HEALTH, ENVIRONMENT AND INNOVATION COMMITTEE

Members present:
Mr R Molhoek MP—Chair
Ms SL Bolton MP
Ms K-A Dooley MP
Mr JP Kelly MP
Mr DJL Lee MP
Dr BF O'Shea MP

Staff present:
Ms K Jones—Committee Secretary
Miss A Bonenfant—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH LEGISLATION AMENDMENT BILL (NO. 3)

TRANSCRIPT OF PROCEEDINGS

Wednesday, 29 October 2025

Brisbane

WEDNESDAY, 29 OCTOBER 2025

The committee met at 9.28 am.

CHAIR: Good morning. I declare open this public briefing for the committee's inquiry into the Health Legislation Amendment Bill (No. 3) 2025. My name is Rob Molhoek MP, the member for Southport and chair of the committee. I acknowledge the Aboriginal people and 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 governance of this state. With me here today are: Mr Joe Kelly MP, the member for Greenslopes and deputy chair; Ms Sandy Bolton MP, the member for Noosa; Ms Kerri-Anne Dooley MP, the member for Redcliffe; Dr Barbara O'Shea MP, the member for South Brisbane; and Mr David Lee MP, the member for Hervey Bay.

This briefing 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 briefing at the discretion of the committee. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of the House.

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. Please turn your mobiles phones off or to silent mode.

BRYANT, Ms Peta, Deputy Director-General, System Policy and Planning Division, Queensland Health

GIBSON, Ms Eve, Manager, Legislative Policy Unit, Queensland Health

MAHLER, Mr Karson, Director, Legislative Policy Unit, Queensland Health

McDOUGALL, Dr Catherine, Chief Health Officer, and Acting Deputy Director-General, Population Health Division, Queensland Health

STONES, Ms Christine, Director, Assisted Reproductive Technology Unit, Queensland Health

CHAIR: I now welcome representatives from Queensland Health who have been invited to brief the committee. Please remember to press your microphones on before you start speaking and off when you are finished. I invite to you brief the committee, after which committee members will have some questions for you.

Ms Bryant: Good morning, Chair and committee members. Thank you for the opportunity to brief you on the Health Legislation Amendment Bill (No. 3) 2025. I would also like to acknowledge the traditional owners of the lands upon which we are meeting, the Yagara and Turrbal people, and pay my respects to elders past, present and emerging.

My name is Peta Bryant. I am the Deputy Director-General of the System, Planning and Policy Division within the Department of Health. Queensland Health welcomes the opportunity to present this bill. It is an omnibus bill that covers matters related to assisted reproductive technology, organ donation, health system governance and cosmetic surgery. The bill makes amendments to eight health portfolio acts and includes five key reforms. The purpose of the amendments is to improve patient safety as well as strengthen governance and the operation of the legislation. I will briefly outline the key aspects of the five reforms before opening for questions.

The first of the reforms in the bill relates to assisted reproductive technology, which I will hereinafter refer to as ART. That is a term that is familiar to stakeholders and the industry. The act partly commenced in September 2024, with the remaining regulatory provisions to commence from March 2026. The bill amends the act to address issues that have been identified during implementation and stakeholder engagement. I will begin with a concrete example. The bill amends the requirements for ART providers to collect specific types of contact information about a donor before that donor's gametes, being sperm or eggs, can be used. Currently if even a single piece of information is missing, such as an email address, the donor's gametes cannot be used. This is so even if alternative contact information such as a phone number or address is available. The bill addresses this unintended consequence by providing a more flexible definition of contact information that still requires adequate information to be collected.

The bill increases flexibility in other areas too. A key reform is the introduction of a case-by-case approach to ensure that Queensland Health can respond fairly in situations where applying the act's requirements strictly in every single case could unfairly disadvantage patients. The ART Act already allows for the director-general to approve on a case-by-case basis the use of older donated material and the destruction of records. The bill extends this discretion by allowing the director-general to also approve the use of gametes or embryos even if all donor information is not collected or if using that donor would exceed the 10-family limit provided there are reasonable grounds. This ensures a fair and practical balance between regulatory requirements and the individual circumstances of patients; for example, where the inability of a clinic to collect all donor information might otherwise prevent a patient from having a child using their chosen donor.

The bill also strengthens Inspector-General of Emergency Management powers to ensure Queensland Health can obtain the information it needs to effectively monitor ART providers across the state and to ensure they are complying with the act. While these Inspector-General of Emergency Management powers are crucial, they are only one part of keeping a safe and effective sector. The other half is around independent accreditation against nationally consistent standards. For this reason, all Australian health ministers have recently agreed to remove the industry aligned accrediting authority, the Reproductive Technology Accreditation Committee, also known as RTAC, and replace RTAC with the Australian Commission on Safety and Quality in Health Care.

Together state and territory regulators, as well as the commission, will ensure that the ART sector is transparent, ethical and one in which the community can have confidence. The bill gives effect to this decision and futureproofs the ART Act by removing references to RTAC. The bill also makes other more minor and technical amendments to the ART Act to ensure the legislative framework operates as intended once it fully commences. The changes ensure that Queensland Health can effectively regulate the ART industry and has the flexibility to appropriately balance the interests of ART patients, donor conceived people and donors.

The second of the five reforms is around the Transplantation and Anatomy Act. This bill amends the Transplantation and Anatomy Act to enable a person's next of kin to consent to simple medical procedures being undertaken to support organ donation following what is known as circulatory death. Circulatory death occurs when a person's heart stops beating and blood stops circulating around the body. For donation following circulatory death certain medical procedures may be required before death to help understand whether a donation is possible, to identify donor recipients, and to keep the organs healthy ahead of transplantation. Currently the act does not provide a framework for consent for these procedures. The bill provides that a person's next of kin can consent to these procedures being undertaken if a person is in hospital and a decision to withdraw life-sustaining measures has been made. An additional safeguard is that the hospital's designated officer must separately authorise the carrying out of these interventions.

The third of the five reforms in the bill is around the Private Health Facilities Act 1999. The proposed changes will improve safety for consumers undergoing cosmetic surgery procedures and make the process for sharing information with other Queensland government agencies more efficient. The amendments clarify the head of power in the act so that a regulation can be made to prescribe standards for cosmetic surgery. These standards have been developed by the Australian Commission for Safety and Quality in Health Care.

The fourth of the five reforms in the bill is around amendments to four health portfolio acts, being the Hospital and Health Boards Act, the Health and Wellbeing Queensland Act, the Pharmacy Business Ownership Act and the Hospital Foundations Act. These aspects of the bill deal with health system governance. The changes focus on improving accountability and responsiveness of leadership in the Queensland public health system. The bill includes provisions to allow certain statutory office holders to be removed from their appointed positions with or without grounds.

Importantly, the decision can only be made by the Governor in Council. This will ensure a considered and thorough decision-making process applies. The changes will apply to hospital and health board members as well as Health and Wellbeing Queensland board members and CEO, pharmacy business ownership council members and CEO as well as hospital foundation board members. These officers hold important positions of trust within the health system. They manage and oversee significant budgets and health programs as well as regulation and need to be held to a high standard. These changes will allow the government to maintain community confidence in appointees. They are consistent with powers that apply to a range of other statutory office holders, including Legal Aid board members, Queensland Rail Transit Authority board members and Gold Coast Waterways Authority board members.

The fifth and final reform in the bill is around the Public Health Act. These are minor amendments being made to the Public Health Act 2005 to ensure that notifications of certain occupational respiratory diseases continue to be made to the appropriate Commonwealth officer. This change is a technical one as a result of the establishment of the Australian Centre for Disease Control. The Australian Centre for Disease Control, or the ACDC, will be the custodian of the National Occupational Respiratory Disease Registry if the relevant laws are passed by the federal parliament. The proposed amendments in this bill have been drafted to ensure they are effective regardless of whether the legislation passes in the federal parliament.

With that, Chair, I would like to conclude the overview of the reforms in the bill. We would be pleased to take any questions.

CHAIR: With respect to the ART changes, can you run us through what sort of information is collected about the donors? Surely it is not just their name and address. How do you keep that information up to date given we live in such a transient world? I assume there is other information around their DNA and blood types, perhaps whether they have had any previous health issues. What is the extent of the information that is collected?

Ms Bryant: The legislation and the regulatory framework that it establishes does have a focus on contact information to ensure that the donor can be identified by donor-conceived people, but I might ask Dr McDougall to elaborate on the type of information collected and how we monitor that.

Dr McDougall: The information that is already required to be collected under the act is things like name, date of birth and contact information. For donors there are additional information requirements such as ethnicity, physical characteristics, any information that someone may have in relation to a donor's raised family or any other donor-conceived children that the donor might have created with their material. There is quite a broad suite of information that is required to be collected. How do we keep it up to date? It is a point-in-time collection of information when the donation is made. We are aware that industry does stay in contact with donors over that time, and across 2026 obviously our partners in the Registry of Births, Deaths and Marriages will be standing up the donor register and so all of that information will transition into that to be accessed by donor-conceived people and donors.

Mr J KELLY: Thanks for your briefing. The amendments generally seem pretty technical and minor. Can you step us through specifically what it is we are achieving here of any great significance?

Dr McDougall: I might start with that. Do you mean the amendments to the ART Act specifically?

Mr J KELLY: Yes.

Dr McDougall: One of the things that has been identified during the early implementation phase was a lack of flexibility in some of the amendments that may cause undue hardship. So then we go back to the purpose of the bill, which is to ensure the welfare and interests of both the people receiving ART treatment as well as those born as a result of ART, and those born are particularly paramount. As we identified the inflexibility, there was a requirement to make sure we remain balanced. I think broadly it does this in a number of ways. One is through a change in the contact information requirement and secondly through the transitional provisions, but I think in particular relating to the case-by-case approval powers for the director-general.

If we talk specifically about prescriptive information collection requirements as well as their family limit, which is a 10-family limit, currently within the act if not every component of that information is collected then that embryo is unable to be used. There might be an example whereby—Christine used ethnicity as an example—ethnicity currently is not collected. The law as it is written means that that embryo is not able to be used; whereas that might be the type of case that then would go to the

director-general to explain that the purpose of it is for donor-conceived people to access information at a later date, potentially not having ethnicity but still having available information would be one that would be deemed appropriate through a case-by-case decision-making process.

The second one in case-by-case decision-making relates to the 10-donor limit, and again it is there for a very important purpose—to limit the number of donor-conceived people by a certain donor—but there may be an example again whereby a family may have a child with one donor and then that family is split. If there is then a requirement or a decision made for that woman to have another child who would be a genetic sibling, at the moment that is not possible under the act as this is written because that would be an additional family and they would have already met the limit. Again, the case-by-case decision-making allows a case like that to be considered and I think the general thought would be that that would still be in the intent of what the original purpose of the legislation is. So they are two examples related to the case-by-case approval powers. We can give you more detail around the change of contact information if you would like?

Mr J KELLY: Yes, but I have just one specific question in relation to that change in the contact information. Does that have any impact on the capacity of organisations to identify and verify the identity of the people involved in these processes?

Ms Stones: It absolutely does not. As we know, under the National Health and Medical Research Council guidelines, since 2004 anonymous donation just is not a thing across Australia, including in Queensland. Additionally, the requirements that you have to have under the section 33 information requirements are a name and date of birth, so as a bare minimum you will know who you are talking about when you are looking at the gamete or the donor material, so it has no impact of no ability of that material.

Mr J KELLY: Thank you. Turning to the section which starts at paragraph 25 in your briefing note around the Hospital and Health Boards Act, the Health and Wellbeing Queensland Act, the Pharmacy Business Ownership Act and the Hospital Foundations Act, the bill allows the Governor in Council to remove office holders—and there is a list of them there—for any reason or none. Can you outline the rationale behind being able to allow no reason to be given for a board member to be removed?

Ms Bryant: This is a policy decision around improving the ability for the government to respond to the board performance needs across a number of organisations in the health system. These arrangements are already in place around the Governor in Council being able to remove a board member with a reason or without a reason and it is about enabling the government to respond in a timely way where there are instances of board members being identified as not contributing to the stewardship and governance and leadership of organisations that have a deep reach in terms of service delivery reform and regulation of the health system. So that is the key benefit of these proposed amendments.

Mr J KELLY: Thank you. In that instance you talked about someone being removed for not contributing. That is not removing someone for no reason or the 'none' reason—there is a reason there—but under this legislation would you have to make public why the minister is making that decision or the Governor in Council is making that decision?

Ms Bryant: It would be up to the Governor in Council as to whether they provide a reason or not. As I mentioned before, they could provide a reason. An example that I have observed at least in working quite closely with the hospital and health boards is around instances where, under the current act, the Governor in Council can remove an individual if they have been charged with an indictable offence, for example. That is quite a high threshold for individuals who are board members whom we need to be actively contributing to the stewardship of these large and influential organisations.

Mr J KELLY: But in that instance someone who is effectively breaking the law could be removed and the public would be told there is no reason for removing that person.

Ms Bryant: It is true that under the proposed amendments the Governor in Council reserves the right to give a reason or to not give a reason, yes. Was that the clarification you were seeking?

Mr J KELLY: Yes, and so you said this is a policy decision. Is this a policy that was recommended by the department or is this a government or a ministerial directive in terms of policy?

Ms Bryant: In fact, member for Greenslopes, all of the amendments are a policy decision of the government. The government would have sought advice on these amendments and so with these amendments part of our advice is to explain that it is similar to other organisations that we have across the Queensland government.

Mr J KELLY: In fact, we have a bill before the parliament at the moment—it has been reported on—with regard to Stadiums Queensland. I think it is the major stadiums bill or something of that nature and this exact clause is being removed in that bill, and I will just read you an extract from the minister's first reading speech. I know it is the Minister for Sport and not the Minister for Health—

Mr LEE: Chair, I raise a point of order on relevance.

CHAIR: I am happy to hear it as it is being used as an example, but I would just caution the member.

Mr J KELLY: I am talking about a provision in another bill that is exactly replicated in this bill and being removed from another bill. I think that is highly relevant, Chair.

CHAIR: It is actually referred to in the explanatory notes as well, member for Hervey Bay, so I will allow it for the moment and see where it goes.

Mr J KELLY: The minister's introductory speech says, and he is referring to the amendment which removes this exact provision that is being inserted into this bill—

> The amendments aim to contemporise the act and bring it into line with current statutory body best practice regarding governance and accountability.

So I guess I am completely confused. If this is a government policy, in one bill they are removing this provision and in another bill they are inserting this provision. Would you be able to provide me with the written advice from the minister that outlines what policy they are relying on in relation to inserting this into this bill?

Ms Bryant: Thanks for the question, member for Greenslopes, and the clarification around another act that is removing this particular clause. This is a policy decision for the minister. I cannot explain, and nor can the team, why that is being pursued in the Stadiums Queensland act—

Mr J KELLY: To be clear, I am not asking you to explain; I am asking you for the written advice that you may have received from the minister in relation to this specific clause.

Ms Bryant: We do not usually provide examples of briefing to the committee around the wide range of amendments. I can seek advice around what we can provide that is not cabinet-in-confidence or part of our briefings relating to the authority to prepare.

Mr J KELLY: Thanks. Could you take that on notice?

Ms Bryant: Yes, I can take that on notice.

Mr J KELLY: Thank you, Chair.

Ms DOOLEY: Thanks for your briefing and for being very clear. How have you sought the balance of the needs of donors and donor-conceived people? I am not sure who is best to answer that.

Ms Bryant: I will let Dr McDougall answer.

Dr McDougall: I guess I responded to some of that in my response to that initial question in that the balance between the needs of donor-conceived people and consumers who use the ART services have been paramount in this space, very specifically related to the case-by-case decision-making power for the director-general but also through two other components that we have not spoken a lot about yet. One relates to the transitionals and one relates to a change in the requirement for the contact details, so maybe we can speak briefly around the transitionals and I will go to Christine. Thanks.

Ms Stones: Just adding to what Dr McDougall has said, just in relation to that balance, that is precisely what this package of amendments is trying to do. Through that implementation we have identified that the inflexibility does have that potential to cause those unfairly harsh outcomes, particularly for patients, and so by introducing, as Dr McDougall has said, that case-by-case approval we are able to take a view through that approval process as to who will be most harshly impacted by the decision and how we balance that. Equally with the transitional provisions, as is common in legislation, as you would well be aware, they basically just make it so that anything that has commenced before the act started and was legal at the time is not inhibited by the act now being in place so that people can continue with their treatment but that certain requirements within the act still apply to those treatments and procedures to make sure that we do not have two classes of donor-conceived people, for example, at the end of this. We want to make sure that the donor-conceived people before the act commenced have access to information as well as people afterwards, so there has been a lot of thought given to how we balance all of those disparate stakeholder groups to make sure that we are taking in all of their voices.

Dr O'SHEA: Good morning. Thank you all for coming. Just looking at the power to share private hospital data with other Queensland government entities, what kind of data would this apply to? I know you have mentioned firearm injuries and road crashes, but does this extend it to other information?

Ms Bryant: I might hand to Karson to elaborate on this. These data-sharing arrangements are arrangements that we do have in place for public facilities to inform an understanding around those kinds of injuries and accidents and cause of death, so this is about creating more consistency with private hospitals, but, Karson, did you want to elaborate on that?

Mr Mahler: I am happy to; thanks, Peta. To answer the question simply, there are no specific categories of information that could be shared. This could apply to a range of circumstances. Some examples are, as mentioned, road crash information between Queensland Health and the Department of Transport and Main Roads and the sharing of information with the Queensland police around injuries related to firearms, but I guess the common thread through all of this is that what we are talking about are department-to-department agreements to share information for that kind of analysis and research purposes.

Ms Bryant: Yes, and forward planning.

Mr Mahler: At the moment under the legislation we can already share this information with the Commonwealth and with other state governments. In fact, under the Hospital and Health Boards Act and under the Public Health Act the department can also share this information using the mechanism proposed in this bill, so really this is about contemporising the Private Health Facilities Act and aligning it with the Hospital and Health Boards Act and the Public Health Act to ensure that the department can enter into these department-to-department information-sharing agreements to be able to share the kind of information that cuts across portfolios, if you like, where there is an interest in police being able to get, say, aggregated de-identified data about road crashes and injuries caused by that, for example. Another example is Maritime Safety Queensland being able to undertake analysis on water transport injuries. Queensland Health has a lot of information that can be relevant to other departments as they are trying to understand how to exercise their regulatory powers or how to reduce fatalities or how to reduce injuries to the public.

I do want to stress that all of this is still subject to the privacy act. Just because it can be shared under an agreement does not mean it is not subject to the privacy act and the agreement is really these days the standard mechanism by which this type of information is shared. It is just that the Private Health Facilities Act is a little bit out of date. Further, just as a last point, under these amendments it is still that the director-general has to approve each agreement and determine that it is in the public interest for that information to be shared and that it is going to be shared in a way that is compliant with the privacy principles and the privacy act.

Dr O'SHEA: That is great. That is what I wanted to make sure of. Thank you very much. Just going back to the change in the transitional powers and other amendments in terms of removing office holders without cause, what is the current process for removing an office holder and have there been any particular issues with the current framework, because it is quite a departure to just have no cause?

Ms Bryant: The current process is in two parts. As I mentioned before, one of the examples or the conditions under which Governor in Council can currently remove a board member straight away is if they are convicted of an indictable offence. Other examples include if they have been found insolvent or in breach of the Corporations Act. In terms of a second part to the process, the minister can make recommendations to Governor in Council to remove a board member if proof can be shown of a number of other conditions being met. That might include a board member not turning up to three board meetings that they have had prior notice of, and recommendations can be made if there is proof of misconduct. What that means is that if, for example, someone was to be charged with an offence, which was the example I used before—and they might even be jailed for an offence—until they are convicted, they cannot be removed for some time because it takes some time to actually develop the proof under the conditions for which the minister can make a recommendation to Governor in Council. In that time there is obviously a gap in the board if the board member cannot fulsomely contribute or is not contributing to the management of the organisation and also the stewardship of that organisation.

There is also a public trust element there. If government cannot respond in a timely way in those circumstances there could be a perception that government is not acting on this individual who is obviously unable to contribute to the board membership. What these amendments aim to do is provide an arrangement under which government can respond in a timely way. I think it is also

important to note that these board memberships are important roles with sometimes if not large budgets certainly programs and organisations that have a lot of influence on regulation and reform, in the example of Health and Wellbeing Queensland. They are also remunerated out of public funds. I think there is that leadership aspect, but the fact that they are also remunerated and will continue to be remunerated even if they are not actively contributing or even if they have been charged with an offence but not convicted until such time as they can be removed. That jeopardises trust that the community can have in the organisation. That gives you a sense of the current process and what we would be moving toward, but also an example of why the current process can be not just slow but problematic in terms of maintaining integrity and public trust.

CHAIR: Can you explain the role of the Governor in Council? Is that an independent appointment? Who actually appoints that person? Who is it? Is it different in every department?

Ms Bryant: Governor in Council is the entity that appoints these roles that we are talking about changing the arrangement for in terms of removal.

CHAIR: For all departments of government or just Health?

Ms Bryant: I actually do not know if Governor in Council appoints all board members across different departments. Certainly under these acts the Governor in Council does appoint these statutory office holders and can remove the statutory office holders under the current legislation in certain conditions. Governor in Council is not autonomous—

CHAIR: A person.

Ms Bryant: Exactly. It has to be with the consultation of cabinet ministers. It is not one individual making a decision unilaterally. The other thing is that with these proposed amendments it is not removing natural justice. The statutory office holder could still have information about what decision is being made; they could still communicate their views on that. It does not remove that natural justice approach.

Dr O'SHEA: Going back to the ART Act, when donors consent at the moment are they consenting to the 10-family limit, and is there any provision in that contract with the donor, or with the donor's consent, to talk about in unusual circumstances as this is bringing up?

Ms Stones: Currently, pre act, it is sporadic whether or not consent from donors does or does not include how many families they intend to make. That is operationally, currently. Under the Assisted Reproductive Technology Act, when the second tranche of amendments comes into effect on 1 March it will be a requirement under section 18 of the act that a donor consent must include the number of families they consent to, but they can only ever consent up to the maximum permitted by the legislation. Even if they were to support an application for one of these case-by-case approvals, certainly what we are talking about with providers operationally is that they may want to get that indication from donors at the outset, or they would go back to them and see if they consent later on to those applications being made, but ultimately because they cannot consent to above the 10 families being created, because that is the legislative maximum, they basically can give an indication of whether or not they support there being additional families created and that would then go some way in our decision-making as to what that looks like and whether or not a case-by-case approval would be granted.

Ms BOLTON: Going to the case-by-case approvals and also the inspector powers, are the changes common or already in place in other jurisdictions?

Ms Bryant: Cath, do you want to answer that or Karson, I know that you and the team have done a review of what is interstate.

Dr McDougall: I think that question related to the interjurisdictional comparison will go to Eve.

Ms Gibson: I am not aware of there being case-by-case discretion for these particular requirements in other jurisdictions, but as has been mentioned, that discretion has been developed based on implementation activities and stakeholder engagement and the need to ensure that we can avoid those individual cases of unnecessary hardship. In relation to the inspector powers, absolutely, those broader powers are available in other jurisdictions' ART legislation. The Australian Capital Territory, Victoria, South Australia and Western Australia all have those broader inspector powers that enable inspectors to seek information to assist with compliance of those acts.

Ms BOLTON: Can you also explain RTAC? Obviously it has transitioned. I am just trying to get my head around how that influences each jurisdiction and whether there is work being undertaking towards a national regulation that is very similar across Australia.

Dr McDougall: At the moment it is a complex space because it is a space where we ensure safety by a combination of both regulation and accreditation. RTAC has been the accreditation body for assisted reproductive technology, but at the moment that has not been effective to ensure appropriate quality and safe care nationally. The health ministers have determined that there is a requirement for a review and a transition now to the Australian Commission on Safety and Quality in Health Care for accreditation standards. That will be national. What we need to do within our bill is to ensure we have appropriate regulation to allow us to regulate against these new accreditation standards.

Ms BOLTON: Does it mean that you can go to another state? If the legislation is different there it could be 100? Is that occurring?

Dr McDougall: The limits are set within each state's legislation. That is independent for each state. The team is better in being able to determine what the differences are, but certainly still donor limits are a consideration in every state.

Ms Stones: The health ministers referred to the Australian Law Reform Commission a review of all of the landscape nationally for the different pieces of legislation with a view, I assume, at some point in a few years, once the ALRC produces its report, to harmonisation of some of those requirements. We do know, for example, New South Wales has a five donor family limit. We have 10, Victoria has 10. Ours is 10 Australia-wide so we do expect that should be tracked across Australia. Down the track there will be a view to how we move to more harmonisation and consistency between the jurisdictions but really for now the most important thing is that we get accreditation right to support our regulatory functions. Obviously the hard water's edge for us is we do not step into the clinical assessment of the providers. That is for accreditation. Because that has been failing we need that done well. It makes a lot of sense that that will be the first cab off the rank in terms of the reforms in this sector. The ALRC will do its review and look at legislative reforms once they hand down their report.

Ms BOLTON: I will move away from that particular issue and go to what you call section 3 which is the proposed amendments to the Private Health Facilities Act. Does this include injectables?

Ms Bryant: It does not include injectables. That is not within the scope of what is proposed here. The amendments to that act are really around enabling the creation of regulation to prescribe standards by which cosmetic surgery will be accredited and to do that in a consistent way. There is work underway around cosmetic injectables. Health ministers have, I think it was in the September meeting, committed to exploring options around better regulation of that sector. Dr McDougall, did you want to add anything in terms of work underway?

Dr McDougall: Just to say in 2023 there was determination that new standards were required for cosmetic surgery. As Peta was saying, the challenge at the moment is we have to ensure that within our regulation we have the ability to measure according to those new accreditation standards. All jurisdictions are moving towards that. That is different from what is measured now. Within our private health regulation at the moment we measure against National Safety and Quality Health Service Standards. They were developed in 2011 and implemented from 2013. That is separate from the cosmetic surgery standards. The reason they are different is cosmetic surgery standards apply to elective procedures that are not used to prevent, diagnose or treat medical diseases or conditions. It is sort of a different entity to what we regulate against within the Private Health Facilities Regulation at present. This amendment is setting us up to ensure that we are able to regulate against the accreditation standards that have been developed nationwide in 2023 after the concerns about poor outcomes with cosmetic surgery.

Ms BOLTON: Was anyone not in support of these changes when you did your consultation feedback?

Dr McDougall: I do not believe so.

Ms BOLTON: It is fine to take it as a question on notice because I realise everyone wants to ask other questions.

Ms Bryant: We might take that on notice. We do have a list and there was broad support from colleges et cetera.

Mr LEE: I have a question about removal clauses. Earlier, in your response to the deputy chair, I understood that you alluded to the existence of these similar provisions in other legislation; is that correct?

Ms Bryant: Yes, I did.

Mr LEE: Are you able to give specific examples where those removal clauses exist?

Ms Bryant: As I was saying in my opening remarks, the three that I can call to my mind are really around the Queensland Rail Transit Authority, the Legal Aid Board and the Gold Coast Waterways Board. From a legislative policy perspective, what we often try to do is look at what is the comparator and is that relevant and, if so, how. With the Queensland Rail Transit Authority, for example, it oversees a budget that is comparable to the Gold Coast Hospital and Health Service. The Gold Coast Hospital and Health Service is one of our larger hospital and health services. The largest is Metro North Hospital and Health Service with a budget of between $4 billion and $5 billion per annum. Gold Coast, much like the Queensland Rail Transit Authority, is between $2 billion and $3 billion per annum. They are big budgets and they have a big reach in terms of the impact on Queenslanders. As I was mentioning before, it is important that board members overseeing those organisations and stewarding them are actively contributing to the performance of those organisations.

As I mentioned before, the standard is currently at being convicted of an offence and a range of other things. Really, this is about, before you hit that watermark, board members actively contributing to conversations, being prepared and engaging with those organisations. That gives you a sense, I hope, of those kinds of comparator organisations and legislations where these removal arrangements already exist. Karson, did you want to add anything to that in terms of consideration of where these arrangements already exist?

Mr Mahler: There are a number of other examples that we have listed in the explanatory notes and I have nine right here that, if the committee would like, I can give you. There are lots of different examples. It is not a particularly novel approach. I think as Peta says, in the development of legislation you really have to look at each entity in its own right: what is its role, what is its responsibility relative to managing the health system and how do you hold these entities accountable?

The member for Greenslopes talked about the Major Sports Facilities and Other Legislation Amendment Bill. I have since looked it up to confirm that that is the piece of legislation that you are referring to. The issues are not as straightforward as you would suggest. While there has been an attempt to modernise the language, there are still removal powers implied in that legislation. For whatever reason—I have not looked at that legislative scheme in detail—based on conversations we have had with Parliamentary Counsel and the way that they approach these things, you look at legislation in the context of the entity that it applies to.

On the grounds for removal, I think as Peta has discussed in this case, these are not long-term infrastructure projects, for example. We have board members who are accountable for the day-to-day operations of health services and there is a need to act quickly. I think there is an argument to be made that, particularly where you have very prescriptive criteria in the legislation and a real burden on government basically to prove that the person has done something that is disqualifying, that can really inhibit that timeliness. I suppose I would caution in terms of making comparisons across different pieces of legislation that it is not always apples to apples. There are lots of examples I can give you and they are in the explanatory notes. I am happy to point you to those.

Mr LEE: Given those specific examples in the legislation, are you aware of any circumstances in which those statutory powers have been exercised and people have been removed from boards?

Ms Bryant: There have been examples of where board members have been removed—sorry, you are referring to these three examples?

Mr LEE: In terms of exercising the removal powers.

Ms Bryant: I am actually not aware that those removal powers have been exercised for the Queensland Rail Transit Authority, Gold Coast Waterways or the Legal Aid Board. We can take that on notice and have a look at that if the committee wants us to do that.

CHAIR: I think we are straying a little.

Ms Bryant: Noted, Chair.

CHAIR: I allowed a little bit of latitude but I think we are starting to stray into asking for opinion. If you can provide some answer in respect of the question on notice, that would be helpful. Member for Hervey Bay, do you have other questions beyond that? If not, I have one I would like to ask.

Mr LEE: Yes, I want to ask a question. In the written briefing, you state that New South Wales and Victoria have similar frameworks to allow for next-of-kin consent to medical intervention to support organ donation. How long have those frameworks been in place and basically how are they working? Have there been any adverse outcomes as a result?

Ms Gibson: Victoria amended its relevant Human Tissue Act in 2020 and New South Wales amended its Human Tissue Act in 2024 to provide for ante-mortem interventions. The way that it is drafted in each jurisdiction is a little bit different. New South Wales, like Queensland, uses the consent framework of the senior available next of kin consenting to these interventions. Victoria uses the medical treatment decision-maker as defined under their legislation. I cannot speak to what the clinical outcomes have been in those jurisdictions, but these amendments have been developed for the Queensland legislation based on feedback from hospital and health services that there is a need to clarify the consent framework so that these simple medical procedures can occur.

CHAIR: With respect to the cosmetic surgery, the notes refer to strengthening regulations surrounding cosmetic surgery. What does that actually mean? What is changing?

Ms Bryant: A significant change is really the national standards, I would argue, which has been a piece of work that the Australian Commission on Safety and Quality in Health Care has been leading. The ability for all governments to hold providers to account and say that they must comply with those standards is a significant reform. Dr McDougall, did you want to add to that?

CHAIR: I am curious as to what that standard is. What does it actually mean? Is it that you have to clean the scalpel with methylated spirits? I have no understanding of what the standards were so what is the difference? What has changed?

Dr McDougall: The creation of the cosmetic surgery standards ensures a lot more around informed consent and understanding, which involves understanding what the risk is not just of having a procedure but also of not having a procedure. It absolutely aligns with all the different components of other quality and safety metrics that exist in other standards. Because cosmetic surgery sits outside a requirement for health to diagnose, treat and manage a health condition, really what was identified in 2021 and before was that there was very little oversight around it. Some terrible outcomes identified nationally led to the recommendation for the development of standards for this industry. They have been developed. We are just wanting to ensure that we have within our regulation the ability to regulate against them.

CHAIR: Does this involve things like age limits on how old you have to be before you can have—I don't know—breast augmentation or a nose job?

Dr McDougall: I am happy to take on notice the specifics. We have the standards. I do not know it in enough detail to be able to talk to what has been developed by the Australian Commission on Safety and Quality in Health Care so I would have to come back to you on the age question.

CHAIR: Can you take that as a question on notice, to get a more fulsome explanation?

Dr McDougall: Of course, of what the standards are, yes.

CHAIR: Am I right in assuming that it also deals with situations where you have had rogue operators performing procedures, things have gone wrong and then they have had to bundle someone into an ambulance and send them to a public health facility? Does it deal with those sorts of matters, because I have heard some horror stories?

Dr McDougall: Certainly now there are already particular cosmetic surgery operations that are required within a hospital facility. Those higher level ones exist currently. Our private health facilities already have those procedures that are occurring. Until 2023, there was not the specific standards just for cosmetic surgery. Absolutely, all of those things were considered as part of the standards and we can provide the standards on notice. Did you have anything else to add, Peta?

Ms Bryant: No, thanks, Cath. I think that is right. Informed consent is a huge focus of the standards.

CHAIR: Am I right in assuming that this deals with cosmetic surgery where people perhaps have had serious injury and need some sort of repair—for want of a better term—versus people who are opting to have enhancements? Does it cover the whole spectrum?

Dr McDougall: That is correct, because the cosmetic surgery standards actually do not include the example that you had initially. If there is a medical need for something, which might be, say, post breast cancer then moving onto breast reconstruction, that is covered already within the other national standards. Cosmetic surgical standards are related specifically to enhancements of appearance, not for a medical reason.

Ms DOOLEY: You did touch on this briefly in your briefing, but for the record can you explain the difference between brain death and circulatory death and how that impacts on organ donation and consent processes in relation to the Transplantation and Anatomy Act?

Dr McDougall: There is a significant difference between the two. Broadly, brain death occurs after the complete loss of brain function, which is incompatible with life. Circulatory death is when the blood stops circulating through your body. The difference, from an organ transplant component, is that when you are deemed brain dead there is a determination of death so there can be consent and conversations and investigations that might occur. If someone has then consented and a decision has been made for organ donation, all of these things can occur, say, prior to a ventilator or something being turned off. It already exists because the person is declared dead. It exists within the act. When you are talking about circulatory death, the person does not die until the heart has stopped and the circulation has stopped through the organs. Obviously, for transplant purposes, we need viable organs and so then the time that you have to be able to, say, perform additional investigations or examinations to determine whether an organ is appropriate and to maintain the quality of it is very limited.

These provisions allow for a much more formalised consent process to ensure the investigations that occur before a person dies can occur in a space that allows the organ to then be appropriate for transplant. What is interesting is that about 65 per cent of organ donation in Australia is after brain death and about 35 per cent is after circulatory death. Clearly, there is a growing need for more organs. The more we can do to simplify or streamline the ability to use organs after circulatory death would be welcome. I also want to acknowledge what an incredible gift it is for patients and their families to choose organ donation and manage the complex emotion of grief while allowing something that affords somebody else new life.

Mr J KELLY: I refer to the technical scrutiny review of this legislation. You may not necessarily be au fait with it, so I will read from it. On page 3 it states—

While it would be expected that the Governor in Council would always act with integrity, if there are no criteria and no review processes available, it may be possible for a person to be removed from office for nefarious reasons or for political expediency.

I note, Ms Bryant, that you said perhaps we are trying to remove people who have done the wrong thing or who may be on a pathway of doing the wrong thing. If a person is removed from a board and no reasons are given, how would a future organisation know that that person is not fit and proper to be a member of a board?

Ms Bryant: The current processes we have in terms of a future organisation knowing that a person is not fit and proper to be a board member include using, for example, the incumbent chair or other board members as a referee. I think that would be one of the processes used to ensure they are—

Mr J KELLY: Would the chair be told if there is no reason given? If the Governor in Council removes somebody and does not put any reason on the table, how would the chair know why that—

Ms Bryant: That is not the only approach. The Governor in Council's rationale or the decision is not the only approach.

Mr J KELLY: But it is an approach this legislation allows.

Ms Bryant: Member for Greenslopes, please let me finish. My response to the question around how one would know if the board member was underperforming or, in fact, performing at a high level or if something else was going on is there would be referee checks. We do probity checks, including police checks. Those are some of the mechanisms that would be used to understand that person's performance.

CHAIR: I think this question may be better left to the next hour when technical scrutiny—

Mr J KELLY: With respect, Chair, I have a number of other questions. I move that we extend this hearing for another 15 minutes.

CHAIR: I am not prepared to support that.

Mr J KELLY: We are having a debate about a matter that relates to transparency and removal of transparency and we are not going to allow public hearings in relation to this matter?

CHAIR: We have had an hour.

Mr J KELLY: That was an hour in which you filibustered and the member for Redcliffe asked a question that any nurse should understand and know. In fact, it was covered in the briefing note in extensive detail. We are simply asking for more time to ask more questions in relation to this matter.

CHAIR: I will put it to a vote. Those in favour of extending? Three. Those against? Three. Being tied, I use my casting vote to say that we will not continue. I am concerned that we are badgering departmental staff, which is not—

Mr J KELLY: No, I refute that. I am not badgering anyone. I am asking specific questions, Chair. I would ask you to withdraw that. I take deep personal offence.

CHAIR: I am happy to withdraw the comment. I remind members of the department that we have questions on notice which are due by Friday, 7 November at 5 pm. With that, I declare this briefing closed. Thanks for your attendance.

The committee adjourned at 10.33 am.