HEALTH, ENVIRONMENT AND INNOVATION SUBCOMMITTEE

Members present:
Mr R Molhoek MP—Chair
Ms SL Bolton MP (via teleconference)
Mr JP Kelly MP
Mr DJL Lee MP

Staff present:
Mr T Horne—Committee Secretary
Ms M Salisbury—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL 2025

TRANSCRIPT OF PROCEEDINGS

Wednesday, 23 April 2025

Brisbane

WEDNESDAY, 23 APRIL 2025

The subcommittee met at 12.31 pm.

CHAIR: Good afternoon. I declare open this public hearing for the committee's inquiry into the Health Legislation Amendment Bill 2025. My name is Robert Molhoek. I am the member for Southport and chair of this subcommittee. I acknowledge the Aboriginal people and the Torres Strait Islander people of this state and their elders past, present and emerging. I also acknowledge the former members of this parliament who have participated in and nourished the democratic institutions of this state. Finally, I acknowledge the people of this state, whether they have been born here or have chosen to make this state their home, whom we represent to make laws and conduct other business for the peace, welfare and good government of this state.

With me here today are: Mr Joe Kelly MP, member for Greenslopes and deputy chair; Ms Sandy Bolton MP, member for Noosa, joining us via videoconference; and Mr David Lee MP, member for Hervey Bay. This hearing is a proceeding of the Queensland parliament and is subject to the parliament's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Members and witnesses, please remember to press your microphones on before you start speaking and off when you are finished, and please turn your mobile phones off or to silent mode.

GARDINER, Mr Matt, Chief Executive Officer, Cancer Council Queensland

JACKMAN, Dr Danielle, Specialist, Policy and Advocacy, Cancer Council Queensland

CHAIR: Good afternoon and welcome. Would you like to make an opening statement before we start our questions?

Mr Gardiner: Good afternoon and thank you, Chair and committee members. I have the privilege of serving as the Chief Executive Officer for Cancer Council Queensland. I am joined today by Dr Danielle Jackman, our policy and advocacy specialist. We, too, acknowledge the traditional owners of the land that we are on today and pay respects to the elders past and present.

Thank you for the opportunity to provide our support—and, to be clear, it is our support—and constructive feedback on the Health Legislation Amendment Bill 2025. As an indication of our level of independence, we do receive a small amount of government income for the services we provide and the research we conduct across the state. That equates to around six per cent of our overall income, so we are a very independent organisation.

As outlined in our submission, the Cancer Council Queensland strongly supports the provisions of the bill that enhance enforcement capabilities for illicit tobacco, vapes and novel products such as nicotine pouches. Specifically, we welcome the removal of show cause requirements for seized illegal vapes which will enable more timely enforcement responses and increase the capacity of Queensland Health to disrupt the growing illicit market. We also welcome the ability for Queensland Health to immediately seize and order the destruction of the illicit products as well as the introduction of the 'polluter pays' model that will recover the costs of storage, destruction and prosecution.

The measures proposed in the bill complement Queensland's recently strengthened on-the-spot penalty regime, which now extends to illicit vapes. On that subject, importantly, we would like to make a brief correction to our submission on page 3. Queensland's recent increases to the on-the-spot fines announced by the Attorney-General, Hon. Deb Frecklington, on 3 April are the highest in the nation for illicit tobacco and vaping supply. This is a rapidly evolving area, with both Queensland and South Australia interchangeably claiming nation-leading penalties. However, the important distinction is the difference between penalty infringement notices here in Queensland,

which are on-the-spot fines issued without court proceedings, and the maximum penalties, which are imposed through court prosecutions. Currently, Queensland leads on the former and South Australia has the highest maximum court imposed penalties.

Cancer Council strongly supports the leadership shown by the health minister and the Attorney-General in strengthening the on-the-spot enforcement mechanisms. Unlike court prosecution pathways, which typically take a minimum of six weeks to progress, Queensland's strengthened infringement notices enable a far more timely and effective response. Illicit products can be seized immediately, effectively halting illegal trade with fines issued just days after. Importantly, Queensland Health retains the ability to issue repeat fines for ongoing or repeat breaches. The swift and flexible approach not only reduces the burden on the court system but also significantly improves public health outcomes by disrupting the illegal supply chains in real time and providing a real deterrence. While the amendments that we are discussing today may appear technical or minor, they represent really important changes that will strengthen illicit tobacco control in Queensland.

The Cancer Council has a direct and longstanding interest in tobacco and nicotine control. Our core mission is to reduce the burden of cancer in Queensland and prevent avoidable disease. The link between tobacco use and cancer is indisputable, and emerging evidence suggests that the widespread uptake of vaping, particularly among young people, risks reversing decades of really important progress in tobacco control. As we pointed out in our submission, daily vaping amongst Queenslanders has increased significantly since 2018, with over a third of high school students having tried vaping. The association between vaping and cancer is not hypothetical. Vapes are known to contain carcinogenic chemicals, and focus groups of over 5,000 young people run by Cancer Council's Generation Vape research project have shown that regular use, particularly among young people, does serve as a gateway to cigarette smoking.

As illicit tobacco and vaping control is a public health concern, Cancer Council strongly supports maintaining enforcement and compliance powers within Queensland Health. Shifting these functions to another agency such as the Office of Liquor and Gaming Regulation, as suggested in the submission by the British American Tobacco, would come at significant cost and a complete regulatory overhaul. Cancer Council is supportive of Queensland Health's integrated prevention-first approach that extends beyond enforcement.

Alongside compliance measures, Queensland Health manages complaints from the community, ensures compliance with smoke-free laws and drives complementary public health campaigns. As we have outlined in our submission, there is a clear opportunity to build on this model by reinvesting enforcement revenue into targeted prevention and cessation efforts, similar to the way we know gambling revenue funds early intervention and prevention programs in that space. Strengthening funding for local health promotion and culturally responsive quit services would significantly enhance Queensland's capacity to reduce nicotine harm. There is particular need for more targeted interventions among high-risk populations including young people, First Nations communities and those in regional and remote areas. We know that this also aligns with cancer prevention.

Once again, I thank the committee for the opportunity to appear today and contribute to this really important discussion.

Mr J KELLY: Thanks for the presentation and the very important work you do in our community. In relation to the first recommendation you made in your submission, do you believe that the bill should have an open-ended option for the minister to add more products based on recommendations from groups like Cancer Council Queensland or other bodies that might be able to provide that independent, evidence-based advice?

Mr Gardiner: Yes. There is an opportunity here to futureproof this bill to include the novelty products that we know are emerging and other gateway substances that particularly young people are susceptible to.

Mr J KELLY: In relation to your second recommendation—I am aware personally but I am not sure other committee members would be—could you perhaps elaborate a bit more on the Blurred Minds project?

Dr Jackman: We are very supportive of the Blurred Minds project that is funded across secondary schools in Queensland, but that is just one target demographic. We think there needs to be more done in terms of health promotion and prevention programs that go beyond the secondary

school cohort up into young adulthood. That is the area that we have done a lot of our research on in Cancer Council Queensland and we can see there is a real need there, and vaping rates are on the rise in the young adult population as well. It is necessary to increase our cessation services that are targeted and localised as well.

Mr J KELLY: In relation to that specific recommendation, have you had any engagement with the government regarding the use of proceeds of enforcement for extending programs like Blurred Minds or other prevention or cessation programs?

Dr Jackman: We have spoken to government decision-makers about our holistic prevention program that we provide within Cancer Council Queensland and the potential to roll this out in particular target areas like smoking cessation and vaping prevention and cessation and targeting key demographics. The program is called Lifestyle 6. We are not trying to promote that specifically in this submission. The response we have received from government has been that they are investing in Blurred Minds in secondary schools. We are very supportive of that, but we think there is a need to extend that.

Mr J KELLY: Is it the view of Cancer Council that perhaps there is a revenue source here from enforcement activities that could be utilised in that way?

Mr Gardiner: That is a really good question and the answer is no. This is not about us generating revenue. This is about the appropriate use of the funds that are generated.

Mr J KELLY: No, I do not mean you generating revenue but the government having a revenue source that could potentially be utilised for this particular purpose, which has been generated from the product that is problematic.

Mr Gardiner: Absolutely. There should be repercussions for that and consequences. Actually, they are natural consequences and they go back into prevention and cessation.

CHAIR: At the risk of being accused of being slightly self-indulgent, I think Professor Timo Dietrich from Blurred Minds is one of my constituents. If he does not live in my electorate, he is certainly based in my electorate out of Griffith University. He is one of the co-founders of Blurred Minds. We heard quite a bit from him in one of the original inquiries into vaping. I just wanted to acknowledge him.

I want to touch on the issue of product definitions. It is my understanding that the current bill already makes provision for—and I remember this being debated quite substantively when the bill was passed originally. There was a desire to make sure that the legislation was broad enough that it could encompass other tobacco and tobacco related products. In fact, the Crisafulli government recently amended the regulation to include nicotine pouches, for example. That is something that has just happened. In fact, that took effect on 3 April. As I understand it, there is already scope to deal with other products. Is that your understanding, or are you suggesting that there is not enough scope to deal with it by regulation and we need to make further amendments?

Dr Jackman: I think there is enough scope. Since writing this submission, we have done some more background research on that. I have some notes here on the current legislation that addresses these emerging products, and the reference to the nicotine pouches was our specific concern there. In the Tobacco and Other Smoking Products and Other Legislation Amendment Regulation 2025 that took effect on 3 April, there is an expanded definition of 'illicit nicotine product'. We are very supportive of that. We think the current legislation is agile enough to be able to address those emerging products. That is, in a way, a correction to our submission.

CHAIR: That is great. I just wanted to clarify it because I was concerned that maybe we had missed something in the previous round.

Dr Jackman: I had thought that initially but I would like to stand corrected on that if I could.

CHAIR: Well, you are on the public record with that.

Ms BOLTON: I want to go to the enforcement regimes which you spoke about in your submission and in your commentary today. Is there any specific area within either the Queensland or Commonwealth enforcement regime that you believe could be improved?

Mr Gardiner: Our response to that is that we think what is captured in this bill would provide a sufficient deterrent, in particular, the immediacy of that. Taking the enforcement notices approach would provide that immediacy and actually stop the prevalence of this in the community and the access, particularly amongst children, young people and other high-risk groups.

Ms BOLTON: You spoke about proceeds of penalties. I think you said 'some' in your submission and you mentioned that earlier. I am trying to figure out why it is not all of the penalties, similar to the Victorian Consumer Law Fund. Why wasn't that a recommendation in your submission?

Dr Jackman: Are you referring to the maximum penalty amounts through the court proceedings?

Ms BOLTON: Yes. You said 'some' of the proceeds. I am trying to understand why it was 'some' instead of all of the proceeds.

Dr Jackman: I think we were trying to be realistic there and making a constructive recommendation that was achievable. Obviously, the enforcement regime would need to absorb some of that revenue to sustain itself. I understand that the revenue does not actually return immediately to Queensland Health; it goes into a centralised Treasury bucket, in effect. I think mandating a small portion at least to go back into prevention and health promotion would be a great step forward.

CHAIR: I think you will find that the quantum of money that is being collected is not that substantial at this stage. You are right: Queensland Health does not get the funds—it goes where all the other offence money goes. There is money funded for Quit, which is about $5 million a year. There is also a smoking cessation program that is being run in Aboriginal and Torres Strait Islander communities that is being funded by the Prevention Strategy Branch. So there is consideration of those things, just for the sake of clarity, and we can get more information on that if you want. If the member for Noosa is finished, we will go to the member for Hervey Bay.

Mr LEE: Thank you for your presentation. When we are talking about pecuniary penalties, there is what we see in the South Australian legislation. From a comparative point of view, to your knowledge, were different jurisdictions assessed as to their effectiveness in terms of the higher pecuniary penalty? How effective has that legislation been as a deterrent?

Mr Gardiner: I will be up-front and say that I am not aware of the value of it. As a mechanism for a deterrent, what we are familiar with anecdotally is that it is causing it to clog up. People who are doing the wrong thing are using the process available to them to slow things down. It becomes expensive and prohibitive, and it is not as enforceable as the on-the-spot fine that Queensland is proposing.

Mr LEE: In relation to enforcement, your submission talks about supporting Queensland Health as the enforcement agency in contrast to another submission. You identify specific high-risk groups. In your opinion, is an enforcement regime warranted from a targeted point of view, identifying those areas that are perhaps more susceptible to exploitation?

Mr Gardiner: That is a fantastic question. I think if we take a public health approach to this then the answer would be absolutely yes. We should prioritise those regions, areas and communities that are most at risk, absolutely. There is an incentive there that is naturally aligned for this to sit within Queensland Health. The mandate that Queensland Health has as an agency means they are incentivised to go out and actually prevent this.

Mr LEE: I am very interested in the gateway effect, and you footnote a particular research project. Has that gateway effect been comprehensively studied? We can make a lot of assumptions but I certainly value good research in support of that.

Dr Jackman: I am happy to provide that research report to the committee if you are interested. I will note that all of the research around vaping is very much emerging. There is not a large body of research on any of the effects because it is evolving so rapidly. The same can be said for whether vaping is an effective cessation tool or not. You can probably find evidence for both sides.

Mr LEE: I note in your submission you say it is too early to actually assess the long-term health effects of vaping. In terms of the gateway effect from vaping to cigarette consumption, I think you said that high school students are 29 times more likely to subsequently try cigarettes.

Dr Jackman: That research was that 12-year-olds who vape are 29 times more likely to progress to cigarette smoking. A significant portion—slightly less—of high school students who are regular vapers will go on to smoke cigarettes. The evidence for that gateway effect is quite compelling.

CHAIR: We are out of time but there is one issue I want to raise with you. You touched on the issue of concerns around the online sale of vaping products by pharmacies. Until I read the submission, it never occurred to me that pharmacies would be in a position to sell vaping products online, and nor should they. My sense of the legislation is that someone goes to see a doctor or a pharmacist and they talk about the specific issues and they work through a plan or they are provided with products to help you with your addiction. Is this something that you have much evidence of?

Dr Jackman: The pharmacy model is the only model where Australians can access legal vapes. In some states, you require a prescription to access vapes for the purposes of cessation. In other states, like Queensland, you can buy a vape over the counter from a pharmacy. With the online pharmacy that you are referring to, we have particular concerns that there is a very close association with the former retail store Vape World, which existed before this legislation came into place and then transitioned to be an online pharmacy. We have concerns about the consultation that takes place in providing these products and whether they are being used as cessation tools or recreational tools. Our other concern that I note in the submission is that there is branding of these vapes on the Pharmacy World website which seems to contravene the legislation against advertising.

CHAIR: Wow. That is not something we have considered along the way, so it is obviously something we need to do a bit more investigation into because it may be an issue that we need to look at coming out of this bill. As I understand it, when you go into a pharmacy for this product, you have to be served by a pharmacist, or can any member of staff dispense?

Dr Jackman: You have to be served by a pharmacist.

CHAIR: By a qualified person. How does that work with the online sales? Do they ring up first?

Dr Jackman: I think they submit an online form and it might be a chat situation. I have never used myself as a guinea pig but maybe I should.

Mr J KELLY: Looking at their website, this is rubbish. This is a complete stepping around of the intent of the legislation. Have you reported that to the federal government and asked them to take action?

Dr Jackman: We have. We have reported it to Queensland Health and we have reported it to the TGA as well. As yet, we have not received any result from our advocacy efforts but I am encouraged to see that you also see the concerns.

Mr J KELLY: This is pure vaping being sold here. There is no intent, no discussion. Other than the word 'therapeutic', it is clear how it is designed. You look at the branding and the way it is done. How long ago did you report this to Queensland Health?

Dr Jackman: In December last year, so in the last four or five months.

Mr J KELLY: That is nearly five months and we have not had a response.

Dr Jackman: No.

CHAIR: As there are no further questions, I thank you for appearing today. Thanks for raising the issues that you have, particularly the latter issue which raises some interesting concerns in terms of the intent of the legislation and what we are trying to achieve.

Mr Gardiner: Thanks to the committee for the important work you are doing. We appreciate it.

SLOAN, Ms Gayle, Chief Executive Officer, Waste Management and Resource Recovery Association of Australia

CHAIR: Welcome. Would you like to make an opening statement?

Ms Sloan: Thanks for having me today. The Waste Management and Resource Recovery Association of Australia are probably a bit left field for this inquiry, but never look a gift horse in the mouth when it comes to raising issues. We are the national peak body for waste and resource recovery. We have over 2,500 members nationally, with about 400 in Queensland. When we saw this inquiry, we thought it was a great opportunity to raise the fact that, yes, we completely support this bill. However, taking a systems approach to thinking about this legislation and these vapes, there is a significant issue for our sector outside of the health issues—that is, the safety issue that vapes pose to us and our workers and facilities due to the lack of safe end-of-life disposal of vapes in Queensland and nationally.

At the outset, I would like to say that we also wrote to the federal Minister for the Environment and Minister Butler, the Minister for Health, when the prohibitions on vapes were being brought in, to suggest that we needed a product stewardship scheme to look at how we manage vapes, lawful and unlawful, when they are placed on the market. We proposed something similar to the needle take-back scheme for vapes so that we could at least try to manage the disposal of them at end of life.

We note that the bill highlights the complexity and the challenge of managing what are complex products that are made of multiple material types, hazardous materials and batteries and also highlights the cost associated with the safe management of it, with $35,000 to $60,000 for the bins. We recognise that at present a lot of these are being disposed of and confiscated—75,000 was quoted in the last two months—but the challenge is where they go once they are confiscated. Queensland is, at this time, treating this material as clinical waste when it is disposed of, which makes it even harder to confiscate and manage it. That is one of the challenges that we have raised with the department of environment and science. We like this bill in the sense that it actually highlights product responsibility or polluter pays, as the previous people pointed out, so that those bringing it to market are responsible for the cost of it, but it does definitely create a divide between those who are caught and those who are not.

We have been advocating that we need a national stewardship scheme for all battery powered items because at present we do not have a scheme that captures anything outside of small lithium batteries. We had around 12,000 fires in facilities and trucks last year. We are very lucky to date that we have not had a death in any of our facilities but, as you would be aware, we have had deaths in homes from batteries. I think we have all been caught unawares by the move from cables and electricity waste to clean energy waste with battery and battery powered. We do not have a system that is scaled to manage any of that. We are also getting caught with people actually using substandard systems so cables and batteries that are not compliant and are causing fires in the home. We have had a significant spate down the east coast of micromobility scooter fires and people dying in the home, which is a significant risk.

Recently in Queensland we saw the Cairns organics facility transfer station catch fire. It was a battery, although whether it was a vape at this stage is not known. That will cost between $24 million and $30 million in terms of damage and impact on that facility alone, which council will have to pick up. It is also going to have between 12 months and 24 months impact on service delivery, because trucks will have to move further to dispose and manage.

We took this opportunity to raise with the committee the fact that it is great and we support polluter pays, but we would argue that we need to consider this to go further to lawful and unlawful vapes. We have to look at end of life and management of these and where they go because they are a risk not only from a health perspective but also from a safety perspective to the broader community.

We did have a proposal for the Environment Ministers Meeting in December last year to look at a national battery mandatory scheme. I appreciate it was a new government in Queensland that at that stage wanted to consider its options. Since that time, in April this year New South Wales has developed a mandatory stewardship scheme through the Product Lifecycle Responsibility Bill that will enable them to start looking at a mandatory scheme for batteries in New South Wales. We would very much urge all battery and battery powered items to come within such a regime. We would be very keen for the Queensland government to mirror the New South Wales legislation, because we are very keen to have safe disposal pathways. We are also very keen for those who make these

materials to be responsible for the costs, similar to what we are doing here but much broader, and we are looking at the producers to be responsible for it because we want safe workplaces for our workers, just like everyone else. Thank you.

CHAIR: Thanks, Gayle. It is interesting.

Ms Sloan: It is a bit left field.

CHAIR: For the sake of the committee, can you talk us through the process of disposing of a vape and pulling it apart? What labour is involved in that and how is it all done? Where do all the bits end up?

Ms Sloan: At present, I do not believe it is. I think there is one business that I am aware of in Queensland that is advertising that it could accept and dismantle. However, the last time I was made aware of it, it was quoting between $6,000 and $8,000 a tonne to separate and then process. We are just like every other business: it has to be economically viable. It is very hard for any business to invest without certainty of throughput given that there is nowhere really that you can take it and dispose of it, there is no guaranteed throughput and there is no investment in managing and pulling apart and then creating a market to take this material back. It is really challenging at present.

At the moment, there are a lot of campaigns about not putting batteries in your bin, which is absolutely correct. Ideally we should be buying products that you can take the battery out of. We should always be looking from a buyer's perspective at whether the battery can be removed because then you can put it through a B-cycle, but if it is integrated and embedded then it is impossible to pull apart and there is risk that they will get damaged and cause fires. There is nowhere to lawfully put those at present in Queensland.

CHAIR: With the vapes that are being disposed of currently, say Queensland seized them and stored them, where do they go after that for disposal?

Ms Sloan: That is a good question. For a period, they were going into some landfill. They can be, in theory, safely put within the landfill and buried as containment. However, we were advised about six months ago that the department of environment now classifies them as clinical waste, so in theory they need to go to a clinical facility, which is generally a thermal facility, to be managed. We are unclear, to be honest. This is an issue nationally, to be fair; it is not just Queensland. We found that in every jurisdiction, as government started to ban these, we would get questions about where to take them.

CHAIR: When you say a 'thermal facility', what does that actually mean?

Ms Sloan: It means that a lot of clinical waste is burnt.

Mr J KELLY: You talk about the battery stewardship program. How do you practically create that for a product that is essentially illegal?

Ms Sloan: That is a challenge. Some are illegal. In this instance, this bill is dealing with the unlawful ones. We also have a category that are lawful and can be put on the marketplace. That was why we wrote to the federal government, to recognise that whilst their enforcement efforts were going on we needed some of the funding that had been put aside to therefore make them unlawful and to fund the scheme and assist as we move to a broader stewardship.

Mr J KELLY: We picked up a bag of them when we were doing Clean Up Australia Day this year. I took them home because I did not know what to do with them. I took them out to the transfer station. I took them up to the recycling place and the guy said, 'You can't put them in the battery section and you can't put them in the e-waste section. I don't really know what to do with them.' So they are still sitting at my house. Obviously, a lot of this falls to local government. Has the LGAQ or any of the state-based local government associations raised concerns about how to manage this particular waste product?

Ms Sloan: Absolutely. It is a huge issue for us and has been for the last two or three years. We find that fires are increasing as we move from cables to power packs. We need a comprehensive scheme to deal with all battery disposal. This is the real challenge in Australia, not to go too far off topic, but you can put almost anything on the market in Australia without any requirement or any lawful need to comply with design requirements and then, at the end of life, it comes to our sector to try to find a solution for it. Ideally, it is not landfill.

In other countries such as in the European Union you have waste directives and battery directives that make anything that is placed on the market the responsibility of those who make it and generate it. We do not have that approach. We work at two speeds—lawfully allowed on market and unlawfully—but we need to find a solution, whether it is being paid for through councils or through generators or private industry, because this is a real safety risk to our workers and our community.

Mr J KELLY: I do not know whether this has happened, but I presume that you were consulted by the state government on the exposure draft of this bill. Have you raised with the state government the fact that at this point there is nowhere to dispose of these products? What was the response if you did raise it?

Ms Sloan: We have been raising continuously the challenge with batteries because we managed to get it on the agenda of the Environment Ministers Meeting about 18 months ago. Queensland originally took the lead under the former government to look at a national solution. There was a lot of talk and not so much action, to be fair. The new government arrived and they have been listening to us. They have put some funding into collection points through local councils. However, no local council is going to step in to the breach to collect because, as you said, where do you take them? The absence of clarity around processing, capacity, cost to manage, end markets—they are a risk.

What New South Wales has been doing, whilst they have been developing the legislation, is also funding 21 recycling centres to take them. They have been funding the cost of managing and recovering at end of process because that is a big cost at present as there is no requirement to do it at scale. Government is listening. There has been some funding given to it, but at this stage we say it is inadequate. What we really need, similar to this bill, is that the polluter pays step into the breach where we say, 'If you are putting it on the market then you actually have to take responsibility for it.'

Ms BOLTON: Gayle, I must admit I am quite shocked at some of what you have been saying. I would have thought that every time new products come on the market that are going to create a waste issue there would be some quite extensive consultation into how the end of life would be managed. Given what you have said about polluter pays, do you think that governments should be sending a terms of reference, maybe to this committee, to actually pull this all apart and, as you said, do something similar to or follow the European Union?

Ms Sloan: Absolutely. That would be music to our industry's ears because one of the challenges often is that what is placed on market is not recoverable, reusable, recyclable. We need to move far. Next week I think you have a hearing about the container refund scheme, which is a classic example of products placed on market that are increasingly more recyclable. What is not happening is sufficient amounts of that being brought back and designed into the use of recycled materials.

We need to have systems thinking about, whatever you place on market, what happens at end of life, particularly as we move towards 80 per cent resource recovery or the circular economy. We have to think about how we use it over and over, how we incorporate Australian recycled content, how we create jobs, how we reduce methane—all of that thinking. To be fair—and I live and breathe this stuff—since China's national thaw in 2018, everyone went, 'Oh my God, we export!' Of course we export because we do not manufacture in Australia. If we want to pivot to manufacturing in Australia then we have to think about that design in the first instance and not just home in the last instance. That is what we are increasingly moving towards.

When we wrote to the federal government we said, 'If you're committed to a circular economy and you want to have this framework then every bill that comes before parliament needs to go through that lens of circularity because, if it is making a product or making material, where will it go at end of life?' That is the framework. We are definitely moving away from landfill, as we should. We have to reduce carbon emissions and we have to use material over and over. We have to increase productivity. I appreciate that I am obsessive, but my industry touches every industry.

Mr LEE: Gayle, you referred to mirroring the New South Wales legislation. Are you talking about mirroring that to the current recycling waste reduction legislation?

Ms Sloan: Yes. There is going to be a review shortly of the recycling and waste reduction policy, at least, in Queensland. There is also the possibility to mirror the New South Wales Product Lifecycle Responsibility Act and bring that into Queensland. It was a resolution of the Environment Ministers Meeting that New South Wales will do the impact statement and do the draft, and then the others states would adopt it, ideally. It has been drafted in a stand-alone manner so that states could actually adopt it. It gives all the states the framework to put many products underneath it based on harm and to make those producers responsible for managing the lifecycle.

CHAIR: Thanks very much, Ms Sloan. Time is against us. It was very informative. Thank you so much for making your presentation. Certainly it opened our eyes to a few issues. We will now take a short break.

Proceedings suspended from 1.14 pm to 1.20 pm.

BOASE, Ms Leanne, Chief Executive Officer, Australian College of Nurse Practitioners (via videoconference)

CHAIR: Welcome. Would you like to make an opening statement?

Ms Boase: No, I do not need to make an opening statement.

CHAIR: Deputy Chair, do you have any questions?

Mr J KELLY: Thanks very much for your submission and for the work you do for the profession of nursing. It is greatly appreciated. I have a couple of background questions, and I know you may not necessarily know the answers to some of these. Do each of the 15 HHSs, to your knowledge, have a director of nursing, and are there directors of nursing for specific hospitals within those HHSs and subspecialties?

Ms Boase: I would not have firsthand knowledge of that. We are a national organisation based in Victoria. To my understanding, all of the EBAs across Australia require a director of nursing for each HHS.

Mr J KELLY: It is quite common—in fact, it is usual practice to have a director of nursing.

Ms Boase: Yes.

Mr J KELLY: Would you expect that those directors of nursing would play a role in terms of strategic decision-making for the HHS or the hospitals?

Ms Boase: I would expect that they would but they would be very well skilled and it would be very appropriate to do so. However, I am not sure whether that is actually occurring and whether the capabilities and skills of directors of nursing are being used effectively to their full capacity. Having experience in different parts of Australia, I know it is not always the case that the director of nursing is valued as part of that strategic plan.

Mr J KELLY: I guess that is where my questions are going. The notion and the basis of this bill is putting doctors and nurses back in charge of hospitals and health care. What evidence has the government shared with you in the consultation around this bill that that is not, in fact, the case now?

Ms Boase: I have not seen any evidence shared by government, but I do have anecdotal evidence from my colleagues around the country, including in Queensland, that a lot of hospital and health service boards comprise—there may be clinicians on those boards, but they are not practising and they are not providing clinical services that are contemporary, that are happening now. That is what I am getting at. They might have been practising in the past, but we are really missing key opportunities to inform contemporary management of hospitals for current and future healthcare needs because we are generally focused on retired or semi-retired clinicians to bring in that clinical component to the board. I think the focus of this bill on 'currently practising' is actually critical and I think it is a really valuable opportunity.

Mr J KELLY: To what extent do HHSs play a role in that clinical direction and governance of a hospital or a HHS?

Ms Boase: I am not sure, I am sorry. As I said, we are a national organisation. I do have feedback from some Queensland members.

Mr J KELLY: I have asked a question on notice to which I received the answer from Queensland Health. Out of the 15 HHSs in Queensland, 11 have CEOs that have very extensive, recent and continuing clinical practice and only three out of the 15 have nobody in a CEO, a chair or a deputy chair role that has no clinical governance. I take your point around recency of practice and the clinical movement. In terms of clinical governance and clinical decision-making, that would not strike me as being core business of a strategic board in an organisation like a HHS.

Ms Boase: Not core business, no. However, I think a board should have representation. I am not suggesting that the entire board or the majority of the board should be comprised of currently practising clinicians, but it would be good to have one currently practising clinician on each board just as a way of keeping the board in touch with current, contemporary healthcare provision.

Mr J KELLY: Do you have any concerns around the fact that you are showing up to work as a nurse, doctor or allied health professional and you are going to board meetings and having to own decisions of the board and then you are going back into your workplace and having to engage with your colleagues and be responsible for those decisions? Do you have any concerns from a governance perspective as to whether that is an appropriate way to structure an organisation?

Ms Boase: It is very challenging to manage that. Often what you see is clinicians sitting on boards outside of their own HHS as a way of mitigating that so they are not working on the floor and also being a board member of that organisation. It does need active management as well. I have

worked in health services where doctors who are currently admitting to the hospital are on the board and there have been actual conflicts or concerns that have arisen as a result of that. That is something that requires active management and consideration.

Mr J KELLY: Going to that issue and that concern around recency of practice of some of the existing boards—without going to specific boards or board members—would an alternative to this proposed legislation be to ensure that the clinician who is on the board has a recency of practice in a relevant clinical setting, whether that is another HHS or even a private facility, aged-care facility, non-profit, whatever?

Ms Boase: Absolutely. Those skills are transferable. Often having someone who is clinically practising in another service or even another sector can mean they bring experience and knowledge into the HHS.

Mr J KELLY: Thank you.

Ms BOLTON: I have a quick question going on from the deputy chair's line of questioning so I can get this clear. What you are saying is that it is important that the clinician is practising in that clinical component but if they are outside of the HHS area it would reduce that potential conflict?

Ms Boase: Absolutely, yes. It is also potentially very challenging for other clinicians and other staff members to work day-to-day alongside a board member. I think that is one way of mitigating that.

Ms BOLTON: Thank you.

Mr LEE: I really appreciate the good work that you do. We certainly need more nurse practitioners in regional Queensland, so well done. You have the benefit of a national perspective and you touched on it before that you are aware of issues with conflicts of interest with respect to medical officers who had, I believe, admission rights to a health service. Are you aware in a broader sense of whether that has presented as an issue across Australia in other jurisdictions, apart from Victoria?

Ms Boase: Yes, I believe it would be. The context I am referring to is the small rural health service where I used to work. Your pool of potential board members was relatively small as well. Having a clinically practising doctor who knows the health service on the board is incredibly valuable, but it is important to have that transparency and the processes in place to ensure that conflicts of interest are identified and managed.

The issue that came about, as an example for me, related to nurse practitioners. The board had taken a very strong interest in establishing nurse practitioner services in this rural health service but this doctor opposed it very strongly and ended up convincing the board not to go there because there was a fear of competition for the local medical practice. Things like that are pretty obvious and should be able to be managed with good conflict-of-interest processes. It is great to have the ideal in mind of having board members from outside the health service, but we also need to have strategies to have board members who work in the health service and to manage those conflicts. In small rural areas with services that cover big geographic regions with sparse populations and distant populations, we may not have a significant pool of people who are available or skilled to be on the board so we need to have a more flexible approach.

Mr LEE: Thank you.

CHAIR: I was a bit remiss earlier but, Leanne, I also want to acknowledge the great work of nurse practitioners. I do not know if you were at the nurse practitioner conference I spoke at on the Gold Coast maybe six years ago; I got thrown in at the last minute as a guest speaker. Until that day I did not even know what a nurse practitioner was so I took the opportunity from the podium to receive an education from the 400 nurse practitioners who were there and I will never make that mistake again. I have since met many nurse practitioners around the state on my travels. In places like Yeppoon, Hervey Bay and Mount Morgan, some of those health services would not survive without the hands-on work of nurse practitioners on a day-to-day basis, filling in for doctors and others who are not available. I did want to say thanks.

Ms Boase: Thank you. It is important for you to understand too that many nurse practitioners are now moving into primary care so we are losing them out of the public sector as well.

CHAIR: We are nearly out of time, but I want to touch on this conflict-of-interest issue. I have served on many boards over many years and continue as a director of both Bravehearts and Common Ground on the Gold Coast. I have sought advice about conflicts. The broad position I have adopted is that I do not think you are ever in conflict if you are acting in the best interests of the cause, the organisation or the board. I note in your submission that you broadly support this next idea, that surely

having someone with clinical experience from that particular health service has to add value to the board and surely those conflicts cannot be that—I am probably leading the witness, sorry, and I should not be using those terms. It just seems to me that the potential for conflict is quite minimal, really, in terms of the broader aims of those boards.

Ms Boase: I absolutely think it is manageable and (inaudible). What I was trying to say before is not that it would not work but that we need to be a little more open-minded about where we might access these board members. It does not have to be from within the health service. Obviously, we need good, robust conflict management, and training in governance for board members is critical. Regardless of what boards you serve on, I think this training is critical. I do not know about Queensland Health and what their approach is, but it is not something that is commonly supported for board members, especially clinician board members, but it is essential. That can help to an extraordinary degree to mitigate any risks as well.

CHAIR: When you say training, do you mean something like the Australian Institute of Company Directors course—something that alerts them to the broader issues but that is perhaps tailored to the medical industry?

Ms Boase: Yes. There are different levels of training you can do through the Institute of Company Directors. There is foundational training for board members, which is a really good coverall for new board members, all the way through to the advanced training. There is no reason health services or government cannot put together resources and training for board members on HHSs that would be probably quite appropriate but there are certainly courses out there. There are also many companies that provide tailored training to board members in particular settings.

CHAIR: There being no further questions, I thank you for making your time available. Thank you for your submission and for the great work that your members provide in supporting our health services across Queensland.

Ms Boase: Thanks for your time.

BEWLEY, Ms Amy, Director, Legal and Integrity Services, Office of the Queensland Integrity Commissioner

BOOTH, Mr Paxton, Acting Integrity Commissioner, Office of the Queensland Integrity Commissioner

CHAIR: Welcome. Thank you for coming today. Would you like to make an opening statement before we commence questions?

Mr Booth: Thank you for the invitation to appear before the committee in relation to its consideration of the Health Legislation Amendment Bill. The Integrity Commissioner has provided a written response to the questions raised by the committee regarding the management of conflicts of interest for employees of hospital and health services who may be appointed to the board of the same hospital and health service. I can also say that the Integrity Commissioner has previously provided ethics and integrity advice and conflict-of-interest management plans for persons who are in a similar situation, so that is a person who is otherwise engaged by the hospital and health service and also a member of the board. That is something we have done before.

The issues identified about this proposal are, in the Integrity Commissioner's view, manageable but will create some additional impost on some of the people within the hospital and health service—primarily the board secretariat of the hospital and health service, the health service chief executive and the clinician, obviously, who is appointed to the board—to ensure that the conflicts of interest are managed appropriately. I am happy to take any questions.

CHAIR: Thank you. You mentioned a need to appropriately manage potential conflicts. Do you see that as something that is fairly onerous, or is it more a broader procedural process that just needs to be acknowledged on occasions when particular issues may be raised?

Mr Booth: The issue around management of conflicts of interest will always depend on a case-by-case basis and what that individual person's interests are. The fact that they are an employee of a hospital and health service will naturally give rise to some conflicts of interest because they are an employee who has a relationship with the chief executive. They are on the board and the board is responsible for employing the chief executive, so it gives rise to some natural conflicts in that regard. The complexity of it will also depend on that particular individual's other personal interests. They may have other family members employed in the hospital and health service; they may have secondary employment which cuts across the hospital and health services as well. There are a number of factors which can impact on the complexity of each individual's management plan.

CHAIR: In terms of the veracity of those issues, I know when I was a councillor with Gold Coast council it was generally accepted that a councillor had no conflict of interest voting on rating matters because they are a ratepayer; nor did the staff who worked for council who provided rating advice have a conflict because they were also ratepayers. Does it sort of fall more generally into that realm—that, if you are a practitioner on a board in a health service, most of what you do is broadly accepted as being for the greater good?

Mr Booth: It will vary. There may well be some issues that come before the board where it will not necessarily give rise to a conflict just because they are an employee, but there will likely be matters that will come before the board that would give rise to a conflict because of their engagement as an employee. For example, if a matter came before the board about a particular department where they are employed or where they work, they would have obviously personal interest themselves because they are employed in that department. They may well have close associations professionally or personally with other people who work in that department. Those decisions would impact, either positively or negatively, on those other individuals or themselves and that would give rise to a conflict that was not applicable across the entire hospital and health service.

CHAIR: They would also bring some unique insights, wouldn't they?

Mr Booth: Yes, absolutely—depending on the issue, yes. Obviously, part of the benefit of having a diverse board is that each member of the board brings their own expertise and insights as part of the group discussion when the board considers matters.

Mr J KELLY: In terms of the relationships on the board that is one thing, but these are clinicians who then have to go back into a workplace and have a day-to-day working relationship with people who may hold them responsible for the decisions that they are making. Do you anticipate any issues or problems in relation to somebody from a subordinate level having a role on a board? Presumably they will be responsible for appointing some staff and perhaps be involved in dismissing staff. Surely that has to create some difficulties for a person in their day-to-day role?

Mr Booth: My view is that probably at a board level they are unlikely to be engaging staff members necessarily, but from time to time there are likely to be issues that may come to the board that they have to participate in or usually participate in decision-making around a particular incident, which could give rise to a conflict where they would potentially have to declare a conflict and step out of the decision-making process.

In terms of managing those issues that you are referring to about having to engage with their fellow employees, I think maintaining confidentiality would obviously be a significant matter that they would have to turn their minds to in making sure that anything that is discussed or that they get access to as a board member, which other employees would not have access to—they maintain confidence in relation to that information. It is really up to the individual whether they are comfortable putting themselves in that position of maintaining that confidence and dealing with, I suppose, some of the potential issues that may arise from time to time with other employees.

Mr J KELLY: Does this legislation include any requirements to have policies in place to manage or deal with these situations? For example, is there anything in the legislation that says that these are the specific things that this person should not be dealing with in their capacity as a board member?

Mr Booth: In relation to the Hospital and Health Boards Act, if they are appointed to the board then there are existing provisions in the act now so that board members are required to disclose conflicts of interest. Under schedule 1 item 9, they have to disclose to the board anything that has that potential that comes to the board. They have to disclose that to the board. The board has to make a decision about how that is dealt with and they have to do that in the member's absence. There is also a requirement in the Integrity Act, under section 40F, that the board member would have to disclose to the minister any actual conflicts of interest that may come up during an appointment and have in place a management plan approved by the minister in relation to how those conflicts would be managed.

Mr J KELLY: Moving beyond conflicts, if we look at other routine activities of boards such as I have been involved in—for example, reviewing a risk register and reviewing incidents—we could anticipate that if you are a registered nurse in, say, an intensive care unit or a medical ward and you are sitting on that board then there will be things on that risk register or critical incidents that you are required to review. We could anticipate that in advance. Should we be putting in place provisions in this legislation to anticipate those issues and mitigate them before they become an actual problem?

Mr Booth: Generally, they are the things that should form part of a conflict-of-interest management plan to try to anticipate, where that is possible, those types of scenarios that give rise to information that may come to them in their role as a board member that they may not ordinarily see if they were an employee so they manage that information appropriately. There are already provisions in relation to the management of confidential information, that they are only to use it for the purposes of performing their functions. Provided they comply with that then that may well address those issues you are referring to.

CHAIR: It would be fair to say that they are already dealing with enormous amounts of confidential information as a result of other aspects of their work so it would not be a new practice for them to maintain confidentiality.

Mr Booth: It is not so much that it would be a new practice. I think all employees in the public sector are—you are quite right—used to dealing with confidential and sensitive information. It is just that the type of information they would be exposed to at a board level would be probably a little bit different to what they are used to seeing. They would then have to engage in working relationships with their fellow employees where they may be privy to something that the other employees were not and they would have to keep that information to themselves and confidential.

Mr LEE: Thank you for your written submission. It is very helpful. I have a couple of questions for clarification in regard to conflicts of interest. I refer to the question that was put to you in paragraph (b). The last paragraph of the response states—

> … the plans created for this scenario are typically complex and necessarily involve an administrative burden for the relevant Board member, the HHS, the Board Secretariat and the Board Chair.

You then go on to talk about balancing the public interest considerations on a case-by-case basis. I am interested in teasing out a bit more what you understand the complexity to be. What does that look like to you?

Mr Booth: As I said at the beginning, the complexity will always depend on the particular circumstances of the actual employee. Some of the things we are referring to in that regard relate to the fact that, depending on the level of the employee who becomes a member of the board, they may

well have a contract of employment that is signed by the chief executive. You will have a position where you have a person on the board that is responsible for employing the chief executive, but then the chief executive has oversight of the employee who is also on the board. You create this circular responsibility of oversight between the two people and the board. That is an issue that has to be managed. For example, if the employee had to disclose or declare a conflict of interest, normally if they are a senior employee that would be declared and signed off by the chief executive. If that person then becomes a member of the board and one of the conflicts of interest they are having to manage is that they are now on a board and still reporting to the chief executive as an employee then they would have to find some alternative mechanism—someone other than the chief executive—to sign off on that management plan for the conflict of interest. One of the challenges in that regard goes back to the chief executive not being able to currently delegate to someone outside the hospital and health service. Anyone else they delegate that to would have to be probably at that level or also reporting to the chief executive, which in itself creates complications.

Mr LEE: On that point, you can distinguish a person who might, say, have a contract to supply goods or services to a hospital as an independent contractor.

Mr Booth: Yes.

Mr LEE: What you are going to is the substance of it being the delegation issue with respect to an employee?

Mr Booth: That is definitely part of it in terms of trying to manage the conflict of interest. It limits the ability for the chief executive to manage those conflicts of interest where they cannot delegate that outside of the hospital and health service to manage it. There is also the potential that, if there was an incident at the hospital and there is a report that comes up to the board about a particular event and if that event happened to occur in the employee's department that they are responsible for, they would have a conflict in reviewing the report because it relates to their department and may relate to their conduct or their staff members' conduct. They would have a conflict of interest that would need to get managed in those circumstances.

Mr LEE: Surely that could be managed in the ordinary course of conflicts. Like my colleague here, I served on council. You declare a conflict of interest. You leave the room. Your fellow colleagues would either make a decision on it or you would be withdrawn completely from the decision.

Mr Booth: That is right. We have not said that these are not manageable, but they do create an extra layer of, I suppose, administration that the board secretariat, the chair and the chief executive would have to be conscious of in relation to what material is coming before the board and how that works.

Mr LEE: What about the role of training—an Australian Institute of Company Directors course or something similar? Do you see director training mitigating the possibility of problems with the declaration and management of conflicts of interest?

Mr Booth: I think training would be very important—making sure people are aware of the importance of managing conflicts of interest and how that can be done. I know that the Integrity Commissioner plays an important role in providing education and information to boards, including hospital and health boards, about the importance of managing conflicts of interest. Yes, certainly an important factor in helping to mitigate those risks would be training and education.

Ms BOLTON: This is a quick question that goes back to the conflicts of interest. In a response, the Integrity Commissioner states—

> … I question from a policy perspective whether this is best or only achieved by appointing a clinician employee of the HHS to its Board …

I asked the previous witness whether this conflict could be removed just by that board member being external to the HHS. The types of conflicts of interest obviously would be reduced but they would not be totally mitigated; is that correct?

Mr Booth: Yes, I would agree with that.

Mr J KELLY: Do the HHS boards play a role in appointing or unappointing the CEO?

Mr Booth: Yes, they do.

Mr J KELLY: So there is a potential for quite a significant conflict of interest there if you have a subordinate having a say in whether or not their superior is employed?

Mr Booth: That gets back to the first issue that I raised, which is that, really, there are two primary conflicts of interest. One is around the relationship between the employee who becomes a board member on the board that is responsible for hiring and firing the chief executive and the chief executive, who is potentially responsible for the employment of the employee.

Mr J KELLY: I want to come back to the notion of regular tasks that a board might complete. Again, I am looking at something like a risk register. Having worked in a clinical setting myself, you could find yourself reviewing information on events and incidents in an environment that you have worked in where you may actually have to play a role in terms of providing evidence or appearing before tribunals or even courts. Is this something we could anticipate and manage better in relation to the information that is shared with that clinician?

Mr Booth: It is certainly something that I think goes back to the point that was raised before, that training and education would assist. Whilst we try to predict as well as we can with our management plans—the draft plans that our office provides—for the types of things that might come up for the individual in relation to their responsibilities if they are on a board, it is not possible to foresee every event in advance. Increasing their education and awareness of what is likely to give rise to a conflict of interest, particularly a perceived conflict of interest, is very important. If they identify or see that as an issue, they can flag it early and they will declare it and then put in place a management plan and even get advice in relation to what they should do.

Mr J KELLY: I guess you cannot unsee information once you have seen it, so it may put you in a position where you are involved in a matter that could be of a criminal nature—not for yourself but for somebody else—and you suddenly become privy to information that biases or prejudices your testimony in a court of law. That is a potential real scenario that could have quite significant impacts if this legislation proceeds.

Mr Booth: I think this is around how they would manage or mitigate those sorts of risks in relation to seeing that information. We would generally put in place or suggest a quarantine strategy if there was any possibility or risk that there was an investigation into their area or where they may be a witness so they do not see the information to start with. That is one of the, I suppose, extra burdens we were referring to in our correspondence that would exist for the secretariat, the board, the chief executive and the member to make sure they are cognisant of those issues before they arrive and before the member sees the information.

Mr J KELLY: Given there is a potential risk there and we can anticipate it, should this legislation be amended to deal with that particular situation—

CHAIR: Member, I think you are starting to stray a bit into hypotheticals.

Mr J KELLY: I am seeking advice from the Integrity Commissioner around the soundness of the legislation.

CHAIR: I will allow a little bit of latitude.

Mr Booth: As I said earlier, the issue around conflicts of interest is going to be an issue and will require management. There is no doubt that putting an employee on a board for that same hospital and health service will give rise to some additional burdens and effort on behalf of some of the people who work there. We have not come across an issue yet in the office where that has created an unmanageable conflict of interest, but it does require extra effort for those individuals.

Mr J KELLY: Has this type of arrangement occurred elsewhere in the Public Service?

Mr Booth: Although the current bill will make it a requirement for there to be a local clinician as a member of the board, at the moment they are capable of having an employee on the board. That has happened and the Integrity Commissioner has given advice to those people in the past.

Mr J KELLY: What about other departments? Is there anywhere else in the Public Service where this sort of model has been rolled out? Independent public schools have a board and I guess you could have a teacher on that.

Mr Booth: I cannot speak to other areas in government where this particular model has been rolled out before or where it currently exists. I did do a little bit of reading prior to coming to the hearing in relation to whether this sort of relationship exists elsewhere. There are some articles available online which talk about it being used in some other countries where employees are members of boards. It is not what I would describe as unheard of, but it does give rise to some of the risks that you have identified.

Mr J KELLY: Could we ask for a copy of those articles to be shared with the committee, Chair?

CHAIR: I have no difficulty with that.

Mr Booth: They are publicly available on the internet.

CHAIR: I think we will close there. Thank you for your time today. I note that in the final paragraph of your letter you say that you do not propose any further amendments to the bill as the existing statutory requirements are already adequate. Thank you for your advice. As always, it is fulsome and fearlessly given. You have a tough role.

That concludes this hearing. Thank you to everyone who has participated today. Thank you to our Hansard reporters. A transcript of these proceedings will be available on the committee's webpage in due course. We do not have questions on notice, but we have requested some further information and reading material. If we could have those responses by Monday, 28 April, that would be appreciated. I declare this public hearing closed.

The subcommittee adjourned at 2.03 pm.