, p 1.

36 Lambert Initiative, submission 1, p 1.

37 HCQ, submission 11, p 5.

38 MCUA, submission 30, p 1.

39 Ms Lanai Carter, submission 34, pp 1-2.

treatment options and the patient's quality of life.[40] Cited barriers to access under the current regime included:

- delays associated with navigating duplicative application requirements and processes, and various other administrative shortcomings[41]
- the prohibitive costs of treatment, with submitters citing cost estimates for some treatments of between $30,000 and $60,000 or in excess of $48,000 annually, depending on the supplier used.[42] Such costs, it was noted, are beyond the reach of most people, and could severely hamper their ability to cover basic living expenses[43]
- supply problems associated with import delays, a lack of licensed local suppliers, and other stock issues, with implications for patient treatment and well-being[44]
- prescription restrictions, including limits on repeat prescriptions, which can force patients to pay for frequent consultations to access treatment, and which can sometimes leave them without a continuous supply,[45] and
- the persistent reluctance of many doctors to prescribe medicinal cannabis for various reasons, including issues of legal liability, or a lack of awareness of the legislation.[46]

It was submitted that these various barriers to access have forced some individuals to self-prescribe and obtain illegal products to ease their suffering, often after trying extensively to access products through legal avenues.[47]

Whilst commending the Bill's repeal of the Medicinal Cannabis Act, many submitters also expressed a view that the amendments would not go far enough to address perceived regulatory problems. To this end, a range of further reforms were suggested, including:

- changes to the scheduling of cannabis products by the TGA[48]
- permitting non-specialist general practitioners to prescribe medicinal cannabis without an approval from Queensland Health, to provide more timely and affordable access for consumers[49]

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40 Mr Gary and Mrs Christine Olive, submission 18, p 1; Name suppressed, submission 20, p 1; Name suppressed, submission 24, p 1; Confidential submission 27; Confidential submission 39; Confidential submission 42. The HCQ submission (submission 11, p 5) reported that one respondent to its survey of consumers, carers and their family members stated that 'While the existing system was designed to ensure patient safety and allay concerns of the broader community as to the use of marijuana, the restrictive nature of the process has caused more harm and distress to patients and their families and carers/support givers'.

41 Confidential submission 27; Ms Lanai Carter, submission 34, pp 1-2.

42 QCCL, submission 37, p 3; Ms Lanai Carter, submission 34, p 3; MCUA, submission 30, pp 4-5.

43 Name suppressed, submission 24, p 2; Ms Tricia Simpson, submission 26, p 1; Ms Lanai Carter, submission 34, p 3; Mr Gary and Mrs Christine Olive, submission 18, pp 1-2; Confidential submission 39; MCUA, submission 30, pp 4-5.

44 Ms Lanai Carter, submission 34, p 3.

45 Confidential submission 5; Name supressed, submission 24, p 1; Ms Tricia Simpson, submission 26, p 1; Ms Lanai Carter, submission 34, p 4; QCCL, submission 37, pp 6-7.

46 Confidential submission 39; Ms Deb Lynch, Committee Member, MCUA, public hearing transcript, Brisbane, 21 January 2018, p 9.

47 Confidential submission 5; Mr Gary and Mrs Christine Olive, submission 18, p 1; Ms Tricia Simpson, submission 26, p 1; Confidential submission 39.

48 MEDIFARM, submission 17, p 1.

49 Lambert Initiative, submission 1, p 1.

- reforms to address the high cost of medicinal cannabis, including consideration of implementing a similar compensation or co-payment scheme to the Controlled Access Scheme employed in Tasmania, or expanding Queensland's existing Compassionate Access Scheme[50]
- addressing the high costs of consultation through cannabis access clinics[51]
- allowing adults to grow a limited number of their own plants for medicinal use[52]
- allowing more flexibility in the approvals system to adjust factors such as dosage, type and supplier
- the full legalisation of cannabis without restrictions,[53] and
- establishing a compassionate use scheme similar to the NSW Terminal Illness Cannabis Scheme, which allows adults with a terminal illness to register as an illicit cannabis user such that if they are found in possession of fewer than 15 grams of cannabis, police have clear guidance to use discretion and can choose not to prosecute.[54]

Medical defence organisation/professional indemnity insurer MIGA and the Australian College of Nursing also emphasised the importance of ensuring that relevant health practitioners involved in prescribing, dispensing and supply of medicinal cannabis are appropriately educated about their obligations, including providing guidelines or other information on the changes to the regulation of medicinal cannabis in Queensland.[55]

The department's response

In its response to the issues raised in submissions, the department acknowledged both the general support for the Bill's amendments and the desire for further reform moving forward.[56]

Whilst noting many of the on-going access issues cited by submitters, the department emphasised that many of the stakeholder proposals for further reforms 'are matters for government that are outside the scope of the Bill' and its objectives and/or 'involve matters dealt with under other legislation, either at the Commonwealth level or under the state's criminal laws'.[57]

For example, in terms of changes to TGA scheduling, Chief Health Officer, Dr Jeanette Young, emphasised that any changes to scheduling will need to occur at the Commonwealth level.[58] Proposals to allow adults to grow limited quantities of cannabis for medical use, similarly, may be inconsistent with the TGA's well-established quality control framework for medical substances:

> *… it is important to remember that medicinal cannabis products in Australia must meet the standards set by the TGA for minimum quality requirements and microbiological standards. To*

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50 Confidential submission 27; QCCL, submission 37, pp 6-7; Mr John Ransley, QCCL representative on drug law reform, QCCL, public hearing transcript, Brisbane, 24 January 2019, p 10.

51 Name suppressed, submission 24, p 1.

52 Mr Gary and Mrs Christine Olive, submission 19, p 1; Name suppressed, submission 20, p 1; Confidential submission 27; MCU, submission 30, p 12.

53 Mr John Ransley, submission 40, pp 2-3; MCUA, submission 30, pp 3-4.

54 Confidential submission 27; Confidential submission 42; QCCL, submission 37, p 5; Mr John Ransley, submission 40, pp 6-7; Mr Gary and Mrs Christine Olive, submission 18, p 1.

55 MIGA, submission 15, p 1; Australian College of Nursing, submission 12, p 2.

56 Department, correspondence, 21 January 2019, pp 2-4.

57 Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 24 January 2018, p 2.

58 Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 24 January 2018, p 2.

ensure that safe prescription and dosage decisions are made by doctors, medicinal cannabis products must be consistent, contaminant free and of high quality.[59]

Cannabis products that are not regulated under Queensland medicines legislation will remain a dangerous drug in Queensland under the *Drugs Misuse Act 1986* and *Drugs Misuse Regulation 1987* – legislation administered separately by the Attorney-General and Minister for Justice through the Department of Justice and Attorney-General.[60]

Dr Young further advised in relation to stakeholders' other proposed reforms:

Similarly, decriminalisation and compassionate access to cannabis are not part of this bill. The focus of the bill is to repeal the Queensland Public Health (Medicinal Cannabis) Act and regulate medicinal cannabis under exactly the same framework as other medicines in this state, that is, the Health (Drugs and Poisons) Regulation…

Several submissions also raised concerns about the cost and availability of medicinal cannabis products. It is important to remember that many factors contribute to the cost of medicinal cannabis products. This includes production costs, wholesale and retail mark-ups and handling fees. The bill's focus is on simplifying the processes associated with the prescription of medicinal cannabis; it does not address those other issues.

One submission noted the current regulatory regime does not allow for repeat prescriptions of medicinal cannabis, which is true, and it causes delays and increases costs for patients. This will no longer be the case once the amendments take effect. As with other schedule 4 and schedule 8 medicines under the Health (Drugs and Poisons) Regulation, repeat prescriptions will be available.[61]

The department also stated in response to calls to allow general practitioners to prescribe medicinal cannabis without approval that it 'considers that requiring non-specialist practitioners to seek an approval from the department before prescribing schedule 8 medicinal cannabis is an appropriate additional control'.[62]

To support the implementation of the reforms, the department affirmed that:

A range of guidance material has been produced by the Commonwealth Department of Health in collaboration with State and Territory health departments. Queensland Health has published Clinical Guidance for the use of medicinal cannabis products in Queensland. Professional bodies also play a role in professional development opportunities for their members.[63]

Opposition to the amendments

The committee received three submissions opposing the amendments, with Drug Free Australia (Queensland), Drug Free Australia (International) and Dr Stuart Reece recommending that no changes be made to the regulatory framework for medicinal cannabis in Queensland.[64]

Drug Free Australia (International) expressed a concern that the repeal of the Medicinal Cannabis Act would lead to 'the provision of substandard cannabis products which have not undergone rigorous

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59 Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 24 January 2018, p 2.

60 Queensland Health, correspondence, 21 January 2019, p 4.

61 Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 24 January 2018, p 2.

62 Queensland Health, correspondence, 21 January 2019, p 3.

63 Queensland Health, correspondence, 21 January 2019, p 2.

64 Drug Free Australia (Queensland), submission 16; Drug Free Australia (International), submission 41; Dr Stuart Reece, submission 33.

clinical testing to masquerade as medicine'.[65] Dr Stuart Reece expressed concern that Queensland repealing the Medicinal Cannabis Act and falling into line with the TGA's 'rescheduling or down-scheduling' would be a 'grave error', arguing that the overseas medicalisation of cannabis and/or cannabinoids has been 'a ruse for the full legalisation of cannabis and cannabinoids which generally follows very rapidly thereafter'.[66]

All three of these submissions highlighted a range of international studies on cannabis use during pregnancy and the effects of recreational use of cannabis on adolescent mental health, together with other effects of illicit cannabis use.

In response to these submissions, the department advised:

> *The proposed repeal of the Medicinal Cannabis Act will reduce the complexity and duplication associated with doctors prescribing medicinal cannabis in Queensland. The reforms will not affect how medicinal cannabis products are dealt with by the Therapeutic Goods Administration, including the scheduling of medicinal cannabis products and the quality standards that are imposed. All medicinal cannabis products in Australia must meet the minimum quality requirements and microbiological standards set by the Therapeutic Goods Administration.*[67]

Regarding the various international studies cited in the submissions, further, the department stated:

> *The articles cited are primarily focused on the illicit or recreational use of cannabis. The focus of the Bill is on the regulation of medicinal cannabis.*
>
> *There are many therapeutic products that are known to cause complications during pregnancy or breastfeeding. Whether a patient is prescribed a medicinal cannabis product will be a matter for their treating medical practitioner to determine based on the available evidence and for the Therapeutic Goods Administration to approve.*
>
> *Queensland Health guidance currently recommends that medicinal cannabis that contains Tetrahydrocannabinol (THC) is generally not appropriate for patients who:*
>
> - *have a personal history or strong family history of psychosis or have concurrent active mood or anxiety disorder;*
> - *are pregnant, planning on becoming pregnant, or breastfeeding; or*
> - *have unstable cardiovascular disease.*[68]

2.1.2.1 Committee comment

The committee supports clause 57 of the Bill which repeals the *Public Health (Medicinal Cannabis) Act 2016* to remove unnecessary regulatory requirements and make medicinal cannabis more accessible to patients, health practitioners and researchers in Queensland.

2.2 Amendments to the *Public Health Act 2005*

2.2.1 Notifiable Dust Lung Disease Register

In May 2017, the Coal Workers' Pneumoconiosis Select Committee of the Queensland Parliament (Select Committee) tabled its report, *Black Lung white lies: Inquiry into the re-identification of Coal Workers' Pneumoconiosis in Queensland* (Report No. 2, 55th Parliament). The Report was the culmination of the Select Committee's extensive inquiry into the apparently sudden emergence of

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65 Drug Free Australia (International), submission 41, p 1.

66 Dr Stuart Reece, submission 33, p 1.

67 Queensland Health, correspondence, 21 January 2019, p 2.

68 Queensland Health, correspondence, 21 January 2019, p 3.

numerous cases of coal workers' pneumoconiosis (CWP) or 'black lung'; an insidious and preventable lung disease arising in the coal industry that was previously thought to have been all but eradiated.[69]

CWP is one of a number of respiratory diseases caused by long-term occupational exposure to high concentrations of respirable coal dust, which are known collectively as coal mine dust lung disease (CMDLD). While CWP is the most commonly known form of CMDLD, other types include silicosis, mixed dust pneumoconiosis, and chronic obstructive pulmonary diseases such as chronic bronchitis and emphysema.[70]

The Select Committee recommended that 'cases of CWP/CMDLD identified or diagnosed by medical professionals should be compulsorily reported to the Chief Health Officer, Queensland, as a notifiable disease under the *Public Health Act 2005*' (recommendation 59).[71] The recommendation stemmed from the Select Committee's observation that because CMDLD is not a notifiable disease, there had been no requirement to report diagnoses of its various forms to Queensland Health. Queensland Health was accordingly unable to provide a definitive number of cases diagnosed, limiting the capacity of the state's chief health agency to identify patterns of incidence or the true scale of the problem.[72] The government response to the report, tabled in September 2017, supported the recommendation.[73]

Currently in Queensland, chapter 3, part 2 of the *Public Health Act 2005* (Public Health Act) provides that diagnoses of notifiable conditions are required to be notified to the chief executive and recorded on the notifiable conditions register. Notifiable conditions prescribed in the Public Health Regulation 2018 include communicable diseases such as measles, Hendra virus and hepatitis.[74] Under section 63(2) of the Public Health Act, a condition can only be prescribed as a notifiable condition if the Minister is satisfied the condition is a significant risk to public health.[75] CMDLD typically only affects coal miners and other related workers through occupational exposure, and therefore is not considered to pose a significant public health risk within the framework established by the Public Health Act.[76]

Accordingly, the Bill proposes to amend the Public Health Act to establish a separate framework for the notification of particular occupational dust lung diseases, including CMDLD.

The department advised that the Bill's establishment of new notification requirements for occupational dust lung diseases will also respond to a sudden spike in the number of confirmed cases of silicosis for workers in the engineered stone benchtop manufacturing industry, including the recent

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69 Explanatory notes, p 3.

70 Queensland Health, correspondence, 27 November 2018, p 5.

71 Coal Workers' Pneumoconiosis Select Committee, *Report No. 2, 55th Parliament – Black lung, white lies: An inquiry into the re-identification of coal workers' pneumoconiosis in Queensland,* May 2017, p 23, https://www.parliament.qld.gov.au/Documents/TableOffice/TabledPapers/2017/5517T815.pdf.

72 Coal Workers' Pneumoconiosis Select Committee, *Report No. 2, 55th Parliament – Black lung, white lies: An inquiry into the re-identification of coal workers' pneumoconiosis in Queensland,* May 2017, pp 216-217.

73 Queensland Government, *Response to Coal Workers' Pneumoconiosis Select Committee Report No. 2, 55th Parliament – Black lung, white lies: An inquiry into the re-identification of coal workers' pneumoconiosis in Queensland*, September 2017, p 31, https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2017/5517T1647.pdf.

74 Explanatory notes, p 4.

75 Specifically, section 63(2) provides that a Minister can only recommend the making of a regulation prescribing a condition as a notifiable condition if they are satisfied that: (a) the condition may have a substantial impact on public health; and (b) the ordinary conduct of a person with the condition is likely to result in the transmission of the condition to someone else; and (c) the transmission of the condition will result in, or is likely to result in, long term or serious deleterious consequences for the health of the person to whom the condition is transmitted.

76 Explanatory notes, p 4.

identification of 12 cases of accelerated silicosis among 35 workers examined on the Gold Coast.[77] The explanatory notes state:

> *There are high levels of silica in engineered stone, which can be breathed in as dust when cut dry. The Queensland Government has issued a safety warning for workers and employers to cease dry cutting of engineered stone benchtop manufacturing.*[78]

2.2.1.1 The proposed amendments

The Bill would insert a new Part 3A ('Notifiable dust lung diseases') into the Public Health Act, establishing a framework under which the chief executive will be required to be notified of particular cases of occupational dust lung disease.

The proposed amendments establish the notification requirements in relation to certain medical practitioners who diagnose a person as having a notifiable dust lung disease, with the following to be prescribed by regulation:

- the medical practitioners to whom the requirements apply ('prescribed medical practitioners')
- the conditions for which notification is required ('notifiable dust lung disease'), and
- the period of time within which the medical practitioner must notify the chief executive.[79]

Under the Draft Regulation tabled with the Bill, a 'prescribed medical practitioner' for these purposes is a registered specialist health practitioner in the fields of occupational and environmental medicine or respiratory and sleep medicine. The Draft Regulation provides that these individuals must notify the chief executive within 30 days from the time they diagnose a person as having any of the following prescribed notifiable dust lung diseases, being respiratory diseases caused by occupational exposure to inorganic dust:

- cancer
- chronic obstructive pulmonary disease, including chronic bronchitis and emphysema, and
- pneumoconiosis, including asbestosis, CWP, mixed dust pneumoconiosis and silicosis.[80]

The department advised that providing for the prescribing of relevant medical specialists and notifiable dust lung diseases in regulation will ensure the framework can adapt to future changes in clinical practice, and be expanded to accommodate broader monitoring of other occupational lung diseases as necessary.[81]

The notification information must be provided in an approved form,[82] with the type of information to be notified including the name of the person diagnosed, date of birth, type of dust lung disease diagnosed and place of exposure. The explanatory notes state that clinical information, such as information about the patient's treatment or prognosis, will not be included.[83]

The chief executive will be required to keep a register of all notifications about occupational dust lung diseases under the framework, 'to be known as the Notifiable Dust Lung Disease Register',[84] with the

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77 Queensland Health, correspondence, 27 November 2018, p 5.

78 Explanatory notes, p 4.

79 Bill, new section 279AF.

80 Health and Other Legislation Amendment Regulation 2018, draft regulation, tabled 13 November 2018, clause 13, new sections 49A-49C.

81 Queensland Health, correspondence, 27 November 2018, p 6.

82 Bill, clause 22, section 279AF(3).

83 Explanatory notes, p 12.

84 Bill, clause 22, new section 279AB(4).

provisions mirroring equivalent requirements for the current register of notifiable conditions under the Public Health Act. As articulated in the amendments, the purposes of establishing and keeping the register are to:

a) monitor and analyse the incidence of notifiable dust lung diseases; and

b) enable information about notifiable dust lung diseases to be exchanged with an entity of the State.[85]

Where the chief executive considers further information about a notification is required to ensure the accuracy or completeness of the register, the amendments provide for the chief executive to issue a notice requiring further information to either the prescribed medical practitioner who gave the notification, or another health practitioner who the chief executive believes has information about the notifiable dust lung disease.[86]

To support the operation and accuracy of the register, the amendments also create offences for:

- failing to notify the chief executive of notifiable lung dust diseases, unless the prescribed medical practitioner has a reasonable excuse, and
- a failure to provide the chief executive with information in response to a notice requiring further information, unless the person has a reasonable excuse (and subject to the chief executive warning the person that a failure to comply with the notice without reasonable excuse is an offence).[87]

The maximum penalty for both offences is 20 penalty units or $2,611.[88]

Outside of the health system, many cases of notifiable dust lung disease already come to the attention of the Queensland government through the *Coal Mining Safety and Health Act 1999* and the *Mining and Quarrying Safety and Health Act 1999* and accompanying regulations. This industry-specific workplace health and safety legislation establishes requirements for employers to appoint a doctor to assess the health of individual workers and report their findings to the chief executive of the Department of Natural Resources, Mines and Energy (DNRME).[89]

To avoid duplication, the Bill provides that a prescribed medical practitioner does not need to notify the chief executive of Queensland Health if the medical practitioner has given the information about the notifiable dust lung disease to:

- the chief executive or a public service employee of the department in which the *Coal Mining Safety and Health Act 1999* is administered (e.g. currently, DNRME), or
- another medical practitioner who is authorised under an Act prescribed by regulation to provide a health assessment about the person.[90]

The proposed amendments would also allow the chief executive of Queensland Health to request information from the chief executive of a relevant agency, including the chief executive of the department administering mining and quarrying safety and health legislation, and the chief executive that administers the *Workers' Compensation and Rehabilitation Act 2003*, about cases of notifiable dust lung disease. The department advised that these provisions would 'ensure the Queensland Health

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85 Bill, clause 22, new section 279AC, 'Purposes of register'.

86 Bill, clause 22, new section 279AG.

87 Bill, clause 22, new sections 279AF(2) and 279AG(4).

88 Bill, clause 22, new sections 279AF(2) and 279AG(4). The current penalty unit value in Queensland is $130.55, as set by the Penalties and Sentences (Penalty Unit Value) Amendment Regulation 2018, commencing from 1 July 2018.

89 Queensland Health, correspondence, 27 November 2018, p 6.

90 Explanatory notes, p 8. See also: Bill, clause 22, new section 279AF.

register is a comprehensive record of all identified cases of occupational dust lung diseases', that will 'interact with existing notification and reporting requirements'.[91]

The chief executive of Queensland Health will be required to report annually to the Minister of Health about the number of notifications received and the activities undertaken by Queensland Health in relation to these diseases. The Minister in turn, will be required to table the report in the Legislative Assembly.[92]

To support the operation of the register and its objectives, the amendments also provide for confidential information associated with the administration of the notifiable dust lung disease register (including information about an individual's personal affairs or health), to be disclosed to certain parties in several limited circumstances, and for specific purposes.

This includes provision for:

- certain relevant persons (e.g. the chief executive, the regulator, public service employees and prescribed medical practitioners, etc.) to disclose confidential information to the extent necessary to comply with an obligation under the Public Health Act; as authorised under another Act or permitted by law; or where the person to whom the information relates consents to the disclosure or the disclosure does not identify the person[93]
- the chief executive (or another relevant person) to disclose confidential information to an authorised person who is contracted by the department to analyse, monitor, or evaluate public health, to be disclosed or received for that purpose only[94]
- the chief executive to disclose to the coroner or an assisting police officer investigating the death of a person, information from the register the that is relevant to the person's death, to be disclosed or received for that purpose only.[95]
- the chief executive to disclose confidential information to another entity of the state or a corresponding department of the Commonwealth or another state or territory, but only if the disclosure is required or permitted under an agreement and the agreement is prescribed by regulation.[96]

With regard to the permitted disclosures to other government entities, the explanatory notes provide the following examples of prescribed agreements into which Queensland Health, or the state, might enter:

- an agreement with another Queensland government department, to enable the disclosure of information about diagnosed cases to that entity, to assist the entity in responding to incidents of dust lung disease
- an agreement with another state or territory department, to facilitate sharing of information about cases diagnosed in one jurisdiction where caused by exposure in the other jurisdiction
- an agreement with the Commonwealth, to facilitate information sharing for the purposes of a national register if established.[97]

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91 Queensland Health, correspondence, 27 November 2018, p 6.

92 Bill, clause 22, new section 279AJ.

93 Bill, clause 22, new section 279AM.

94 Bill, clause 22, new section 279AN.

95 Bill, clause 22, new section 279AP.

96 Bill, clause 22, new section 279AO.

97 Explanatory notes, p 13.

The Bill also expressly provides that giving information as required under the new notification framework does not contravene any existing confidentiality requirements, either in legislation or otherwise (including with respect to any code of professional etiquette or ethics, or accepted standards of professional conduct).[98] However, the disclosure of confidential information other than that permitted under the new framework will be an offence, with a maximum penalty of 50 penalty units ($6,527).

The offence provision and information safeguards incorporated in these amendments are considered further in section 3.1 of this report - Fundamental legislative principles.

2.2.1.2 Stakeholder views and the department's response

Submissions on the Bill indicated broad support for the establishment of the notifiable dust lung register and its associated provisions.

The Lung Foundation Australia (LFA) submitted that the establishment of a process for mandatory notification of occupational lung diseases was identified as an area for priority investigation during its development of the first National Strategic Action Plan for Lung Conditions.[99] LFA stated that the proposed amendments are 'an important first step in working towards the establishment of a system to identify workplaces where there are unsafe work practices that increase the risk of lung disease to workers, employers and the community'.[100]

The Australasian Faculty of Occupational and Environmental Medicine (AFOEM) submitted:

> *As per the Bill's Explanatory Notes, we note that The Thoracic Society of Australia and New Zealand, (TSANZ), The Royal Australian and New Zealand College of Radiologists and the Australasian and New Zealand Society of Occupational Medicine have previously been consulted on the proposed register and have also expressed their support.*[101]

Similarly, the AMA Queensland submitted that the 'new regulations for notifiable dust lung diseases which has arisen from the Black Lung Inquiry', were reforms 'which AMA Queensland has previously advocated for and supported'.[102]

Submitters placed significant emphasis on the importance of including silicosis in the register, with 82 form submissions received to this effect, a number of which were made by individuals who indicated they had been diagnosed with the condition.[103] The committee also received individual submissions which outlined the experiences of individuals and families affected by silicosis in greater detail, and expanded on the need for improved prevention and early identification of occupational lung diseases, and enhanced options for treatment and support.[104] Citing the experiences of family and friends who have been diagnosed with silicosis from working in the artificial stone benchtop industry, David Price submitted that the earlier establishment of a register may have helped 'to prevent further cases a few years ago'.[105] Ms Lynda Eastburn, who similarly advised of a silicosis diagnosis from the same industry within her own family, considered that the lack of available information on 'the magnitude of this tragedy' to date may have hindered efforts to prevent it.[106] Ms Wendy Rayner, who detailed her son-in-law's diagnosis of stonemasonry silicosis and the distressing effects on his health

98 Bill, clause 22, new section 279AI.

99 Lung Foundation Australia (LFA), submission 28, p 1.

100 LFA, submission 28, pp 1-2.

101 Australian Faculty of Occupational and Environmental Medicine (AFOEM), Submission 31, p 2.

102 AMA Queensland, submission 29, p 1.

103 Form submission 43 (82 received).

104 Ms Wendy Rayner, submission 21; Mr David Price, submission 22; Ms Lynda Eastburn, submission 23.

105 Mr David Price, submission 22, p 1.

106 Ms Lynda Eastburn, submission 23, p 1.

and on his family, submitted that the establishment of a dust register including cases of silicosis, 'is positive but probably not enough'.[107]

HCQ also expressed its support for the amendments and establishment of the notifiable dust lung disease register, and outlined a range of comments from survey respondents regarding its operation.[108] One respondent noted that the register 'could assist future generations regarding harmful exposure, based on statistics, and awareness of this occurring in community', while another noted that 'being on the register means information about these illnesses can be collected more accurately'.[109] Other comments supported the use of appropriate informational safeguards to ensure the privacy of the patient, and mandatory reporting provisions to ensure the accuracy of the register.[110]

HCQ also reported feedback from survey respondents calling for the publication of de-identified summary information to inform the community of locations of possible exposure and enable 'the public to make an informed choice about working in those companies or purchasing their products'.[111] In addition, HCQ noted respondent interest in capturing other conditions within the register, 'to acknowledge and support not just paid workforce but others who are impacted by being in the environment (neighbours to building sites for example)'.[112]

Many submitters also emphasised the need for a national register of dust lung diseases, noting occupational lung diseases are a national problem and require a coordinated national response.[113]

The department's response

In responding to submissions, the department noted both the 'general support for the reform' and the 'strong support for diagnoses of silicosis being included in the register'.[114]

The department affirmed that the Bill would require the chief executive of Queensland Health to be notified of cases of occupational dust lung diseases prescribed in regulation; and that silicosis has been included as one of the prescribed respiratory diseases in the draft regulation.[115]

With respect to the feedback from HCQ regarding the capture of related conditions from possible dust exposure of members of public and the publication of information regarding potential clusters of disease and responsible companies, the department advised:

> *A notifiable dust lung disease will be defined as a respiratory disease prescribed by regulation that is caused by occupational exposure to a type of dust prescribed by regulation. The types of dust lung diseases that the register covers ordinarily arise after prolonged exposure. This would generally occur in the workplace. It is unlikely that these types of occupational diseases could develop as the result of incidental exposure to dust.*
>
> *The Bill provides that the chief executive must report annually to the Minister on the number of notifications, types of diseases recorded, actions the Department has taken to implement the purposes of the register and any other information the chief executive considers appropriate.*

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107 Ms Wendy Rayner, submission 21, p 1.

108 HCQ, submission 11, p 7.

109 HCQ, submission 11, p 8.

110 HCQ, submission 11, pp 8-9.

111 HCQ, submission 11, p 7.

112 HCQ, submission 11, p 7.

113 Mr David Price, submission 22, p 1; Ms Lynda Eastburn, submission 23, p 1; LFA, submission 28, pp 1-2; AFOEM, submission 31, p 2;

114 Queensland Health, correspondence, 21 January 2019, p 5.

115 Queensland Health, correspondence, 21 January 2019, p 5; Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 24 January 2018, p 2.

The Bill further provides that the Minister must table this annual report on the notifiable dust lung register in the Legislative Assembly as soon as practicable after receiving it, so the report will be made public annually through this process.

Information about individual companies is not intended to be published. The purpose of the register is for Queensland Health to monitor and analyse the incidence of notifiable dust lung diseases, and exchange information about notifiable dust lung diseases with other Queensland Government entities. Any issues involving dust exposure related to particular companies or worksites will continue to be managed through existing processes, such as under workplace health and safety legislation.[116]

2.2.1.3 Committee comment

The committee supports the amendments to the *Public Health Act 2005*, principally clause 22, to establish the Notifiable Dust Lung Disease register and improve the reporting of cases of notifiable dust lung disease.

2.2.2 Pollution events

In recent years, there have been a number of pollution events in Queensland that have had the potential to cause a public health risk, often involving instances of contamination of water supplies from chemicals found in firefighting foams.[117]

The department advised that in such circumstances, 'Queensland Health thinks it is critical that Queenslanders are notified quickly where there is a potential risk to their health from a pollution event'.[118]

Currently, under the Public Health Act, authorised persons have a range of powers. This includes a power to issue a public health order to a person they believe to be responsible for a public health risk, requiring that person to take remedial action to remove or reduce the public health risk associated with a pollution event or prevent it from recurring.[119]

However, the Public Health Act does not specifically empower Queensland Health to require the person responsible for the public health risk to notify the public of the risk arising from the pollution.[120]

The explanatory notes advise that 'this can result in delays in the public receiving notice of the public health risks caused by a pollution event',[121] with Queensland Health or the local council typically having to perform this role if the person causing the pollution does not comply with a request to issue public advice about the incident.[122]

2.2.2.1 The proposed amendments

The Bill inserts a new Chapter 7A 'Pollution events' into the Public Health Act, to give the chief executive new powers to respond to a pollution event in a way that informs the public of the potential public health risk and, where appropriate, any actions necessary to avoid or reduce the effect of the

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116 Queensland Health, correspondence, 21 January 2019, p 5.

117 Queensland Health, correspondence, 27 November 2018, p 7; Dr Sonya Bennett, Acting Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 5 December 2018, p 9.

118 Dr Sonya Bennett, Acting Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 5 December 2018, p 9.

119 *Public Health Act 2005,* section 23.

120 Queensland Health, correspondence, 27 November 2018, p 7.

121 Explanatory notes, p 4.

122 Queensland Health, correspondence, 27 November 2018, p 7.

pollution event on public health.[123] A 'pollution event' is described broadly as 'the release or dispersal of a contaminant or pollutant that may adversely affect public health'.[124]

Under new section 313E, the chief executive will have the power to direct a person responsible for a pollution event to publish a pollution notice that informs the public of the nature and extent of the pollution event, and any action required to remove or reduce the effect of the pollution event.[125]

The chief executive will have the power to specify the content of the notice, and when and how it is published, including 'for example, a media statement, newspaper notice, radio announcement or letter to impacted persons or entities', with accompanying direction as to 'the time within which the notice must be made'.[126] The explanatory notes advise that 'this will ensure that the notice is disseminated to impacted persons or entities and that the content of the notice is appropriate'.[127]

Non-compliance with a direction to publish a pollution notice will carry a maximum penalty of 200 penalty units ($26,110). The explanatory notes state that this is consistent with a number of other penalties in the Public Health Act, including the offence of failing to comply with a public health order.[128]

The Bill would also create a new power for the chief executive to publish a pollution notice, where:

- the person responsible for the pollution event cannot be readily identified or otherwise cannot comply
- the person responsible has been given a direction to publish a notice but has not published the notice by the date specified or otherwise has not complied with the direction, or
- the pollution event is naturally occurring.[129]

Before giving a direction to publish a pollution notice or publishing a notice, the proposed amendments require the chief executive to consult with any relevant public service officer having the necessary expertise and experience to provide advice to the chief executive about the pollution event.[130]

The explanatory notes advise:

> *Depending on the pollution event, this could include officers from the Department of Environment and Science, the Department of Natural Resources, Mines and Energy, the Department of Transport and Main Roads, the Department of Agriculture and Fisheries and Workplace Health and Safety Queensland. The provisions will enable Queensland Health to ensure there is timely, accurate and appropriate advice to the public about the health risks arising from the pollution, while ensuring other agencies can continue to lead any remedial actions required to respond to pollution events.*[131]

The Bill will also allow a person who suffers a loss because of the exercise of the new pollution event powers to claim compensation from the state. However, compensation will only be available for a loss arising from an accidental, negligent or unlawful act or omission.[132]

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123 Bill, clause 14, new section 313A, 'Purpose of chapter'.

124 Bill, clause 14, new section 313C, 'Meaning of pollution event'.

125 Bill, clause 14, new section 313E. See also new section 313D, 'meaning of a pollution notice'.

126 Queensland Health, correspondence, 27 November 2018, p 7.

127 Explanatory notes, p 9.

128 Explanatory notes, p 9.

129 Bill, clause 14, new section 313F.

130 Bill, clause 14, new section 313G.

131 Explanatory notes, p 9.

132 Bill, clause, 14, new section 313H(2).

Further, a court may order the payment of the compensation only if it is satisfied that it is just to do so the circumstances of the particular case, having regard to:

- the nature of the pollution event and the risk to public health, and
- whether the loss arose from the publication of a pollution notice in relation to the pollution event.[133]

New section 313(H) also provides for a regulation to prescribe other matters that may, or must, be taken into account by the court when considering whether to order compensation. This regulation-making provision is considered further in section 3.1 of this report – *Fundamental legislative principles*.

2.2.2.2 Stakeholder views and the department's response

Just two submissions addressed the amendments regarding pollution events.

HCQ expressed its support for the amendments, commending Queensland Health for taking this direction.[134] Commentary from respondents to a survey conducted by the organisation included remarks:

- that more information in the public domain can only assist, and legal obligations for responsible persons to notify the public are appropriate[135]
- that the amendments should go further so that the public should be notified immediately or as soon as possible and by text message as well as other forms of media,[136] and
- that the amendments should include information about steps to be taken to minimise risks as well as information on support services available. [137]

In response to the HCQ commentary, the department advised:

> *The proposed amendments will give the chief executive the power to specify the form of the public notice, for example, a media statement, newspaper notice, radio announcement or letter to impacted persons or entities. The pollution notice must describe the nature of the pollution event, the area that is or may be affected, the type and duration of any actions the public may be required to take to avoid exposure, and any other matters the chief executive considers appropriate. The chief executive will also have the power to prescribe the time within which the notice must be made.*
>
> *This will mean that the response is able to be tailored to the type and scale of pollution event and to the population affected.*[138]

The Local Government Association of Queensland (LGAQ), identified a number of concerns about the amendments, some of which were acknowledged in the explanatory notes as having been raised during consultation on the Bill.[139] Specifically, the LGAQ submitted:

- allowing polluters to control public health messaging could result in delayed or inaccurate information

133 Bill, clause, 14, new section 313H(4).

134 HCQ, submission 11, p 9.

135 HCQ, submission 11, p 9.

136 HCQ, submission 11, p 9.

137 HCQ, submission 11, p10.

138 Queensland Health, response to submissions, 21 January 2019, p 4.

139 LGAQ, submission 38, p 3; Explanatory notes, p 18.

- local government must be recognised and consulted during any direction or pollution notice owing to local government responsibilities under the Health Act
- communication about pollution events must be facilitated by trained public health professionals and that management of communication processes should be consistent[140]
- the Bill should include a legislated pollution or contamination threshold to confine the notification to significant events and avoid unnecessary alarm in areas affected by minor or adequately managed pollution[141]
- the Bill does not acknowledge how the provisions will operate in the context of a declared disaster, where relevant reporting requirements apply as per the *Disaster Management Act 2003*, potentially confusing or delaying these reporting processes ('efforts to ensure consistent messaging during disasters should be maintained').[142]

In respect of the LGAQ's concerns about polluters controlling public health messaging, the explanatory notes emphasise:

> *The chief executive will have the power to specify the content of the pollution notice, and when and how the notice is published. This will ensure that the notice is disseminated to impacted persons or entities and that the content of the notice is appropriate.*[143]

The remaining LGAQ concerns were addressed in the department's response to submissions as follows:

> *With regard to mandating consultation with local government, the need for broader consultation before issuing a notice must be weighed against the risk to public health and the public's right to know, in a timely manner, that a pollution event has occurred. Incorporating a more extensive consultation process would delay the publication of a pollution notice at a time when there could be a significant risk to public health. For this reason, a requirement to consult with local government has not been included as priority has been given to ensuring pollution notices are issued as soon as possible.*
>
> *The Department considers that legislating a threshold for pollution events carries significant risks, given the varying and unpredictable nature of pollution events. For example, numerous pollutants can pose a risk to public health if dispersed in waterways, and it is not practicable to attempt to specify a threshold for each. The Bill provides that a pollution event is the release or dispersal of a contaminant or pollutant that may adversely affect public health. The requirement for the event to adversely affect public health is considered an appropriate threshold.*
>
> *In disaster events, it is not intended that the new power be exercised if public information about health risks from a pollution event that is part of the disaster has already been disseminated. The issuing of a direction is at the chief executive's discretion.*[144]

2.2.2.3 Committee comment

The committee supports the proposed amendments to the *Public Health Act 2005*, principally clause 14, to enable Queensland Health to better manage public health risks associated with pollution events.

2.2.3 Poisons Standard

The Public Health Act requires the manufacture, sale, supply or use of paint to occur in accordance with a standard, being 'the prescribed part of the Standard for the Uniform Scheduling of Drugs and

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140 LGAQ, submission 38, p 3.

141 LGAQ, submission 38, p 4.

142 LGAQ, submission 38, p 5.

143 Explanatory notes, p 10.

144 Queensland Health, response to submissions, 21 January 2019, pp 4-5.

Poisons dealing with paint, compiled by the Ministers' Advisory Council and published by the Commonwealth'.[145]

The explanatory notes advise that the name of the relevant standard, that is, the Poisons Standard mentioned previously in chapter 2.1, has changed to the *Standard for the Uniform Scheduling of Medicines and Poisons.* Accordingly, the reference in the Public Health Act requires updating.[146]

The Bill amends the Public Health Act to remove the existing reference to the standard and instead require compliance with 'a provision of a standard prescribed by regulation'.[147] The explanatory notes advise that this will mean that '…any future changes, such as to the name of the national standard, can be applied without amending the Act'.[148]

The Public Health Regulation 2018 will prescribe the relevant standard.[149]

2.3 Amendments to the *Radiation Safety Act 1999*

In Queensland, people who use or transport ionising and harmful non-ionising radiation sources are required to hold a use licence or a transport licence respectively under the *Radiation Safety Act 1999* (Radiation Safety Act).[150] The purpose of this requirement is to ensure that individuals using or transporting radioactive substances within the state are appropriately trained to safely and competently do so without endangering themselves or other persons, or causing adverse effects to the environment.[151]

Currently, this licence requirement also extends to a range of persons who have been assessed under an equivalent process as suitable to use a radiation source or transport a radioactive substance. This includes various individuals assessed through a professional registration process (particularly health professionals), or individuals granted an equivalent licence in another jurisdiction.

For example:

- Use licence: A dentist is required to hold a use licence to utilise intra-oral dental X-ray equipment to produce images which are used to diagnose various dental conditions. To be registered as a dentist by the Dental Board of Australia, as is required under the Health Practitioner Regulation National Law, a person must hold an approved qualification. Courses approved by the Dental Board have been assessed to determine their adequacy for patient assessment and radiographic training to provide dentists with the knowledge and skills to:
    a) assess the risk of radiation exposure against clinical need (e.g. the justification from a radiation and safety perspective)
    b) perform the necessary imaging, and
    c) undertake radiological assessment of the images.[152]
- Transport licence: People who are transporting radioactive substances from another jurisdiction into Queensland are required to hold a transport licence issued under the Radiation Safety Act, even if that person is licensed or authorised to transport radioactive substances in the other jurisdiction.

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145 *Public Health Act 2005,* section 60.

146 Explanatory notes, p 4.

147 Bill, clause 16, new section 60.

148 Explanatory notes, p 9.

149 Explanatory notes, p 9.

150 *Radiation Safety Act 1999,* sections 13-15.

151 Queensland Health, correspondence, 27 November 2018, p 8.

152 Queensland Health, correspondence, 27 November 2018, p 9.

The regulatory frameworks for the Commonwealth, state and territory jurisdictions currently apply the Code for the Safe Transport of Radioactive Material (Transport Code).[153] As a result, a person transporting radioactive material is subject to the same requirements under the Transport Code in every state and territory.

The cost to make an application for a new use or transport licence is $94.50, with licence fees ranging from $67.50 for a one-year licence, to $202.50 for a three-year licence.[154]

2.3.1 The proposed amendments

The Bill proposes to amend the Radiation Safety Act to make provision for a regulation to prescribe a person or class of persons (a prescribed licensee) who is taken to hold a use licence or a transport licence.[155]

This will allow for the recognition of qualifications, registrations or licences that have equivalent assessment processes to those for use and transport licences under the Radiation Safety Act, reducing the need for these 'prescribed licensees' to also obtain and pay for a separate Queensland licence.[156]

Prescribed use licensees will be identified in regulation by their qualification, registration status or training.[157] Prescribed transport licensees may be identified by the type of radioactive substance, how the radioactive substance must be transported, and the amount of the substance the prescribed licensee is allowed to transport under the transport licence.[158]

The chief executive of Queensland Health may also identify additional conditions for these prescribed licensees where necessary or desirable to protect persons or the environment from the harmful effects of radiation, or to ensure the security of a radiation source.[159]

Further, as an additional safeguard, the amendments specify that before a regulation is made:

> *the Minister must—*
>
> *a) consult with and consider any recommendations made by the council [Radiation Advisory Council]; and*
>
> *b) be satisfied the regulation will be consistent with the radiation safety, protection and security principles.*[160]

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153 The Code requires people transporting radioactive material to receive appropriate radiation protection training, including training in the safe packaging and consigning of radioactive material; and the precautions to be observed to restrict their occupational exposure and the exposure of other persons who may be affected by their actions. See: Australian Radiation Protection and Nuclear Safety Agency, *Code for the Safe Transport of Radioactive Material (2008)*, Radiation Protection Series 2, https://www.arpansa.gov.au/sites/default/files/legacy/pubs/rps/rps2_2008.pdf.

154 Queensland Health, correspondence, 27 November 2018, p 8.

155 Bill, clause 31, section 103K.

156 The draft Health Legislation Amendment Regulation tabled with the Bill included provisions that recognise as prescribed licensees both: a) a person registered under the Health Practitioner National Law to practice in the dental profession as a dentist (other than a student); and b) a person who holds an authority under a corresponding transport law to transport a radioactive substance. See: Health Legislation Amendment Regulation 2018, draft regulation, tabled 13 November 2018, clauses 15-19, https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2018/5618T1870.pdf.

157 Bill, clause 31, new section 103K(2). The regulation must specify the particulars of the radiation source the prescribed licensee is allowed to use under the use licence, and the radiation practice the prescribed licensee is allowed to carry out under the use licence using the source.

158 Bill, clause 31, new section 103K(3).

159 Bill, clause 31, new section 103K(4).

160 Bill, clause 31, new section 103L.

Prescribed licensees will still be subject to the same requirements, standard conditions and penalties for contravention as other licence holders.[161] To this end, the Bill also provides for the register of licensees to include prescribed licensees whose licences have been suspended or cancelled.[162]

This regulation-making provision in Clause 31, proposed section 103K, is considered further in section 3.1 of this report – Fundamental legislative principles.

2.3.1.1 Stakeholder views

While there were a number of general statements of support from submitters regarding the various sets of amendments contained within the Bill, no witnesses or submitters commented specifically on the amendments to the Radiation Safety Act.

The explanatory notes advise that each of the Radiation Advisory Council, Australian Dental Association (Queensland Branch) (ADAQ) and the Transport Workers Union were consulted on the amendments and that 'the Radiation Advisory Council and ADAQ responded supporting the amendments'.[163]

2.3.1.2 Committee comment

The committee supports the proposed amendments to the *Radiation Safety Act 1999* to simplify the licensing and training requirements for persons who use and transport of radiation substances within Queensland.

2.4 Amendments to the *Transplantation and Anatomy Act 1979*

2.4.1 Tissue removal for research purposes

The Transplantation and Anatomy Act provides a regulatory framework for the removal and donation of tissue from adults and children. Currently, the Transplantation and Anatomy Act provides authorisation for the removal of tissue from an adult's body for research purposes, but there is no specific provision which applies to children.[164]

The explanatory notes advise:

> *A significant number of paediatric oncology patients receive treatment through a clinical trial. These patients receive either the current best practice treatment or an experimental treatment that is considered likely to be better than the current practice. Clinical trials have been particularly successful for children. As child enrolment in clinical trials has improved, the overall survival rate for children with cancer has increased from 15 per cent to over 80 per cent.*
>
> *There has been uncertainty among some clinical researchers about the application of the Transplantation and Anatomy Act to the removal of tissue, other than blood, from children for use in research, including in clinical trials, as the research provisions do not specifically apply to children.*

2.4.2 The proposed amendments

The Bill proposes amendments to the Transplantation and Anatomy Act that will outline the circumstances in which tissue can be taken from adults and children for research purposes.[165] The

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161 Dr Sonya Bennett, Acting Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health, public briefing transcript, Brisbane, 5 December 2018, p 3.

162 Explanatory notes, p 5.

163 Explanatory notes, p 19.

164 *Transplantation and Anatomy Act 1979*, s 21B; explanatory notes, p 5.

165 Bill, cl 53; explanatory notes, p 10.

explanatory notes state that the amendments include additional safeguards for children, so that tissue may only be taken in three circumstances:

- *the research is for the benefit of the child; or*
- *the tissue is removed during a procedure that is for the benefit of the child, and a medical practitioner is satisfied that removal of the tissue is not likely to prejudice the health of the child; or*
- *a medical practitioner is satisfied that removal of the tissue will involve a negligible or low risk of harm and minimal discomfort to the child.*[166]

The explanatory notes also advise that these amendments 'will provide clinical researchers with certainty, and give family members and carers comfort, that the Transplantation and Anatomy Act enables children to participate in clinical trials'.[167]

2.4.2.1 Stakeholders views and the department's response

The Acting Deputy Vice Chancellor and Vice President (Research and Innovation) at the QUT, Mr Michael McArdle, submitted that the proposed amendment is welcomed by the research community and does in part remove some degree of ambiguity, particularly for research involving children.[168]

Health Consumers Queensland suggested:

> *…that additional consultation with families of paediatric oncology patients be undertaken prior to Health Consumers Queensland agreeing to this amendment as it stands. One respondent has asked for this amendment to be debated with community input and we would support this additional consultation.*[169]

This statement was made due to the comments received from the survey undertaken by Health Consumers Queensland on the proposed amendments. The majority of comments mentioned the need for consultation and discussion with parents leading to informed parental consent prior to any tissue being collected.[170]

In response to the comments, the department advised:

> *The Department notes that all the concerns raised by community members are addressed by the requirements that approved research is to be approved by a Human Research Ethics Committee in accordance with the National Statement on Ethical Conduct in Human Research (National Statement). Informed consent is an essential part of the process and the amendment requires consent to be given as required under the National Statement. The National Statement requires that a person's decision to participate in research should be voluntary and based on an adequate understanding of both the proposed research and the implications of participating in it.*
>
> *The National Statement also requires that information be presented in a way suitable to the age of the participant. The researcher should consider how they will judge a child's vulnerability and capacity to consent. Any discussion with children should be guided by their level of comprehension.*
>
> *Researchers and clinicians are required, and will continue to be required, to consult with patients (including their parents if they are children) in the clinical setting when tissue is proposed to be*

166 Explanatory notes, p 10.

167 Explanatory notes, p 10.

168 QUT, submission 25, attachment, p 1.

169 HCQ, submission 11, p 11.

170 HCQ, submission 11, p 12.

taken for research purposes and to obtain informed consent, as outlined above. This consultation will be tailored to each family's circumstances.[171]

2.4.3 Exemptions for trade in tissue

The Transplantation and Anatomy Act prohibits the trading of human tissue, except in special circumstances for which the Minister must issue a permit that authorises trade in tissue. Under s 42AA of the Transplantation and Anatomy Act, tissue that has been subjected to processing or treatment, along with a number of other requirements, is not included in the prohibition of tissue trading.[172]

The definition of tissue under the Transplantation and Anatomy Act excludes laboratory reagents, or reference and control materials, derived wholly or in part from pooled human plasma. The explanatory notes advise that pathology laboratories must purchase these excluded materials to carry out routine diagnostic activities and to attain accreditation through national accreditation schemes.[173]

The explanatory notes then state:

Some of the tissue required by pathology laboratories is captured by this exclusion, and may therefore be purchased. However, since the exclusion was inserted in the Act in 1993, tissue types derived other than from pooled human plasma have come to be used as reagents, reference materials and control materials, and accordingly also for quality assurance purposes. These tissue types include whole blood, red blood cells, cerebrospinal fluid, bone marrow cells and cardiac enzymes.

Given these advances in technology, quality assurance program providers and pathology laboratories must apply to the Minister for a permit before they can purchase some of the types of tissue they legitimately require.[174]

2.4.3.1 The proposed amendments

The Bill proposes amending the Transplantation and Anatomy Act so that material declared as exempt from the prohibition will apply to material derived wholly or in part from tissue, which covers laboratory reagents, quality assurance materials and reference and control material.[175]

The explanatory notes advise that these amendments 'will significantly reduce the administrative burden on pathology laboratories who currently must apply to the Minister for a permit before they can purchase some of the types of tissue they require'.[176]

2.4.3.2 Stakeholder views and the department's response

The Royal College of Australian Pathologists of Australasia Quality Assurance Programs (RCPAQAP) advised that it is strongly in favour of the objective of the intended amendments to the Act in relation to Section 42AA, but go on to state:

However, we are concerned that the objective of the amendment to the Section will not be fully achieved because we would consider that it is difficult to characterise much of the tissue that we provide as having been the subject of "processing or treatment". Indeed it is quite important that many of the tissue samples we source and provide are in fact in their native state, and are unprocessed.

…

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171 Queensland Health, correspondence dated 21 January 2019, attachment, p 6.

172 *Transplantation and Anatomy Act 1979*, s 42AA(1)(a)

173 Explanatory notes, p 5.

174 Explanatory notes, p 5.

175 Bill, cl 55.

176 Explanatory notes, p 10.

if the pre-condition of "processing or treatment" is retained for this category of what is proposed to be termed "exempt material", what we understand to be a key objective of the amendment will not be fully achieved, and RCPA QAP will for some categories of tissue still be required to utilise the Ministerial permit system.[177]

The RCPAQAP also raised a concern:

about the language proposed to be inserted as sub-paragraph (iii) in Section 42AA(1)(c) of the Act. It refers to exempt material being "derived wholly or in part from tissue". Our concern again is that what we provide is actually tissue, it is not in the usual sense of the word "derived" from tissue. Again this is partly reflective of the reality that there often isn't any processing or treatment of the relevant samples.[178]

The RCPAQAP expressed a preference for the wording of the equivalent provision in New South Wales' *Tissue Act 1983*[179] which it states 'appropriately balances the State's interest in preventing trade in human tissue, with the benefits of allowing use of tissue in quality assurance programs which are designed to help maintain and enhance the quality of the services provided by the participating pathology laboratories' and proposed amendments to reflect the approach taken in the *Tissue Act 1983* (NSW).[180]

The department advised in its response to submissions:

The Department considers the word "processing" as subjecting something to a series of actions to achieve a particular result. In the instance of quality assurance materials, the Department considers this to be any action performed on the tissue. This action can be either by the pathology laboratory prior to it being sent to a quality assurance provider, or by the quality assurance provider itself, such as cutting/slicing the tissue, putting it on a slide, refrigerating or freezing the tissue, adding a preservative product, or simply packaging the tissue, to enable distribution and examination. Therefore, the Department considers that all tissue sent out to pathology laboratories by the Royal College of Pathologists of Australasia Quality Assurance Programs Pty Ltd and other quality assurance providers as a part of its quality assurance program, are "processed" in some way.

In relation to the second issue, the amendment refers to laboratory reagents, quality assurance materials and reference and control materials derived wholly or in part from tissue. The Department considers that any tissue sent out from a quality assurance provider would have gone through some processing and, as such, the wording "derived" from tissue would cover any tissue sent from a quality assurance provider. The Department does not consider the amendments suggested in this submission to be necessary.[181]

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177 RCPAQAP, submission 36, p 1.

178 RCPAQAP, submission 36, p 2.

179 Section 34(1)(b3)(i) in the *NSW Tissue Act 1983* provides that the following is exempt from the relevant prohibitions in this Act: *the use of small samples of any tissue that is lawfully removed from the body of a person (whether living or deceased) for the purpose of carrying out analyses or tests that are part of a program (including any quality assurance program, quality control program, audit or evaluation) to ensure, or improve, the quality of services carried out at or by a hospital, a forensic institution, a laboratory, an educational or research institution or a supplier of blood or blood products.*

180 RCPAQAP, submission 36, p 2.

181 Queensland Health, correspondence dated 21 January 2019, attachment, p 7.

2.4.4 Location of post-mortem examinations conducted in hospitals

The Transplantation and Anatomy Act provides that a post-mortem examination of the body of a deceased person in a hospital must be made in the mortuary of the hospital.[182]

The explanatory notes state:

> *Post-mortem examinations not only advance medical knowledge, particularly in relation to new or unusual conditions or the efficacy of emerging treatments, but may also identify hereditary and other conditions of importance to relatives of the deceased. However, in the past 10 to 15 years, there has been a significant decline in consensual post-mortems, largely attributed to changed community attitudes regarding invasive procedures and the retention of organs and other tissue for testing purposes.*
>
> *A traditional surgical examination constitutes best practice in the conduct of post-mortems. However, use of imaging equipment can complement a traditional post-mortem, for example, by facilitating guided needle biopsies. Imaging may also be used as a full or partial non-invasive alternative to a surgical examination. Hospital mortuaries are typically not equipped with machinery to undertake X-rays, CT scans, and magnetic resonance imaging, which are available in radiology departments. Confining hospital post-mortems to mortuaries places a significant limitation on the form they can take and does not reflect contemporary approaches to post-mortems.* [183]

2.4.4.1 The proposed amendments

The Bill will amend the Transplantation and Anatomy Act so that a post-mortem can be conducted in any location within the hospital approved by the medical superintendent of the hospital as being suitable for a post-mortem.[184] The explanatory notes state 'This will allow for imaging equipment to be used in post-mortem examinations'.[185]

2.4.4.2 Stakeholder views

Health Consumers Queensland supported the amendment 'with the understanding that current post-mortem practices limit the opportunity to undertake less invasive procedures resulting in a reduced number of families agreeing to invasive post-mortems'.[186] Health Consumers Queensland surveyed its stakeholders asking 'would you be more likely to give consent for a non-invasive post-mortem examination for your family member if that option was available?', and advised that approximately 92 per cent of respondents indicated support for the proposal in the question. Some of the quotes provided in the submission included:

> *Cultural safety and appropriateness may be enhanced for Indigenous people and other cultures, does the family receive a full report?*
>
> *This would also meet the needs of Muslim community members.*
>
> *If a doctor told me a full autopsy was required and the reasons why, despite my own misgivings, I would likely give permission if there was a question over the manner of death. If imaging and scanning can avoid that, I would support it wholeheartedly*
>
> *Didn't think there was any choice - unexpected death in young person is mandatory post mortem. It would be important to me that the numbers seeking this procedure didn't have implications*

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182 *Transplantation and Anatomy Act 1979*, s 30(2)(a); explanatory notes, p 5.

183 Explanatory notes, p 6.

184 Bill, cl 54; explanatory notes, p 10.

185 Explanatory notes, p 10.

186 Submission 11, p 13.

for people living, who need scans and imaging i.e. delays to people requiring imagining for diagnosis or treatment/monitoring. It should not cause any delays to living patients.

Where I live, bodies are sent away for post-mortems. This may allow them to be done locally if required.

Provided that there is a guarantee that any invasive procedures will be carried out in a mortuary and nowhere else.

Make sure procedures are relevant for today's population when seeking permission for post-mortems.

This just makes good sense. Save the purchase of duplicate equipment.

This will fasten the process and is a great step taken in this direction of exploiting the technology for the better of mankind. Great work by the government on this one.[187]

2.4.4.3 Other legislative issues

QUT's Mr McArdle raised a number of other issues regarding the Transplantation and Anatomy Act in his submission that were outside the scope of the Bill, stating that the amendments in the Bill 'presents a valuable opportunity to address other relevant legislative issues in light of the advances made in the use of human tissue for purposes relating to approved research more broadly'.[188] The proposed amendments outside of the Bill's scope were to:

- review the definition of 'human tissue' so that it
    - reflects the contemporary language of 'bio-specimens' as defined in the National Health and Medical Research Council (NHMRC) National Statement on the Ethical Conduct in Human Research 2007, which Mr McArdle states will 'assist with clarifying the scope of what human tissue is included within the meaning of the Act and authorised tissue donations for approved research under Division 6 of the Act'
    - removes the ambiguity as to whether derivatives of human tissue, such as cell lines, are considered a 'substance extracted' and would therefore be included in the scope of the Act's definition of a 'tissue'
- amend s 42A to reduce the administrative burden of the current requirement for researchers and non-prescribed tissue bank custodians to seek a Ministerial permit to trade human tissue on a cost recovery basis or import tissue for the purposes of approved research by
    - broadening the legislative scope of what is considered a 'prescribed' tissue bank, or
    - amending section 42AA 'Trading of tissue for particular purposes' to include human tissue collected for the purposes of approved research where trade is limited to charging a cost-recovery amount to recover the reasonable costs associated with removing, evaluating, processing, storing or distributing donated tissue, or[189]
    - removing the need for any permit for the exchange either as traded or imported human tissue where there is an ethical approval in place or the research is deemed as being negligible risk as defined under the National Statement or an international equivalent standard.[190]

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187 HCQ, submission 11, p 13.

188 QUT, submission 25, attachment, p 1.

189 QUT, submission 25, attachment, pp 1-2.

190 QUT, submission 25, attachment, p 3.

In response to these suggested amendments, the department advised:

> *The Department notes that the additional proposals raised by Queensland University of Technology are outside the scope of the Bill. However, the Department will consider these issues as part of any future review of the Act. Australia's Health Ministers are advocating for a national review of human tissue Acts to ensure they are contemporary, based on principles that can accommodate emerging technologies, promote national consistency across Australia and do not contribute to barriers to organ and tissue donation. Health Ministers have asked for the national review to be undertaken by the Australian Law Reform Commission. The decision to refer this matter to the Australian Law Reform Commission is one for the Commonwealth Attorney-General.*[191]

2.4.5 Simplifying procedures surrounding the use of human body parts for the study and practice of anatomy and their disposal

Under the *Coroners Act 2003* (Coroners Act), a person must not prepare a human body for burial or bury a human body unless a cause of death certificate has been issued, or the coroner has ordered the release of the body under section 26 of the Coroners Act.[192] Similarly, under the *Cremations Act 2003* (Cremations Act), human remains must not be cremated unless permission is given by the coroner who ordered the autopsy or, if that coroner is unavailable, another coroner, or otherwise an independent doctor.[193] However, these provisions in the Coroners Act and Cremations Act do not apply to part of a human body taken during an autopsy or during a medical procedure.[194]

For schools of anatomy that are authorised to use bodies of deceased persons for anatomical examination or the study and teaching of human anatomy, the *Transplantation and Anatomy Act 1979* requires donor bodies to be cremated or buried as soon as possible after the period for which the body is authorised to be retained, or as soon as possible after the body has been used for the purpose for which it was retained. This includes part of a body.[195]

The explanatory notes advise that while schools of anatomy possess death certificates for bodies donated under their body donor programs, and are lawfully able to cremate these bodies if an independent doctor issues an approval, during dissection of donor bodies it is not always practicable to collect and store parts of donor bodies on a per-donor basis for later cremation. The explanatory notes state:

> *This makes it onerous for an independent doctor to match each individual body part with a cause of death certificate and issue an approval.*[196]

The explanatory notes also advise that there are circumstances in which a school of anatomy may possess human body parts for which the cause of death certificates are not available:

> *For example:*
>
> - *historical specimens of unknown identity, such as skeletons donated by the estates of deceased general practitioners; and*
> - *tissue imported from overseas body donor programs for which identifying information may not be provided for reasons of confidentiality.*[197]

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191 Queensland Health, correspondence dated 21 January 2019, attachment, p 7.

192 *Coroners Act 2003*, s 95. Section 26 of the Coroners Act provides for the Coroners control of a body.

193 *Cremations Act 2003*, s 5.

194 *Coroners Act 2003*, s 95; *Cremations Act 2003*, s 4(b).

195 Explanatory notes, p 6.

196 Explanatory notes, p 6.

197 Explanatory notes, p 6.

Furthermore, under the *Births, Deaths and Marriages Registration Act 2003* (BDMR Act), a person who disposes of a human body under certain circumstances must give notice of this to the registrar-general.[198] While the BDMR Act provides that this requirement does not apply to a school of anatomy when disposing of a human body given to the school, it does not apply to disposal of a part of a body. The explanatory notes state that 'notifying every occasion of disposal of a part of a body is onerous'.[199]

2.4.5.1 The proposed amendments

The Bill amends the Coroners Act and the Cremations Act to provide an exemption from the requirements for burial or cremation (under those Acts) for parts of a body used at a school of anatomy for the study and practice of anatomy, in addition to the exemption for parts of a human body taken during an autopsy or during a medical procedure.[200]

The Bill also amends the BDMR Act to extend the existing notification exemption associated with the donation of a human body to a school of anatomy, to also apply to parts of a human body donated to a school of anatomy.[201] The Minister, in his introductory speech, advised:

> *The amendments will ensure schools of anatomy can respectfully dispose of donor body parts where the parts of the body were used at a school of anatomy for the study and practice of anatomy.*[202]

2.4.5.2 Stakeholder views and the department's response

The AMA Queensland stated that the changes regarding death certificates for schools of anatomy are 'common sense changes'.[203]

HCQ also agreed with the amendments 'with the understanding that the family is informed of this Amendment at the time of donation to schools of anatomy'.[204]

In addition, HCQ included in their submission the results of their survey of stakeholders on the proposed amendments, in which they asked 'if a family member's body or body parts have been donated to a school of anatomy, or you are planning to donate to a school of anatomy do you agree with these amendments?'. According to HCQ, the survey showed that 80 per cent of respondents who provided feedback on the amendments to the Coroners Act, Cremations Act and BDMR Act, supported the amendments. Comments made by those who expressed support included:

> *As long as the person donating is fully aware of the conditions of cremation/burial.*
>
> *Yes, provided that there are internal processes in place to ensure only donated organs are disposed of.*
>
> *Can this be written to the conditions of the original body donation that this is what will be done with the body/part when the time comes? That way family is unlikely to have a problem if the donor or family consents to that at the point of donation.*
>
> *Once a body part is removed it's not the body anymore it's biological waste it should be treated with respect and disposed as such.*[205]

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198 *Births, Deaths and Marriages Registration Act 2003*, s 32(2); explanatory notes, p 10.

199 Explanatory notes, pp 10-11.

200 Bill, clause 6 & 8.

201 Bill, clause 4; explanatory notes, p 11.

202 Hon Steven Miles MP, Minister for Health and Minister for Ambulance Services, Queensland Parliament, Record of Proceedings, 13 November 2018, p 3393.

203 AMA Queensland, submission 29, p 1.

204 HCQ, submission 11, p 14.

205 HCQ, submission 11, p 14.

Only one comment included in the submission was not supportive of the amendments. This respondent stated:

> *Very uneasy about this provision: "an exemption from the requirements for burial or cremation under those Acts for part of a body used at a school of anatomy for the study and practice of anatomy." Does that mean that donated bodies or their parts can be held in perpetuity and used or disposed of at the inclination of the school of anatomy?*[206]

In response to this respondent's comments, the department stated:

> *The Department notes that section 6 of the Transplantation and Anatomy Regulation requires a school of anatomy to dispose of a body as soon as practicable after the end of the period for which it is authorised to be retained, or otherwise as soon as possible after the body has been used for the purpose for which the retention of the body was authorised.*
>
> *This means that people who donate their bodies to schools of anatomy consent to the period for which a school of anatomy is authorised to keep the body. Bodies are not able to be held indefinitely by schools of anatomy without consent. The proposed amendments will ensure that bodies and parts of bodies are able to be disposed of lawfully as soon as the period of retention finishes.*[207]

2.4.5.3 Committee comment

The committee supports the proposed amendments to the *Transplantation and Anatomy Act 1979* to clarify the regulatory requirements for the removal of tissue for research purposes; reduce the regulatory burden on pathology laboratories in relation to their access to certain tissues; and to allow post-mortems to be conducted in hospitals outside of mortuaries. The committee also supports the amendments to simplify procedures for the use and disposal of human body parts for the purposes of anatomy.

2.4.6 Amendments to the *Retirement Villages Act 1999*

The sale of retirement village residences is distinct from the sale of a suburban home in that the market is significantly smaller (often restricted by age), and the sale process is often managed by the retirement village operator. Unlike the sale of a suburban home, a retirement village resident generally does not occupy their unit or rent out their unit while it is up for sale.[208]

In some cases, the sale process can take many months or even years, and can result in significant hardships for residents. This is particularly the case given most retirement village residents use the majority of their capital (such as the sale proceeds from a residential home) to buy into a retirement village. The proceeds of sale from their retirement village unit may therefore be required to fund their move to their next place of accommodation, particularly for transitions into higher forms of care.[209]

In 2017, amendments were made to the *Retirement Villages Act 1999* (Retirement Villages Act) which ensured that if a retirement village unit remains unsold, a resident would receive their exit entitlement (i.e. the return of their capital, less exit fees and costs) no later than 18 months after they terminate their right to reside in the retirement village (2017 reforms).

The explanatory notes state that the policy intent of the amendments 'was to apply the new payout timeframe to all tenure types to improve consumer protection'.[210] However, the 2017 amendments applied specifically to exit entitlements. Under the Retirement Villages Act, no exit entitlement is

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206 HCQ, submission 11, p 14.

207 Queensland Health, correspondence, 21 January 2019, p 7.

208 Queensland Health, correspondence, 27 November 2018, p 14.

209 Queensland Health, correspondence, 27 November 2018, p 14.

210 Explanatory notes, p 7.

payable by the scheme operator to residents with freehold tenure. Owners of freehold units rather receive a payment directly from the incoming resident, and therefore currently do not have access to the security of the 18-month maximum payment period established by those amendments.[211]

The Department of Housing and Public Works (DHPW), which administers the Retirement Villages Act, has estimated that there are 2,201 freehold retirement village units in Queensland, representing 7.4 per cent of all units.[212]

2.4.6.1 The proposed amendments

The Bill will amend the Retirement Villages Act to ensure that the protections introduced by the 2017 reforms apply equally to all tenure types.[213]

Given the difference in tenure between freehold and other unit types, the Bill effectively requires the village operator to 'buy back' an unsold unit from the outgoing resident after 18 months, by entering into a contract with the resident to purchase the property.[214]

The mandatory purchase must occur unless the operator has a reasonable excuse, with the scheme operator required to enter into the contract in sufficient time for the purchase to be completed within the 18-month period from the termination date (the date on which the resident terminated their right to reside in the retirement village).[215]

The explanatory notes advise:

> *A reasonable excuse includes where the operator has made all reasonable efforts to complete the contract, but a former resident has not made necessary arrangements, for example arrangements for the release of a mortgage; or where an application is made to the Queensland Civil and Administrative Tribunal (QCAT) about a dispute relating to the contract; or where a private contract for the sale has been entered into by the resident.*[216]

As with other tenure types, where an operator would suffer financial hardship as a result of the mandatory purchase, the operator may seek an extension of time from QCAT. In such circumstances, QCAT must take into consideration whether an extension would be unfair to the former resident.[217]

Where a former resident has died or otherwise terminated their right to reside, the Bill maintains the protections afforded to a relative of the former resident who continues to reside in the unit, as is permitted under existing section 70B of the Retirement Villages Act. That is, the termination date is taken to be the last day that the relative resides in the unit under section 70B.[218]

Consistent with the previous 'buyback' amendments to other tenure types, the amendments outline equivalent processes for:

- good faith negotiation and agreement in writing on the resale value of the accommodation unit within 30 days from termination, including the requirement for the scheme operator to obtain a valuation within 14 days if agreement cannot be reached in this time
- reimbursement of the operator's reasonable legal costs

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211 Explanatory notes, p 7.

212 Explanatory notes, p 7.

213 Mr Mark Wall, General Manager, Strategy, Policy and Programs, Housing, Homelessness and Sport, DHPW, public briefing transcript, Brisbane, 5 December 2018, p 6.

214 Explanatory notes, p 11.

215 Bill, clause 38, new section 63A(2)(b).

216 Explanatory notes, p 28.

217 DHPW, correspondence, 27 November 2018, p 16.

218 Bill, clause 38, new section 63H.

- the arrangements for the sharing of ongoing costs once a resident has left a village.[219]

Significantly, and as was also the case with the 2017 amendments, the amendments in the Bill will apply to existing residence contracts. In advice to the committee, DHPW explained:

> *This retrospectivity is required to maintain the original intention of the 2017 amendments and ensure there is equity between freehold tenure residents and residents with other kinds of tenure, as well as between existing and new residents.*[220]

And:

> *To ensure the provisions strike the right balance between resident protection and industry viability, the 2017 amendments to the Retirement Villages Act (section 225) provide for an independent statutory review of the 18-month timeframe for payment of a former resident's exit entitlements. The statutory review will determine the impact of the timeframe on residents, former residents, their families and retirement village operators. The review will start by 10 November 2019, which is six months after the first payments are expected to be made under the provisions. The 18 month timeframe for the mandatory purchase of freehold units, as well as the starting point for the 18 month period, will be considered at the same time.*[221]

To support the accommodation of the amendments in contract documentation, the Bill includes provision for regulation to prescribe and/or prohibit terms to be included in a sale contract for the mandatory purchase of a freehold tenured unit in regulation.[222]The explanatory notes state:

> *The use of a head of power to make a regulation is justified due to the detailed and technical nature of contracts of sale for retirement village units and the potential need to adapt to rapidly changing business practices and innovations in the retirement village sector.*[223]

The Bill also includes a power to make a regulation that makes temporary amendments to the Retirement Villages Act which are of a transitional or savings nature, to facilitate the transition to the amended Act where there is 'insufficient provision' in the Act for sections related to the 18-month payment to operate.[224] The Bill provides that any transitional regulation made under the provision will expire one year after commencement.[225]

The retrospective application of the provisions and the regulation-making powers are considered further in chapter 3.1 – *Fundamental legislative principles.*

As the Bill compels the mandatory purchase of a property by the scheme operator and transfer duty may apply to the transaction, the Bill amends the Duties Act to provide a transfer duty exemption.[226]

2.4.6.2 Stakeholder views and the department's response

2.4.6.3 Policy intent of 2017 reforms to the Retirement Villages Act 1999

Some submitters commented on the intent of the 2017 reforms and differed on whether the Bill does clarify the policy intent of the 2017 reforms as stated in the explanatory notes.

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219 DHPW, correspondence, 27 November 2018, pp 15-16;

220 DHPW, correspondence, 27 November 2018, p 16.

221 DHPW, correspondence, 27 November 2018, p 16.

222 Bill, clause 38, new section 63C(2).

223 Explanatory notes, p 15.

224 Explanatory notes, p 11.

225 Bill, clause 28, new section 237R(4).

226 Explanatory notes, p 11.

The Property Council of Australia (PCA) submitted that they do not agree with the statement in the explanatory notes suggesting that this amendment seeks to clarify the policy intent of the 2017 amendments, stating:

> *The fact that this amendment contains 11 detailed clauses seeking to further amend the RV Act, in our view shows that this was never a policy intent. Indeed, this affirms the industry was correct in forming the view that the 2017 amendments would not apply to freehold villages.*[227]

In contrast, the Caxton Legal Centre submitted 'However it is clear from the explanatory notes to the Building Better Futures Act, and submissions made during the consultation process, that it was always intended that the legislation apply to all types of retirement village interests'.[228]

Similarly, the Queensland Law Society submitted:

> *Whilst QLS considers that arguably, this intention was already fulfilled by virtue of the amendments made to the Retirement Villages Act upon the passing of the Housing Legislation (Building Better Futures) Amendment Act 2017, we agree that the proposed amendments set out in the Bill now puts these requirements beyond any doubt.*[229]

In response to these submissions, DHPW stated:

> *The policy intent was always that seniors who have left retirement villages should not have to wait more than 18 months to receive their funds.*
>
> *The legal difference between lease or licence situations and freeholds was not identified by stakeholders until after the 2017 amendments were passed.*
>
> *The department confirms that the amendments in the Bill are intended to clarify that a resident is entitled to payment for their unit 18 months after they terminate their right to reside in the village, regardless of tenure type.*
>
> *The contradictory nature of the submissions demonstrates that clarity on this matter is required.*[230]

2.4.6.4 Financial impacts on operators

Submitters raised the issue of the likely financial impacts of the proposed amendments on operators of retirement villages. A number of submitters raised concerns about the financial impact, particularly smaller operators.[231] For example, the PCA submitted:

> *This is completely unacceptable and will add to the significant financial liability that Operators are currently carrying for leasehold and licence villages as we approach the date in May 2019 when Exit Entitlements will start to be paid on units that have not sold.*[232]

Mr Gordon Saul, the owner of an independent living retirement village, submitted that the amendments could result in fees being increased to compensate for the increased risk, stating:

> *As discussed above, I believe this proposed legislation has a number of unintended consequences, and will probably result in increased deferred management fees in the strata sector and in increased incoming fees in the case of the leasehold and right to occupy sector – how can it not?. It increases the risk to the scheme operator, and the stated aim of providing "financial certainty"*

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227 PCA, submission 10, p 1. The Property Council of Australia's submission was supported by Stockland Communities (submission 35, p 1).

228 Caxton Legal Centre, submission 32, p 3. The Caxton Legal Centre's submission was supported by National Seniors Australia, the Association of Residents of Queensland Retirement Villages, and Tenants Queensland.

229 QLS, submission 19, p 2.

230 DHPW, correspondence, 18 January 2019, attachment, p 7.

231 See for example submissions 3, 10 & 35.

232 PCA, submission 10, p 1.

is uncertain, with the consequence to the resident seeking to move on to a higher level of care, being significantly less funds to contribute to their next choice, and may well result in a lowering of their standard of living and general well being. In many cases, the amendments proposed here will as often reward the beneficiaries of an estate, rather than the residents these amendments seek to protect. As studies have shown, 65% of residents in Nursing Homes die within 1 year of admission (Geripal, 2010), so sales proceeds are passed to the estate. This should also put into perspective the 18 month time frame proposed in these amendments.[233]

The Caxton Legal Centre anticipated the argument regarding the financial impact on operators, and submitted that while the 2017 reforms always intended that the legislation apply to all types of retirement village interests, 'the industry is now aware of the proposed changes (some 6 months before they will take effect), which should provide them with adequate time to budget for any mandatory buy-back costs'.[234]

In response, DHPW stated:

Following the 2017 amendments, approximately 93% of all village operators are already required to make payment to a former resident 18 months after they terminate their right to reside in a unit. The Bill extends the requirement to the remaining 7% of operators.

Where an operator would suffer financial hardship as a result of the mandatory purchase of the freehold unit, they may apply to QCAT for an extension of time. There is no limit on the number of extensions an operator may seek.

This provides a fair balance between industry viability and consumer protection.[235]

2.4.6.5 Differences between freehold and leasehold or licence tenure units

Some submitters argued that there is a fundamental difference between freehold and leasehold or licence tenure arrangements, and therefore different rules should apply depending on the nature of the tenure.[236] For example, the PCA submitted:

The tenure arrangements between freehold and leasehold or licence arrangements is fundamentally different and therefore the financial structure and arrangements for Operators are completely different in a freehold scenario.

In broad terms, an Operator of a freehold strata village is somewhat similar to a body corporate manager, as opposed to an Operator in a leasehold or license setting where the underlying ownership of the units and the land sits with the Operator and a contract is formed between the Operator and the resident to reside in the village.[237]

Similarly, Mr Saul submitted:

I would argue that there is a fundamental difference between a right to occupy or leasehold arrangement, and an interest in a freehold strata title. The difference is both practical and philosophical. When a purchase is made in a freehold, that person owns the property, and is subject to the vagaries of the real estate market in the same sense as any land owner. When a person purchases a right to occupy or a leasehold interest, then their interests are governed by contract law. You may also bear in mind that those entering into a strata title purchase are not paying any moneys upfront directly to the scheme operator, in contrast to a right to occupy or leasehold arrangement. Rather, the strata title scheme operator is only remunerated when a unit

233 Mr Gordon Saul, submission 3, p 2.

234 Caxton Legal Centre, submission 32, p 3.

235 DHPW, correspondence, 18 January 2019, attachment, pp 7-8.

236 See for example submissions 3, 10 & 13.

237 PCA, submission 10, p 2.

sells, and doesn't have the luxury of an entry fee to rely on. It is noted in the discussion around these amendments that 7.4% of all retirement units available in Queensland have a strata title. I would point out that the majority of these are within smaller, owner operated villages that actually have significantly lower fees than many of the "corporate" villages with alternative fee models.[238]

In advice to the committee in response to the submissions, DHPW stated:

A fundamental element of living in a retirement village is the level of control able to be exercised by the operator in relation to the property. In a retirement village, a freehold resident generally has a reduced level of control over any resale (compared with a freehold property outside a retirement village).

Regardless of the tenure type of the retirement village unit, resale can only ever occur as permitted under the residence contract. After six months, a resident may appoint a real estate agent to manage the resale as per section 64 of the Retirement Villages Act.

The Retirement Villages Act provides for the operator to be involved in setting the price for the resale of the unit. An operator and a resident need to agree on a resale price, and if they are unable to agree, they obtain an independent valuation which becomes the resale price. This is reviewed by them every three months.

The resale will likely be conditional upon a new resident entering into a residence contract with the operator, and in some cases, the operator will be a party to the resale contract.

Once a right to reside in a retirement village unit is terminated, the resident generally needs to move out of the unit and can't live in the unit or rent it out during the resale process. This results in less flexibility for the former resident and means they may need to fund their next place of accommodation before they receive the proceeds of sale.

Due to the limited control able to be exercised by a resident of a freehold unit in a retirement village, it is considered that they are in a similar position to a resident holding licence or leasehold tenure.

The Bill will address the current gap in protection for residents in freehold units and improve fairness by ensuring they have the same protection as residents with other tenure types.[239]

2.4.6.6 Operator control of the sale process

Issues were also raised about the impacts on operators regarding the selling of the unit. Stockland submitted:

In a Freehold Village, the resident owns their unit. In this context, the resident has a choice as to who they engage to sell the unit on their behalf when they wish to depart the village. Whilst many residents of Freehold Villages chose to appoint the operator (or an agent nominated by the operator) to sell the unit, the resident is under no obligation to do so and some residents chose to appoint another agent.

Without amendment, this would require operators to assume the full burden of having to compulsorily acquire a unit when it or its nominee is not appointed to sell the unit and therefore has no opportunity to effect the sale of the unit. This will likely create a number of significant operational and commercial issues for owners, particularly for smaller operators.

We would suggest that if the Amendments are to be introduced the following provisions ought to be included:

238 Mr Gordon Saul, submission 3, p 1.

239 DHPW, correspondence, 18 January 2019, attachment, pp 8-9.

1. operators of Freehold Villages be afforded a right under the RV Act to sell the unit; and

2. residents (and their estates) be obliged to do all things reasonably necessary and in a timely manner to facilitate the sale of the unit by the operator, including make the unit available for inspection by prospective residents, etc.[240]

The PCA submitted:

Operators of leasehold and licence villages have a level of control over the sales process that is not afforded to operators within freehold villages. In a freehold context, owners are at liberty to appoint external agents and determine a listing price for that appointment and the Operator has no oversight or control of this process.

If the price is set too high for the market, then it is likely that the Operator will be required to carry out a mandatory purchase. In this scenario the Operator will offer a mandatory purchase price at a point in time before the 18 month period expires, and at a more comparable price to the market value. The resident may not agree to this price and this will then trigger additional costs due to the Operator being required to obtain a valuation that will then be taken to be the agreed value.

To assist in mitigating the need for an Operator to carry out a mandatory purchase the HOLA Bill should be amended so that the Operator has the exclusive right to market and sell the unit from the date that notice is given (by the resident or the Operator) triggering the sale.[241]

Similarly, Mr Gordon Saul submitted:

Previously, it has been in both the scheme operators and the resident interests to see an increase in value for the property as a whole. This is one of the rare occasions when a business operator and their clients (in this case the residents) interests precisely coincide. A better village, better services, better management, better maintenance and care is exactly what both parties want, as the results are an improved quality of life and hopefully, a waiting list of people wanting to enter a well run village. I am not sure that this will still be the case in the future, as there may be less incentive to both parties to improve a village, particularly if the village is caught in a real estate market lull with significant unsold units. Note that it is the strata title owners responsibility to sell their property, and to choose their own real estate agents. These amendments will adversely impact the scheme operator if the vendors choice of agent or selling method is poor. One can well imagine the scenario where there is no incentive to promote a sale through advertising or flexibility on price, when the vendor can be assured a return through these proposed amendments. It is also the former residents responsibility to return the unit to a reasonable state for sale. This can often, and frequently does, take months. As scheme operator, we endeavour to assist in any way we can, however, particularly with deceased estates, this is often a long drawn out process that is out of the scheme operators control.[242]

The Domain Residents Association Inc (DRA) submitted:

The siting of residences is something over which residents have no control but, as is the case in The Domain, the operator has persistently ignored repeated requests by the DRA and the affected residents to have appropriate access to the properties waiting to be sold. We consider that a "reasonable excuse" should not be available to a village operator whose "benign neglect" of a marketing opportunity renders it practically impossible for the subject residence to be marketed effectively or sold.[243]

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240 Stockland Communities, submission 35, p 2.

241 PCA, submission 10, p 2

242 Mr Gordon Saul, submission 3, p 2.

243 The Domain Residents Association Inc, submission 4, p 2.

In advice to the committee, DHPW stated:

> *The Retirement Villages Act provides for the operator to be involved in setting the price for the resale of the unit. An operator and a resident need to agree on a resale price, and if they are unable to agree, they obtain an independent valuation which becomes the resale price. This is reviewed by them every three months.*
>
> *Regardless of the tenure type of the retirement village unit, resale can only ever occur as permitted under the residence contract. After six months, a resident is entitled under s.64 of the Retirement Villages Act to appoint a real estate agent to manage the resale.*
>
> *The scheme operator must promptly give to the former resident details of each offer to purchase the unit.*[244]

2.4.6.7 Retrospectivity

The PCA submitted that it is unacceptable to make the amendments retrospective, stating that the retrospectivity 'will add to the significant financial liability that Operators are currently carrying for leasehold and licence villages as we approach the date in May 2019 when Exit Entitlements will start to be paid on units that have not sold'.[245]

In contrast, the Caxton Legal Centre submitted:

> *To ensure that equal treatment is extended to all residents, it is also essential that the new buyback provisions apply retrospectively. In this regard QRVPAS strongly support the introduction of new section 237Q, which will ensure that former residents with freehold interests can expect to have their homes bought-back in approximately the same timeframe as other retirement village residents. This amendment is necessary to rectify the situation for former residents with freehold interests, who may have moved out of their retirement village with the mistaken belief that the 18-month buy-back provisions would apply, and will ensure that they are not unfairly excluded by the earlier amendments to the RV Act.*[246]

2.4.6.8 Insufficient regulatory impact assessment

The PCA expressed disappointment that the committee had not been provided with a Regulatory Impact Statement (RIS) and raised concerns that the amendment 'will have unforeseen implications due to it being pushed through without broader analysis or simply understanding what issue the amendment is trying to resolve- and ultimately whether or not this amendment will serve that purpose'.[247]

In response to the comments about the RIS, DHPW stated:

> *A Consultation Regulatory Impact Statement (RIS) and Decision RIS were prepared and published in relation to the review of the Retirement Villages Act.*
>
> *These documents considered the need to introduce protections for residents in the event the resale of their unit was delayed. It was determined that former residents should receive their funds 18 months after terminating their right to reside in a village.*
>
> *These protections to improve financial security were introduced as part of the 2017 amendments, and their application is being clarified as part of the Bill.*[248]

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244 DHPW, correspondence, 18 January 2019, attachment, pp 10-11.

245 PCA, submission 10, p 1.

246 Caxton Legal Centre, submission 32, p 3.

247 PCA, submission 10, p 2.

248 DHPW, correspondence, 18 January 2019, attachment, pp 9-10.

2.4.6.9 Resident-operated villages

Six submissions were received from residents of the same resident-operated village (Pebble Beach Retirement Village), all of whom requested that resident-operated villages be made exempt from the mandatory purchase requirements as proposed in the Bill.[249]

Submitters raised concerns that residents in such a village would be disadvantaged by the proposed amendments 'as all unit holders in the village have an equal share in the village and would be liable to equal costs should this occur',[250] which could cause financial hardship for residents.[251] Concerns were raised that should there be a number of unsold units the cost to purchase the units would be very high with no guarantee of recouping the amount paid out,[252] with the suggestion that it may 'create an untenable situation whereby the village may have to go into major debt in order to fund mandatory acquisitions'

In response to these concerns, DHPW advised:

> *It is important to note the proposed 18-month buyback provisions will only be triggered where the right to reside in the unit has been terminated. A freehold resident may list their unit for sale and remain in the unit indefinitely where the right to reside has not been terminated.*
>
> *Where the right to reside in a unit has been terminated, the mandatory purchase provisions in the Bill will commence.*
>
> *As with other operators, resident-operators can apply to QCAT for an extension of time for the mandatory purchase of an unsold unit where the requirement to purchase the unit would cause the operator undue financial hardship.*
>
> *The unit remains on the market during the extension and the matter would be resolved by any resale to an incoming resident. Alternatively, the resident-operators may apply to QCAT for further extensions of time, if needed.*[253]

In addition to the above response to concerns about resident-operated villages, DHPW provided the more general response:

> *The main objects of the Retirement Villages Act are to promote consumer protection and fair-trading practices in operating retirement villages and in supplying services to residents. It does this by regulating the relationship between operators and residents. The Act is not designed specifically to cover the situation where residents are also the village operator, however all operators and residents are bound by the legislation.*
>
> *The department has identified 10 retirement villages where the residents are the scheme operator for the village in some capacity. The legal and financial structures are different in each village, with varying levels of complexity. These freehold units in resident-operated villages represent approximately two percent of all retirement village units in Queensland.*
>
> *It is important to note that for a freehold unit, this 18-month payout timeframe commences from the termination of the resident's right to reside in the unit and not from the date they list the property for sale or vacate their unit. The resident's right to reside in a village can only be terminated in certain circumstances under the Act, including by their death or by written notice to the scheme operator. This means that a resident may leave the village or list their unit for sale*

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249 See submissions 2, 6, 8, 9, 13 & 14.

250 Ms Anne Eagles, submission 2, p 1.

251 Mr Wayne and Mrs Lorraine McClear, submission 8, p 1.

252 Ms Anne Eagles, submission 2, p 1; Mr Wayne and Mrs Lorraine McClear, submission 8, p 1.

253 DHPW, correspondence, 18 January 2019, attachment, p 12.

without terminating their right to reside and without triggering the commencement of the 18 months mandatory purchase provisions.

When a buyback provision is triggered, resident-operators can apply to QCAT for an extension of time to complete the purchase if the operator is likely to suffer financial hardship as a result of the purchase. The unit remains on the market during the extension and would be resolved by the resale. There is no limit on the number of times an operator can seek extensions from QCAT.

The department is working with these resident-operated villages to support them to understand the proposed amendments and their obligations regarding the other legislative changes arising from the 2017 amendments to the Act which are commencing progressively throughout 2019. It may be relevant for resident-operated villages to consider whether operating as a registered retirement village continues to offer the most appropriate model for the village and residents.

It is anticipated that some of these villages may elect to deregister as a retirement village and continue to operate as a community title scheme. They may also wish to apply for an exemption to the antidiscrimination legislation so that they can continue to offer accommodation exclusively to seniors.

The QRVPAS is available to provide free legal advice and has offered support to resident-operators in applying for an anti-discrimination exemption, if needed.[254]

2.4.6.10 Committee comment

The committee supports the intent of the proposed amendments to the *Retirement Villages Act 1999* to ensure protections implemented in 2017 apply to all tenure types, so that residents who choose to leave a retirement village, receive the proceeds from the sale of their residences and are able to finance their next accommodation, within 18 months regardless of the type of tenure.

254 DHPW, correspondence, 18 January 2019, attachment, p 5.

3 Compliance with the *Legislative Standards Act 1992*

3.1 Fundamental legislative principles

Section 4 of the *Legislative Standards Act 1992* (LSA) states that 'fundamental legislative principles' (FLPs) 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, and
- the institution of Parliament.

The committee has examined the application of the FLPs to the Bill. The committee brings the following to the attention of the Legislative Assembly.

3.1.1 Rights and liberties of individuals

Section 4(2)(a) of the LSA requires that legislation has sufficient regard to the rights and liberties of individuals.

3.1.1.1 Right to privacy of information

The Bill contains a number of provisions which provide for the disclosure of private and otherwise confidential information. These arise from the creation of the notifiable dust lung disease register and associated provisions for the collection and disclosure of health information (clauses 22 and 23).

As outlined in section 2.2.1, clause 22 inserts new part 3A in the Public Health Act, providing for the establishment of the notifiable dust lung disease register, including the collection and disclosure of personal and confidential information dealing with notifiable dust lung diseases. Part 3A contains various provisions allowing for the collection and disclosure of personal and confidential information. This includes:

- new sections 279AF and 279AG, which compel prescribed medical practitioners to notify the chief executive about any notifiable dust lung disease diagnosed by them and to provide further information to the chief executive if requested
- new section 279AH, which would enable the chief executive of Queensland Health to require a relevant chief executive to provide information that they, or their employee, have been given about a notifiable dust lung disease[255]
- new section 279AO, which would allow the chief executive of Queensland Health to disclose confidential information to an entity of the state, another state or a territory, or the Commonwealth, if the disclosure is required or permitted under a prescribed agreement between the chief executive or the state, and the other entity
- new section 279AN, which would enable disclosure of confidential information to a person contracted by Queensland Health to undertake analysis of data to analyse, monitor or evaluate public health (subject to the person having the written approval of the chief executive to receive the information), and
- new section 279AP, which would allow the chief executive to disclose (to a coroner investigating the death of a person or to a police officer assisting the coroner) information on the notifiable dust lung disease register that is relevant to the person's death.

[255] 'Relevant chief executive' is defined in section 279AA to mean either the chief executive of the department in which the *Coal Mining Safety and Health Act 1999* is administered, the chief executive of the department in which the *Workers' Compensation and Rehabilitation Act 2003* is administered, or another chief executive prescribed by regulation.

Clause 23 also provides for disclosure of confidential information through its amendment of the definition of 'health information held by a health agency' in schedule 2 of the Public Health Act, to include:

> *… information about a person's health or the provision of a health service to a person held or obtained by an approved operator … for the purpose of keeping the Notifiable Dust Lung Disease Register.*[256]

Potential issues of fundamental legislative principle

Clause 22

The explanatory notes acknowledge that clause 22:

> *… potentially breaches the principle that legislation must have sufficient regard to individuals' rights and liberties (Legislative Standards Act 1992, section 4(3)(a)) as it allows disclosure of personal information in limited circumstances.*[257]

However, the explanatory notes assert that 'appropriate safeguards have been included to protect the personal information' of patients, such that the potential breach may be considered justified.[258] These safeguards and other relevant factors for consideration are examined below.

<u>New penalty provision for unauthorised disclosure</u>

Firstly, in justifying the provisions, the explanatory notes make reference to a confidentiality provision in the Bill:

> *New section 279AL of the Public Health Act creates an offence for disclosing confidential information unless permitted under the Act. The maximum penalty for breach of this requirement is 50 penalty units. This is consistent with other provisions relating to disclosing confidential information in the Public Health Act, which relate to confidentiality of information for the Notifiable Conditions Register.*[259]

Regarding this aspect, it should be noted that this proposed new section 279AL of the *Public Health Act* also provides that the provisions of current sections 142 and 142A of the *Hospital and Health Boards Act 2011* (HHB Act) do not apply to a 'relevant person' in relation to confidential information.

The excluded provisions in section 142 and 142A establish similar offences for the disclosure of confidential information unless required or permitted under the HHB Act, with respect to a 'designated person' (section 142) or a 'prescribed health practitioner' (section 142A). Maximum penalties of 100 penalty units ($13,055) and 600 penalty units ($78,330) apply to a 'designated person' or 'prescribed health practitioner', compared to the proposed maximum penalty of 50 penalty units ($6,527) for a relevant person in proposed section 279AL of the Bill.

For prescribed health practitioners, the rationale for the significantly higher penalties in section 142A of the HHB Act were justified at the time of their introduction on the basis that:

> *… prescribed health practitioners such as GPs are not subject to equivalent control or oversight by Queensland Health as designated persons. For this reason, greater incentive to comply is thought to be required to ensure private information is protected. The penalties are also comparable to the civil penalties in section 59 the My Health Records Act 2012 (Cwlth) for*

256 Bill, clause 23 (4).

257 Explanatory notes, p 12.

258 Explanatory notes, p 12.

259 Explanatory notes, p 12.

unauthorised collection, use and disclosure of health information included in a healthcare recipient's My Health record.[260]

However, the reason for the difference in maximum penalties for 'relevant persons' and 'designated persons' under proposed section 279AL and the broadly analogous[261] excluded section 142 of the HHB Act was less apparent to the committee. While not of a substantial magnitude, the discrepancy has relevance for consideration of the adequacy of the confidentiality provision as a safeguard in the context of any justification for the potential FLP breach regarding the disclosure of private information.

The committee accordingly sought further information from the department regarding the reasons for both the exclusion of sections 142 and 142A of the (HHB Act) from proposed section 279AL, and the discrepancy in maximum penalties. In response, the department advised:

The exclusion of section 142 of the Hospital and Health Boards Act also applies to other similar provisions in the Public Health Act, including those relating to the environmental health event register (section 55), notifiable conditions register (section 77), contact tracing (section 105), contagious conditions (section 175) and perinatal statistics (section 220). Section 142A of the Hospital and Health Boards Act was included in the Act in 2016.

The rationale for excluding the operation of section 142 of the Hospital and Health Boards Act is discussed in a note to section 55 of the Public Health Act. The note states that as a specific offence is created in section 55 of the Public Health Act, the more general provision in section 142 of the Hospital and Health Boards Act does not apply. Similarly, the intention with the proposed new section 279AL is that if the disclosure of confidential information is regulated by the Public Health Act, it should not also be regulated by the more general provisions of sections 142 and 142A of the Hospital and Health Boards Act.

The maximum penalty in proposed new section 279AL is 50 penalty units, compared to 100 penalty units and 600 penalty units in sections 142 and 142A of the Hospital and Health Boards Act, respectively. As noted above, the proposed penalty of 50 penalty units in section 279AL is consistent with the existing penalties for similar conduct in sections 54, 77, 105, 175, 220, 228, 238, and 266 of the Public Health Act. Sections 142 and 142A of the Hospital and Health Boards Act are general provisions that are designed to provide a broad duty of confidentiality under the Act. The maximum penalties provided must cover a broad range of potential breaches of confidentiality. Therefore, a high maximum penalty is required. The provisions in the Public Health Act, in contrast, are related to particular registers and other distinct processes under discrete parts of the Act. Therefore, the seriousness of a breach is less and a lower maximum penalty is justified.[262]

3.1.1.2 Committee comment

The committee was satisfied with the department's explanation regarding the application of the safeguard in proposed section 279AL, and the level of the maximum penalty set for the provision.

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260 Health and Other Legislation Amendment Bill 2016, explanatory notes, p 7.

261 Broadly analogous in the sense that they both cover individuals in the public health sector.
For 'designated person' see s139A of the *Hospital and Health Boards Act 2011*. For 'relevant person' see proposed s279AK of the *Public Health Act 2005* (clause 22 of the Bill). The term also includes a person who receives information under section 279AO. The proposed confidentiality provision also extends to certain private medical practitioners – those required to give a notification of a notifiable dust lung disease diagnosis.

262 Queensland Health, correspondence, 6 February 2019, pp 2-3.

Other relevant factors

The Bill's explanatory notes also set out the following further material by way of justification for the FLP breach in clause 22:

In relation to the notifiable dust lung disease register (sections 279AF and 279AG):

> *The* [register] *is not a public register and cannot be accessed by members of the public or employers. The purpose of the register is for Queensland Health to monitor and analyse the incidence of notifiable dust lung diseases, and exchange information about notifiable dust lung diseases with other entities of the State.*[263]

- Regarding the provision of personal information by the chief executives (section 279AO):

> *Requesting information from a relevant chief executive will enable Queensland Health to have a complete register of all diagnosed cases, including those that come through other government agencies such as the Department of Natural Resources, Mines and Energy or the Office of Industrial Relations.*
>
> *This potential breach of the fundamental legislative principles is considered justified as it will provide greater clarity about the rates of occupational dust lung disease in Queensland. As noted above, it will be an offence for the chief executive of Queensland Health to disclose the information obtained from other chief executives unless authorised. The information being disclosed to the chief executive is limited to the information needed to accurately maintain the register.*[264]

- Regarding the sharing by the chief executive of private information with corresponding entities (section 279AO):

> *Information sharing between entities enables the government to take a coordinated approach to managing occupational dust lung disease cases. The Bill provides safeguards for information sharing between agencies. The agreement must be prescribed in the regulation. A government entity that receives confidential information under an agreement must not disclose the information to any other entity unless required or permitted to do so under the agreement, or permitted in writing by the chief executive. The government entity must ensure the confidential information is used only for the purpose for which it was disclosed under the agreement.*[265]

- In relation to the disclosures for data analysis (section 279AN) and for coronial investigations (section 279AP):

> *These potential breaches of the fundamental legislative principles are justified as they allow disclosure of confidential information in limited circumstances, and with safeguards as noted above. The provisions will enable disclosure in circumstances that are consistent with the overall purpose of the register, which is to monitor and analyse the incidence of notifiable dust lung diseases, and exchange information about notifiable dust lung diseases with other entities of the State… the information on the register will be limited and will not include, for example, information about a patient's prognosis or treatment.*[266]

263 Explanatory notes, p 12.

264 Explanatory notes, p 13.

265 Explanatory notes, p 13.

266 Explanatory notes, p 14.

Clause 23

As noted earlier, clause 23 also involves disclosure of confidential information. The clause amends the definition of 'health information held by a health agency' in schedule 2 of the Public Health Act to include:

> *… information about a person's health or the provision of a health service to a person held or obtained by an approved operator … for the purpose of keeping the Notifiable Dust Lung Disease Register.*[267]

The explanatory notes advise that this amendment is to ensure that the current framework for the provision of access to health information for research purposes will apply to information from the notifiable dust lung disease register.[268] The notes provide further details of that framework:

> *Research is defined in section 280 of the Public Health Act to mean systematic investigation for the purpose of adding to knowledge about human health and well-being and includes a biomedical study, a clinical and applied study, an epidemiological study, an evaluation and planning study, and a monitoring and surveillance study.*
>
> *Under section 282 of the Public Health Act, a person may apply to the chief executive of Queensland Health to be given health information for research. The chief executive may only grant the application if the chief executive is satisfied:*
>
> - *the giving of the health information is in the public interest having regard to the opportunities the research will provide for increased knowledge and improved health outcomes and the privacy of individuals to whom the health information relates; and*
> - *the identification of any person by the information is necessary for the relevant research.*
>
> *Section 288 of the Public Health Act provides the chief executive must establish a register of granted approvals and under section 289 the chief executive must give a person access to the register. The register must include the type of information to be given for the research, a description of the research, the name of the person or entity conducting the research, and the period for which the application has been granted.*

The explanatory notes justify the potential FLP breach in clause 23 as follows:

> *The potential breach of fundamental legislative principles is justified given the strict criteria for the approval processes. These amendments will ensure appropriate research can be undertaken into occupational dust lung diseases, while protecting the confidentiality of the information.*[269]

3.1.1.3 Committee comment

The committee is satisfied that both the health risk posed by occupational dust lung diseases, and the potential public benefit arising from allowing access to health information for research purposes, are sufficient to warrant the release of health information for research purposes, subject to the established safeguards for research under the Public Health Act.

The amendments are in keeping with the purposes of the new provisions, one of which was to 'monitor and analyse the incidence of notifiable dust lung diseases',[270] to support improved system responses to these conditions into the future.

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267 Bill, clause 23(4).

268 Explanatory notes, p 14.

269 Explanatory notes, p 14.

270 Bill, clause 22, new section 279AC, 'Purposes of register'.

3.1.1.4 Appropriateness of penalties

The Bill contains a number of offence provisions, some with substantial maximum penalties.

Clause 14 inserts new section 313E in the Public Health Act requiring a person to publish a pollution notice if directed by the chief executive. The maximum penalty for non-compliance with this provision is 200 penalty units ($26,110).

Clause 16 replaces the current section 60 of the Public Health Act and requires that a person manufacturing, selling, supplying or using paint must comply with a provision of a standard prescribed by regulation. (Currently, the section refers to a specific named standard.) The clause preserves the current maximum penalty of 100 penalty units.

Clause 22 inserts a number of penalty provisions:

- new section 279AF of the Public Health Act, creating an offence for not notifying the chief executive of notifiable dust lung diseases, unless the practitioner has a reasonable excuse (maximum penalty of 20 penalty units)
- new section 279AG of the Public Health Act, creating an offence for not providing the chief executive with additional information if required (maximum penalty of 20 penalty units), and
- new section 279AL of the Public Health Act 2005, which creates an offence for disclosing confidential information unless authorised under the Act (maximum penalty of 50 penalty units).

As noted at section 2.6, the Bill also amends the Retirement Villages Act to clarify that a resident is entitled to payment for their unit 18 months after they terminate their right to reside in the village, regardless of their tenure type, and includes a new process for the mandatory purchase by the operator of unsold freehold units. Clause 38 inserts in the Retirement Villages Act a penalty for an operator who does not complete a mandatory purchase within the required timeframe, without reasonable excuse. The maximum penalty is 540 penalty units ($70,497).

Potential issues of fundamental legislative principle

The offence provisions contained in the Bill potentially breach the principle that legislation must have sufficient regard to individuals' rights and liberties (see LSA section 4(3)(a)).

In determining whether legislation has sufficient regard to the rights and liberties of individuals, it is necessary to consider whether the penalties imposed for offences are proportionate and relevant to the actions to which the consequences are applied by the legislation. The Office of the Queensland Parliamentary Counsel's (OQPC) *FLP Notebook* states:

> *… the desirable attitude should be to maximise the reasonableness, appropriateness and proportionality of the legislative provisions devised to give effect to policy …*
>
> *Legislation should provide a higher penalty for an offence of greater seriousness than for a lesser offence. Penalties within legislation should be consistent with each other.*[271]

The explanatory notes provide the following justifications for the various offences and penalties:

- Clause 14 (maximum penalty of 200 penalty units for failure to publish a pollution notice as directed by the chief executive):

  > *This potential breach of fundamental legislative principles is justified as it will encourage compliance with the direction, ensuring the person responsible for a pollution event provides timely advice to the public about the health risks of the*

[271] OQPC, *Fundamental Legislative Principles: The OQPC Notebook*, p 120.

pollution. The maximum penalty of 200 penalty units is consistent with the penalty for not complying with a public health order under section 23 of the Public Health Act. [272]

- Clause 22 (maximum penalties of 20 penalty units for failure by a practitioner to notify a notifiable dust lung disease or to comply with a requirement to provide additional information regarding such a notification):

  Both of these provisions are necessary to ensure the register can be established and maintained. The penalties are consistent with the penalties for failing to notify the chief executive or failing to provide further information under the cancer notification provisions of the Public Health Act and are considered a sufficient deterrent for non-compliance.[273]

- Clause 22 (new section 279AL setting a maximum penalty of 50 penalty units for disclosing confidential information unless authorised):

  This is consistent *with other provisions relating to disclosing confidential information in the Public Health Act, such as the confidentiality of information for the Notifiable Conditions Register and is considered a sufficient deterrent for non-compliance.*[274]

  [Further consideration of this penalty is included in section 3.1.1.1].

- Clause 38 (maximum penalty of 540 penalty units ($70,497) for an operator who does not complete a mandatory purchase under the Retirement Villages Act within the required timeframe):

  This penalty mirrors the penalty which applies to the required timing for payment of exit entitlements in other tenure types. It is justified to maintain equity among tenure types and to discourage scheme operators from attempting to abrogate their obligation to purchase the unit.[275]

Noting the difference in maximum penalty levels under the notifiable dust lung disease register framework in respect of failing to notify or provide information (20 units), versus unauthorised disclosures of information (50 units); the committee sought further information from the department on the setting of these penalties. Whilst acknowledging the consistency of the penalties with equivalent provisions under the Public Health Act, the committee recognised that just as penalties for unauthorised disclosures must be sufficient to safeguard private information; equally, penalties for failing to notify or provide required information must be sufficient to support the operation and accuracy of the notifiable dust lung disease register, and ensure that its objectives will be met.

In response to the committee's request, the department advised:

The Bill establishes a reporting framework for occupational dust lung diseases that mirrors, as far as possible, the existing provisions in the Public Health Act for the Queensland Cancer Register.

The penalty provisions in proposed new sections 279AF, 279AG and 279AL are consistent with the equivalent penalty provisions for the Queensland Cancer Register, namely:

- *Failure to provide a notification — 20 penalty units — section 234*
- *Failure to provide further information — 20 penalty units — section 236*

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272 Explanatory notes, p 16.

273 Explanatory notes, p 16.

274 Explanatory notes, p 16.

275 Explanatory notes, p 17.

- *Disclosing confidential information — 50 penalty units — section 237.*

… the Office of the Queensland Parliamentary Counsel's Fundamental Legislative Principles notebook states that legislation should generally provide a higher penalty for an offence of greater seriousness than for a lesser offence.

The penalty provisions in proposed new sections 279AF and 279AG are intended to protect the integrity of the notifiable dust lung disease register. They will ensure that the information contained in the register is current and comprehensive. However, a failure to comply with these sections is unlikely to adversely affect an individual. Similar penalties of 20 penalty units apply for failure to provide information under other similar circumstances in the Public Health Act, such as those in sections 70 to 73, 217, 218, 228F, 228G, and 234 to 236.

In contrast, the penalty in proposed new section 279AL is to protect the confidential information of persons. A breach of this provision could have very serious consequences for the person whose confidential information is released. The Department considers that this protection is of greater seriousness than those in new sections 279AF and 279AG, and therefore a higher penalty is warranted. A penalty of 50 penalty units is consistent with other similar provisions that protect confidential information in the Public Health Act, including sections 54, 77, 105, 175, 220, 2281, 238, and 266.[276]

3.1.1.5 Committee comment

The committee is satisfied that the various penalty provisions established under the Bill are consistent with existing regulatory frameworks and appropriate in the circumstances.

3.1.1.6 Retrospectivity

Section 4(3)(g) of the LSA provides that whether legislation has sufficient regard to the rights and liberties of individuals depends on, for example, whether the legislation does not adversely affect rights and liberties, or impose obligations, retrospectively. Strong argument is required to justify an adverse effect on rights and liberties, or imposition of obligations, retrospectively.

Clause 46 of the Bill contains a transitional provision for the operation of the amendments to the Retirement Villages Act (proposed section 237Q).

Clause 46 also makes provision for a transitional regulation-making power, for the purposes of the Retirement Villages Act amendments (proposed section 237R).

There are two elements of retrospectivity involved in clause 46:

- The amendment in proposed section 237Q will apply to contracts entered into by scheme operators and retirement village residents prior to the commencement of the amendments.
- The provision in proposed section 237R for a transitional regulation-making power allows for a transitional regulation to be retrospective to no earlier than the commencement of the provision.

The retrospective operation of these amendments constitutes a potential FLP breach.

Potential fundamental legislative principle issue

The explanatory notes are silent on the issue of the retrospective aspect of the provision for a transitional regulation-making power under 237R. The scope of subject-matter of any regulation made under proposed section 237R is quite broad; and the potential content of any regulation pursuant to the clause is unclear.

[276] Queensland Health, correspondence, 6 February 2019, pp 1-2.

The proposed section is considered in further detail at section 3.1.2.1 of this report – *Delegation of legislative power.*

Regarding proposed section 237Q, the explanatory notes state:

> *As the amendments seek to ensure that the same protections apply equally to all retirement village residents regardless of their tenure type, it is necessary for the amendments to apply retrospectively from the passing of the Housing Legislation (Building Better Futures) Amendment Act.*
>
> *The provisions in the Housing Legislation (Building Better Futures) Amendment Act requiring operators to pay a former resident's exit entitlements 18 months after they leave a village apply retrospectively to existing contracts, but with a prospective focus. This means that for residents holding leasehold or licence tenure who had left a village before the commencement of those provisions on 10 November 2017, the 18-month period started on the date of assent, rather than the date of departure.*
>
> *It is considered that retrospectivity of the provisions requiring operators to purchase a former resident's freehold unit 18 months after they leave a village is also justified to maintain the original intention of the Housing Legislation (Building Better Futures) Amendment Act and to ensure there is equity between freehold tenure residents and residents with other kinds of retirement village tenure, as well as between existing residents and new residents. This will allow the first payments to be made to freehold residents on the same date they are made to residents holding leasehold or licence tenure. To do otherwise would provide a two-tiered system of protections for residents, leaving freehold residents at a disadvantage.*
>
> *These amendments provide clarity about the intent of the 2017 amendments and give certainty to all retirement village residents about the maximum length of time they must wait before they receive their funds. Retrospective application of the amendments is justified in circumstances where a former resident has not been able access what may be their only capital for an 18-month period. While the process is different to reflect the differences applying to each tenure type, the end result and the delivery of the policy will be the same for all retirement village residents.*[277]

The committee notes that it is only an *adverse* retrospective effect that infringes on FLPs. Also, the FLPs are concerned with rights and liberties of *individuals*, not corporate bodies.

It can be anticipated that the vast majority of freehold residents will be individuals. The retrospective effect on these individuals is expected to be beneficial (at least in terms of the direct impacts of the retrospective operation of the provisions).

On the other hand, scheme operators - the more likely to be adversely affected - are most likely to be corporate bodies. However, as outlined in chapter 2, some scheme operators, while being corporate entities on their face in a legal sense, will in practice consist of individual unit holders, whose rights would be adversely affected.

3.1.1.7 Committee comment

The committee is satisfied with the explanation provided regarding the justification for the potential FLP breach occasioned by the retrospective effects of section 237Q.

[277] Explanatory notes, p 17.

3.1.2 Institution of Parliament

Section 4(2)(b) of the LSA requires legislation to have sufficient regard to the institution of Parliament.

3.1.2.1 Delegation of legislative power

Section 4(4) of the LSA states:

> *Whether a Bill has sufficient regard to the institution of Parliament depends on whether, for example, the Bill -*
>
> *(a) allows the delegation of legislative power only in appropriate cases and to appropriate persons; and*
>
> *(b) sufficiently subjects the exercise of a delegated legislative power to the scrutiny of the Legislative Assembly; and*
>
> *(c) authorises the amendment of an Act only by another Act.*

A number of clauses provide for potentially significant matters to be prescribed by regulation.

Clause 14 inserts Chapter 7A in the Public Health Act, to deal with pollution events. Proposed section 313H(5) would allow a regulation to prescribe matters that a court may, or must, have regard to in making determinations on claims for compensation arising from actions taking by the chief executive following pollution events.

Clause 22 inserts new section 279AF in the Public Health Act to require a prescribed medical practitioner to notify the chief executive of a diagnosis of a notifiable dust lung disease. It also inserts new section 279AA to provide definitions. This includes definitions of 'prescribed medical practitioner' and 'notifiable dust lung disease' which in effect allow those terms to be defined by regulation.

Clause 31 inserts new section 103K in the Radiation Safety Act to provide that a regulation may prescribe a person or a class of persons who is taken to hold a use or transport licence.

Clause 38 amends the Retirement Villages Act and includes provision (section 63C(2)) for a regulation to prescribe mandatory terms, prohibited terms, and other requirements in a sale contract for the mandatory purchase of a freehold unit.

Clause 46 contains a transitional regulation making power for the purposes of the Retirement Villages Act amendments.

Potential fundamental legislative principle issue

These clauses allow for potentially significant matters to be prescribed by regulation. As such, these clauses potentially breach section 4(4)(a) of the LSA, which requires that a Bill allow the delegation of legislative power only in appropriate cases and to appropriate persons.

It may be argued these matters are of sufficient importance such that they should be set out in an Act and not a regulation.

Clauses 22, 31 and 38

The explanatory notes provide further background and justifications regarding the various clauses as follows:

- Clause 22 and the definitions of 'prescribed medical practitioner' and 'notifiable dust lung disease':

  > *This potential breach of fundamental legislative principle is justified as it will enable the types of occupational lung diseases required to be reported, and the medical practitioners required to report them, to be changed if new types of occupational dust*

lung diseases emerge, or changes in clinical practice make it appropriate to require other types of medical practitioners to notify diagnoses to Queensland Health.[278]

- Clause 31 and the prescription of persons or classes of persons to be taken to hold a use or transport licence:

  … this power [of prescription by regulation] *is limited. The regulation must state for a prescribed use licence the qualifications, professional registration or training that must be held by the prescribed licensee. Prescribed transport licensees may be identified in the Radiation Safety Regulation by the type of radioactive substance, how the radioactive substance must be transported and the amount of substance they can transport.*

  Clause 31 provides safeguards by [requiring] the Minister to consult with the Radiation Advisory Council and consider any recommendations made by the Council before making a regulation under section 103K. It also requires the Minister to be satisfied that making the regulation will be consistent with the radiation safety, protection and security principles.[279]

- Clause 38 and the prescription of terms in sale contracts for retirement village units:

  The use of a head of power to make a regulation is justified due to the detailed and technical nature of contracts of sale for retirement village units and the potential need to adapt to rapidly changing business practices and innovations in the retirement village sector.[280]

The explanatory notes also refer to the fact that any regulations made under the above provisions will be subject to potential disallowance by the Legislative Assembly.[281]

3.1.2.2 Committee comment

Noting the explanations and justifications provided, the committee is satisfied that these provisions allowing matters to be prescribed are justified in the circumstances.

Clause 46

Clause 46 provides for a transitional regulation-making power, for the purposes of the Retirement Village Act amendments, in the following terms (proposed section 237R):

(1) A regulation (a transitional regulation) may make provision of a saving or transitional nature for which –

(a) it is necessary to make provision to allow or facilitate the doing of anything to achieve the transition from the pre-amended Act to the amended Act; and

(b) this Act does not make provision or sufficient provision.

(2) A transitional regulation may have retrospective operation to a day that is not earlier than the day this section commences

(3) A transitional regulation must declare it is a transitional regulation.

(4) This section and any transitional regulation expire 1 year after the commencement of this section.

278 Explanatory notes, p 15.

279 Explanatory notes, p 15.

280 Explanatory notes, p 15.

281 Under section 50 of the *Statutory Instruments Act 1992*. See explanatory notes, p 16.

(5) In this section -

amended Act means this Act as amended by the Health and Other Legislation Amendment Act 2018.

pre-amended Act means this Act as in force immediately before its amendment by the Health and Other Legislation Amendment Act 2018.

Potential fundamental legislative principle issue

Section 4(4)(a) of the LSA provides that a Bill should allow the delegation of legislative power only in appropriate cases and to appropriate persons. Section 4(5) of that Act provides that subordinate legislation should only contain matter appropriate to subordinate legislation.

Generally, the greater the level of interference with individual rights and liberties, or the institution of Parliament, the greater the likelihood that the power should be prescribed in an Act of Parliament and not delegated below Parliament.

Committees have previously regarded it as an inappropriate delegation to provide that a regulation may be made about any matter of a savings, transitional or validating nature 'for which this part does not make provision or enough provision', because this anticipates that the Bill may be inadequate and that a matter, which otherwise would have been of sufficient importance to be dealt with in the Act, would instead be dealt with by regulation.[282]

The form of transitional regulation-making power most objectionable has the following aspects:

- it is expressed to allow for a regulation that can override an Act
- it is so general as to allow for a provision about any subject matter, including those that should be dealt with in an Act rather than in subordinate legislation
- it is not subject to any other control, for example, a sunset clause.

In this instance, the explanatory notes state:

This provision mirrors transitional provisions in the Housing Legislation (Building Better Futures) Amendment Act 2017 and is justified to manage the risk of issues that may emerge after the amendments commence and the complexity of differing tenure types and contracts of sale. Concerns are further mitigated by the inclusion of a one-year sunset clause on both the empowering provision and any regulation made under it.[283]

Explanatory notes accompanying other recent Bills that contained similar clauses have provided a justification along the lines of the clause being a temporary measure to help a smooth transition to a new legislative scheme by enabling a regulation to be made to address any 'emerging or unforeseen' transitional issues.[284] One such clause was criticised by the Queensland Law Society on the basis that it:

… allows the legislature to by-pass the parliamentary process. Although the purpose of the power is to facilitate a smooth transition into the new scheme, any material that imposes obligations or affects the rights of individual should be included in the primary legislation. [285]

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282 See: OQPC, *Fundamental Legislative Principles: The OQPC* Notebook, p. 161.

283 Explanatory notes, p 16.

284 See for example the explanatory notes to the Plumbing and Drainage Bill 2018, commenting (at p5) on a transitional regulation-making power in similar terms to that under consideration here.

285 Queensland Law Society, in a submission on the provision referred to in footnote 23. See the discussion in Transport and Public Works Committee, Report No. 3, 56th Parliament, Plumbing and Drainage Bill 2018, April 2018, from p 60.

The Retirement Villages Act contains a general regulation-making power in section 228:

(1) The Governor in Council may make regulations under this Act.

(2) In particular, a regulation may -

(a) provide for the fees payable under this Act; or

(b) create offences and prescribe penalties of not more than 20 penalty units for each offence.

The proposed transitional regulation-making power is very broad in scope, especially given the wording of section 237R(1)(a). The content of a transitional regulation could be quite wide. Moreover, the clause would allow any transitional regulation to have retrospective effect (see section 237R(2)).

However, both the clause itself (and so the transitional regulation-making power) and any transitional regulation expire 12 months from the commencement date of the section, limiting the scope for their use, or potential misuse.

3.1.2.3 Committee comment

In this instance, noting both the advice from the department and stakeholders about the evolving nature of the industry, and consequently, the possible need to legislatively address any (unspecified) issues that might arise, the committee is satisfied that the broad and potentially retrospective transitional regulation-making provision is justified.

The committee notes that the application of the sunset clause will serve to limit the application of the provision.

Clause 14

Clause 14 inserts Chapter 7A in the Public Health Act, to deal with pollution events. Proposed section 313H provides that a person may claim compensation from the State if the person incurs loss because of the exercise, or purported exercise, of a power by or for the chief executive under that chapter, including a loss arising from compliance with a requirement made of the person. Applications for compensation are to be made to a court, and proposed section 313H(5) and (6) provide:

(5) In considering whether it is just to order compensation, the court must have regard to —

(a) the nature of the pollution event and the risk to public health; and

(b) whether the loss arose from the publication of a pollution notice in relation to the pollution event.

(6) A regulation may prescribe other matters that may, or must, be taken into account by the court when considering whether it is just to order compensation.

In short, section 313H(6) would allow a regulation to prescribe matters that a court may, or must, have regard to in making determinations on such compensation claims.

Potential fundamental legislative principle issue

As noted earlier, section 4(4)(a) of the LSA provides that a Bill should allow the delegation of legislative power only in appropriate cases and to appropriate persons.

Section 313H(5) would allow the executive to specify matters (which are not set out or limited in the Act as amended as proposed) that a court *must* take into account in considering a compensation matter. It could be argued that it is inappropriate for such matters to be provided for in regulation.

In the past, clauses such as this have been considered, from a technical scrutiny point of view, in the context of the FLP that the delegation of legislative power should be allowed only in appropriate cases and to appropriate persons.

In relation to clause 14, the explanatory notes do not refer to any issue of fundamental legislative principle arsing in relation to clause 14. As such, it was not clear to the committee why this aspect has been left to regulation, and as to why the provision includes a 'mandatory' element.

It appears that clauses allowing a regulation to prescribe matters a court must take into account are relatively common in Bills in Queensland – particularly in this context of claims for compensation. It also appears that no such regulation has actually been promulgated.

The Office of the Queensland Parliamentary Counsel has discussed a range of issues regarding the impact of legislation on the institutional integrity of courts and judicial independence in a chapter of its online *Principles of good legislation: OQPC guide to FLPs*.[286] On occasion, legislation is held to be invalid on constitutional grounds.

As noted in that publication:

> *Even if legislation is not necessarily likely to be considered invalid, parliamentary committees may express concern about it if they consider it may affect or interfere with judicial independence and judicial process. The types of legislation about which parliamentary committees have commented on this basis include legislation that:*
>
> - *affects sentencing discretion by, for example, requiring mandatory minimum sentences*
> - *abolishes, or changes the constitution of, particular courts or tribunals*
> - *affects judicial entitlements*
> - *changes the law applicable in pending litigation.*

The committee notes that the present case is certainly not within any of those categories.

Further, an important consideration is the degree of discretion courts are able to exercise.

In the present case, the clause is providing for the prescription by regulation of matters that a court must take into account. On the face of it, there would appear to still be discretion on the part of the court as to how it takes any such matter into account. That might depend upon the actual content of the prescribed matter. Conceivably, such content could be worded so as to dramatically narrow the discretion of the court.

It is relevant here to have regard to the concept of the separation of powers. Where a provision is in primary legislation, it is a creature of the legislature. Where a regulation is promulgated, it is a creature of the executive.

There is generally no difficulty with a legislative provision stipulating matters that a court must take into account. Any such provision might be considered to be unobjectionable if it were in principal legislation, but inappropriate for inclusion in subordinate legislation, as is contemplated here.

The committee requested further information from the department to support its consideration of these matters. The department advised, in response:

> *Section 313H(4) provides that a court may order the payment of compensation only if it is satisfied it is just to make the order in the circumstances of the particular case. In considering whether it is just to order compensation, section 313H(5) requires the court to have regard to the nature of the pollution event and the risk to public health, and whether the loss arose from the publication of a pollution notice in relation to the pollution event. Subsection 313H(6) allows a regulation to prescribe other matters that may or must be taken into account by the court when considering whether it is just to order compensation.*

[286] See: *Principles of good legislation: OQPC guide to FLPs - Institutional integrity of courts and judicial independence*, www.legislation.qld.gov.au/file/Leg_Info_publications_FLP_Institutional_integrity_of_courts.pdf

The most important matters that a court must have regard to in deciding whether to order compensation have been included in the Act and are outlined in section 313H(5). It is not expected that additional matters will need to be prescribed in regulation. However, the regulation-making power could be used to allow additional matters to be prescribed to respond

to developing jurisprudence about compensation if cases arise with unforeseen factors that it is considered a court should have regard to. The Parliament will have oversight of any proposed regulation through its usual tabling and disallowance procedures. The provision allowing a regulation to prescribe matters that a court may or must consider is a common clause used in these circumstances. There are examples of similar provisions in many Acts in the Queensland statute book. Some recent examples include:

- *Education (Overseas Students) Act 2018, section 78(5)*
- *Labour Hire Licensing Act 2017, section 87(5)*
- *Public Health (Medicinal Cannabis) Act 2016, section 158(5)*
- *Mental Health Act 2016, section 407(4).*[287]

3.1.2.4 Committee comment

The committee considers that, on balance, the delegation of legislative powers proposed in Clause 14 is reasonable and justified. The committee also notes that any regulations made pursuant to new section 313H once they are tabled would be subject to scrutiny and possible disallowance by the Parliament.

3.2 Explanatory notes

Part 4 of the LSA 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.

3.2.1.1 Committee comment

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

There are two minor comments to be made about the content of the explanatory notes.

- the explanatory notes do not fully discuss all the FLP issues that arise in the Bill (see the discussion of clause 14, proposed section 313H(6) of the Public Health Act, in section 3.1.2.1 above), and
- there are some minor instances where the explanatory notes do not fully explain the operation of the proposed clauses (see the discussion of clause 22, proposed section 279AL of the Public Health Act, and the exemption of its provisions in respect of sections 142 and 142A of the HHB Act).

The department provided further information on these matters to support the committee's consideration of the Bill.

[287] Queensland Health, correspondence, 6 February 2019, p 3.

Appendix A – Submitters

Sub #	Submitter
001	Lambert Initiative for Cannabinoid Therapeutics
002	Ms Anne Eagles
003	Mr Gordon Saul
004	The Domain Residents Association Inc
005	Confidential
006	Mrs Sylvia and Mr Karl Gustafsson
007	Multiple Sclerosis Australia and Multiple Sclerosis Research Australia
008	Mr Wayne and Mrs Lorraine McClear
009	Ms Linda Smith
010	Property Council of Australia
011	Health Consumers Queensland
012	Australian College of Nursing
013	Mr Graham Davies
014	Mr John and Mrs Dorothy Graf
015	MIGA
016	Drug Free Australia – Queensland Branch
017	MEDIFARM
018	Mr Gary and Mrs Christine Olive
019	Queensland Law Society
020	Name suppressed
021	Ms Wendy Rayner
022	Mr David Price
023	Ms Lynda Eastburn
024	Name suppressed
025	Queensland University of Technology
026	Ms Tricia Simpson

027	Confidential
028	Lung Foundation Australia
029	Australian Medical Association Queensland
030	Medical Cannabis Users Association of Australia
031	Australasian Faculty of Occupational and Environmental Medicine, Royal Australasian College of Physicians
032	Caxton Legal Centre Inc
033	Dr Stuart Reece
034	Ms Lanai Carter
035	Stockland Communities
036	Royal College of Pathologists of Australasia Quality Assurance Programs Pty Ltd
037	Queensland Council for Civil Liberties
038	The Local Government Association of Queensland
039	Confidential
040	Mr John Ransley
041	Drug Free Australia
042	Confidential
043	Form submissions – 82 received

Appendix B – Officials at public departmental briefings

5 December 2018 briefing

Department of Health

- Dr Sue Ballatyne, Senior Medical Advisor, Prevention Division
- Dr Sonya Bennett, Acting Chief Health Officer and Deputy Director-General, Prevention Division
- Ms Kirsten Law, Director, Legislative Policy Unit, Strategy, Policy and Planning Division
- Ms Tricia Matthias, Manager, Legislative Policy Unit, Strategy, Policy and Planning Division

Department of Housing and Public Works

- Mr Damian Sammon, Director, Legislation and Reform, Housing, Homelessness and Sport
- Mr Mark Wall, General Manager, Strategy, Policy and Programs, Housing, Homelessness and Sport

24 January 2018 briefing

Department of Health

- Dr Jeanette Young, Chief Health Officer and Deputy Director-General, Prevention Division
- Ms Tricia Matthias, Manager, Legislative Policy Unit, Strategy, Policy and Planning Division

Department of Housing and Public Works

- Ms Lisa Pollard, Manager, Legislation and Reform, Housing, Homelessness and Sport
- Mr Damian Sammon, Director, Legislation and Reform, Housing, Homelessness and Sport
- Mr Mark Wall, General Manager, Strategy, Policy and Programs, Housing, Homelessness and Sport

Appendix C – Witnesses at public hearing

Queensland University of Technology

- Professor Lyn Griffiths, Executive Director, Institute of Health and Biomedical Innovation
- Adjunct Professor Conor Brophy, Chair, QUT University Human Research Ethics Committee
- Ms Anne Walsh, Acting Director, Office of Research Ethics and Integrity

Royal College of Pathologists of Australasia Quality Assurance Programs Pty Ltd

- Dr Tony Badrick, Chief Executive Officer

Queensland Council for Civil Liberties

- Mr Michael Cope, President
- Mr John Ransley, QCCL representative on drug law reform

Medical Cannabis Users Association of Australia Inc

- Ms Deb Lynch, Committee Member
- Ms Grace Sands, Committee Member

Property Council of Australia

- Ms Jen Williams, Queensland Deputy Executive Director
- Mr Robin Lyons, Partner, Minter Ellison

Caxton Legal Centre Inc

- Ms Brittany Smeed, Solicitor, Human Rights and Civil Law Practice (Queensland Retirement Village and Park Advice Service)

Pebble Beach Retirement Village

- Mr John Graf, Resident
- Mr Wayne McClear, Resident

The Domain Residents Association Inc

- Dr John McCorquodale, President
- Ms Lynette Shorthouse, Secretary

Statements of Reservation

STATEMENT OF RESERVATIONS

by

LNP Members of the Health Committee

With respect to the Health and Other Legislation Amendment Bill 2018.

The major issue the LNP Members of the Committee have with the Bill relates to the amendments to the Retirement Villages Act 1999.

The Explanatory Notes at Page 1 states the intent of amendment is to:

"amend the Retirement Villages Act 1999 to clarify a recent amendment in relation to timely payment of exit entitlements at retirement villages, then make associated amendments to the Duties Act 2001."

Page 11 of the Explanatory Notes states;

"The Bill will amend the Retirement Villages Act to provide processes to ensure that residents with an interest in freehold tenure receive payment for their retirement village unit 18 months after they leave a retirement village. Given the difference in tenure between freehold and other unit types the amendment requires the scheme operator to effectively "buy-back" the unsold unit from the outgoing resident after 18 months by entering into a contract with the resident to purchase the property."

The amendment has come about, as we understand, due to the interpretation of the phrase "exit entitlement" in an earlier amendment interpretation which excluded freehold title from the buy back obligation. (Property Council of Australia submission at Page 1)

The Bill therefore seeks to remedy the situation so that both leasehold and freehold tenure being caught by the buy-back obligation.

It is important to understand the distinction between leasehold and freehold tenure in these circumstances to understand how this amendment came about.

LEASEHOLD TENURE

Under a leasehold structure the operator owns title to the whole complex. It grants a 99 year lease to each individual resident. The resident and the operator agree the resident cannot sell or transfer their lease to another person, in fact ownership of the unit remains with the operator at all times. At the time of termination of the lease, the resident's interest in the unit ends and possession returns to the operator.

When the resident leaves, under the terms of the original agreement, the operator pays the resident an agreed sum plus or minus any agreed fees and adjustments.

The method to determine the "exit entitlement" and how it is calculated are documented in the lease signed on entry. There is absolutely no contractual or other relationship between the departing resident and the new resident.

Where a leasehold tenure exists, the current Act determines when the "former residents exit entitlement" is payable and pursuant to Section 16, on "exit entitlement" is defined as:

(1) A. an exit entitlement is the amount that a scheme operator may be liable to pay or credit the account of a former resident under a residence contract arising from;
   (a) The resident ceasing to reside in the accommodation unit to which the contract relates or
   (b) The settlement of the sale of the Right to Reside in the accommodation unit.

Thus, an exit entitlement is derived from the "resident's contract." In leasehold situations the "buy back" obligation currently exists. However there is a direct contractual arrangement between the operator, the first resident and any subsequent resident.

FREEHOLD TENURE

Contrast this to freehold tenure. In this circumstance the whole of the property including units, community facilities, infrastructure and the like are subdivided into separate lots and common property. Each unit is given a separate freehold title enabling the unit to be separately owned and transferred from person to person.

A strata title scheme and a body corporate are established for the village. The developer/operator sells separately titled units to individual residents each of whom becomes "owner" of their units and is registered as such on the Land Title Register.

On the departure or death of a resident, the departing resident is responsible to sell their freehold title directly to a new incoming resident. They are required to take all steps to find a buyer resident including appointing a real estate agent of their choice and deciding on the selling price. The purchaser becomes the new registered owner of the unit. Each time a unit is resold the former

owner must pay the exit fee and other agreed amounts to the operator out of the sale proceeds they receive from the buyer. The former resident receives their money from the new owner.

The intention is that once the developer/operator first sells the units there is no intention that they will have an obligation to "buy back" a unit as devised under the terms of the Bill and performs management functions only.

As we said, the resident who is leaving the complex receives the sale proceeds for their unit directly from the next resident and though an operator may choose to buy back a freehold unit this is a voluntary purchase by operator and not an obligation imposed by law.

There are also a number of "resident operated freehold schemes." They are identical to the freehold structure described above with the exception that the developer exits the village completely and the ongoing management of the village passes to the residents or a company or association to which the residents are members. Collectively the residents are the scheme operator for the purposes of the operation of the Act. As in other freehold scheme these residents remain responsible for selling their unit to new buyers and do not receive any money from any operator on departing the village. This arrangement has the owners of the units owning and operating the whole scheme. No other party is involved.

Thus, there is a very clear distinction in the obligations between the leasehold and freehold arrangements into which "purchasers" enter when they move into the unit. This can mean there are contracts in place which are very much slanted to a scheme operator but in many cases this may occur pursuant to the terms of the initial contract.

PROPERTY COUNCIL OF AUSTRALIA SUBMISSION

The Property Council of Australia in their submission argues that the Department's claim that this amendment seeks to clarify the policy intent of the 2017 Amendment is not correct stating

> "The fact that this amendment contains 11 different detailed clauses seeking to further amend RV Act, in our view shows that this was never a policy intent. Indeed, this affirms the industry was correct in forming the view the 2017 amendments would not apply to freehold villages."

They then question the nature of the "retrospective" application to existing units purchased under the current legislation for the 18 month period beginning November 2017.

They highlight the distinct differences between freehold, leasehold/licence arrangements and the fundamentally different financial structure and arrangements entered into by operators when you consider a freehold scenario.

They make the point that the buy-back is in fact "similar to compulsory acquisition powers" and that it is being "applied in the open market."

They raise the point that the Regulatory Impact Statement was not provided to the Committee for consideration.

At Page 3 of their submission they make this point ".... While other forms of buy backs exist in other jurisdictions to our knowledge there is no other jurisdiction that mandates the compulsory purchase of freehold units and retirement village by an operator, similarly there is not other jurisdiction who mandate the compulsory acquisition. In fact, contracts that have freeholdlike tenures are specifically separated from buy-back legislation in other states e.g. NSW. Therefore this amendment is likely to have broader consequences for the operators across Australia as other jurisdictions are likely to follow the lead of Queensland.

The submission by Pebble Beach Retirement Village is a structure in point. In the submission signed by Wayne McClear and Lorraine McClear they make the following comment:

> "We are the owners of freehold Lot 103 in the Pebble Beach Retirement Village which is a self-managed owner occupied resident retirement village of 151 freehold lots (Community Titles Scheme No 33548.) There is no exit entitlement."

They further state;

"The village has a simple management structure. The scheme operator does not own any assets in the retirement village and only provides one general service, thus keeping the Scheme Operator fee as low as possible so residents can enjoy retirement without unnecessary demands on their funds."

As we stated the current Act currently captures a "leasehold" position in the "buy back" arrangement but doubt exists if it covers "freehold tenure" given the confusion of the meaning of the phrase "exit entitlement."

The important question is do we want to move into an area where freehold title is caught by this obligation given the nature of a freehold interest and how important that legal right has been to our legal system.

This is even more acute when the developer completely vacates the village, with the unit owners owning their unit and are managers of the village via an association. Pebble Beach Retirement Village is such an example.

This is an important point. We, by passing this amendment and based on the Property Council's advice are taking a step that binds freehold tenure holders to what could be a significant monetary obligation.

The Property Council in their submission raises a number of other concerns which we ask the Minister to address. These are contained in detail in their submission with the concern clearly articulated and potential solutions.

DATED 13 February 2019

Mark McArdle
State Member for Caloundra

Marty Hunt
State Member for Nicklin