Speech by

John-Paul Langbroek

MEMBER FOR SURFERS PARADISE

Hansard Tuesday, 31 October 2006

HEALTH LEGISLATION AMENDMENT BILL

Mr LANGBROEK (Surfers Paradise—Lib) (8.46 pm): I rise to speak to the Health Amendment Legislation Bill 2006. Before I begin, I would like to thank the staff, Cynthia Kennedy, Jeremy Kirby and Helen from the department, for their briefing on the legislation at the end of the first week of parliament resuming. The bill's main objective, as noted in the explanatory notes, is to amend the 13 health practitioner registration acts to provide greater opportunities for the recruitment of medical and allied health professionals. The coalition understands that we need to provide these opportunities because the Beattie Labor government has overseen an exodus of 800 doctors from Queensland Health every year. These are opportunities the Queensland coalition understands that we need to provide because the lack of planning in Health from the Beattie Labor government over the last 8½ years has led to an exodus of health professionals from the Queensland health system.

The Queensland coalition and I are more than happy to support the main crux of this bill and its objectives, but it cannot go without saying that the bill needs a step up if we are to overcome the crisis in the health workforce that has been created by the Labor government's failure to plan. Time and again in Health we have watched those opposite embarking on quests as a form of reaction. The Beattie Labor government has allowed the system to be run down and to fall into a state of crisis before deciding to act. This is yet another example of watching those opposite work their way towards a means to fix the crises that they should have foreseen and prevented well before now.

The bill amends a total of 19 Health portfolio acts, 13 health practitioners registration acts as well as the Tobacco and Other Smoking Products Act, the Transplantation and Anatomy Act, the Mental Health Act, the Radiation Safety Act, the Private Health Facilities Act and the Health Services Act. I will turn my attention to the registration acts before looking at the other six pieces of legislation that this bill seeks to amend.

The bill seeks to amend the Medical Practitioners Registration Act 2001—a piece of legislation that has already been amended this year. At the end of March this year the Medical Practitioners Registration Amendment Bill was debated. The then shadow health minister and now Leader of the Liberal Party made the most poignant point with regard to what those, these and future reactionary changes the Labor government will have to make to practitioners registration legislation in light of the health workforce crisis that it has watched grow out of control. The member for Moggill said—

> In many respects this is a very unusual bill to have before the House. To be legislating that the Medical Board must speed up the applications for registration of doctors but at the same time uphold the standards and quality of doctors practising within Queensland seems to me a very odd measure to have to legislate for.

It is quite an odd measure. However, that is the situation the Labor government has put itself into—a situation of reaction, a situation caused by the Beattie Labor government overseeing the development of the health workforce crisis in Queensland to the extent where the need to provide greater opportunities for the recruitment of health professionals has led to the fast-tracking assessment of professionals and other desperate ploys to recruit.

In licensing health professionals, registration aims to protect the community by ensuring the quality and safety of health services provision. At the end of 2005, the Australian government's *Productivity Commission research report: Australia's health workforce* suggested that when a health professional is required to be registered to practise it should be on the basis of uniform national standards for that profession and that overseas trained health professionals should be assessed against the same standards. However, when they do not meet the standards required for unconditional registration, the registration authority could, if considered appropriate, allow them to work under specified terms and conditions. These sorts of sentiments are being made in recognition that there is a health workforce crisis. These sentiments were echoed in the Davies report, which found that staffing shortages were more acute in Queensland than in any other state in this country.

Included in the Davies report was a section dedicated to what is needed to make area of need registration effective and safe—an area of need being an area in need of a medical service. The Davies report found that a defective system of area of need registration exists in Queensland. The report found there were two aspects of such registration that were the reasons the system was defective. The first involved the making of decisions by the minister's delegate, pursuant to the Medical Practitioners Registration Act 2001, that an area was an area of need. The second involved the process of registration under section 135.

The report defined an 'area of need' as a geographic area in which the general population need for healthcare is not met. It is determined by examining a range of factors including Medicare statistics, health workforce data and evidence of unsuccessful attempts to recruit an Australian doctor to a position. The report noted that it is necessary to consider the last of these factors—evidence of unsuccessful attempts to recruit an Australian doctor to a position—in a context in which steps have already been taken to fulfil the government's aim 'to encourage both new and existing general practitioners to relocate to rural areas through a variety of incentive programs'.

The report went on to note that the only incentive offered to new general practitioners to go to rural areas was the rural scholarship system. The report stated—

There was no evidence of any incentives provided to existing general practitioners to relocate to rural or even provincial centres to work in public hospitals. Given that it was in the context of such incentives having been provided that ... areas of need would be determined, in my opinion there can be no genuine area of need decision made unless such incentives are provided ...

This is what the Davies report said. It went on—

It is therefore essential that, without delay, incentives be provided to Australian trained doctors to work in hospitals outside metropolitan areas ... Only after those incentives are in place can a realistic area of need decision be made.

So the Davies report concluded that incentives must be provided to Australian trained doctors, established as well as recently graduated, to relocate to provincial areas where further medical staff are required and that guidelines must be provided to the board as to how to determine whether an area is an area of need for a medical service. This bill goes towards recognising those recommendations of the Davies report.

The Medical Practitioners Registration Act 2001 is to be amended by this latest bill to enable the minister or delegate to decide an area of need for a stated class of medical practitioners in the state, to specify the key criteria for making such decisions and to allow area of need decisions to remain in force for up to four years. It will also allow junior medical officers to transfer between area of need positions without affecting their registration and allow deemed specialists and senior medical officers to undertake supervised training in health facilities throughout the state without affecting their registration. The bill will also set standard conditions on special purpose registration so that registrants must practise under supervision and obtain general or specialist registration within set time frames. These amendments aim to reduce the red tape involved in processing area of need applications and give medical graduates greater employment certainty which will hopefully, as a result, increase Queensland's capacity to attract such graduates.

There should, as this bill aims to do, be greater scope for practitioners in area of need positions to transfer to other positions or facilities and to receive further training. As I said, the bill seeks to do this by allowing junior medical staff to transfer, for example, to a high-level junior position or to another facility without affecting their registration. This gives junior medical staff greater mobility and employers greater flexibility to manage. The safeguard here, being prior notice of transfers, has to be given to the Medical Board. The bill also allows for specialists and senior medical officers to transfer to practise at other health facilities in the state for training purposes without affecting their registration with the same notification requirements applying.

The criteria to be considered for making area of need decisions include a shortage of medical practitioners to provide a medical service at one health facility and whether it is reasonable for the service to be provided at another facility. These criteria were recommended in the Davies report and will give greater transparency and accountability to the area of need process.

The Davies report suggested that special purposes registrants should practise under supervision only and should progress to general or specialists registration within a specified time frame. The bill amends the act to require applicants for special purpose registration to submit a supervised practice plan and, as a condition of registration, practise only in accordance with the plan. Set time lines are the feature here. For example, registrants in the area of need category must do so within four years after obtaining special purpose registration. This will improve the quality of medical services in the area by ensuring that all international medical graduates progress through a process which will lead to an Australian standard qualification.

The AMA, which, like the Queensland coalition, supports much of this bill, does have concerns here, however, about the follow-up capacity of the Medical Board with respect to supervised practice plans mentioned in clauses 80, 81 and 86. There is no doubt that the Medical Board has more onus being put on it. But can the people of Queensland be confident that there will be adequate monitoring or supervised practice plans, just as the previous shadow health minister expressed concern about the Medical Board having to speed up applications but at the same time uphold the quality?

In seeking to improve health outcomes in areas of need, a reduction in the maldistribution of the health workforce through amendments like these have to continue to be a high priority for this House. There is no doubt that healthcare provision in rural and remote areas poses particular challenges. However, the health workforce outlook in rural and remote Australia is far from universally negative. Greater use of new technologies to enable arms-length care, funding related initiatives such as practice improvement grants and a strong focus on regionally based education and training, which may be particularly beneficial in the long term, are targeted initiatives. It is the Queensland coalition's goal to bring these to the attention of the Beattie Labor government. The Beattie Labor government needs to start addressing our health crisis with foresight, with vision and with the aim of preventing what has happened to our state's health system from happening again as its priority.

I would like to refer again to the Productivity Commission report again on the health workforce. The commission stated that, whatever particular policy settings are adopted to enhance health workforce outcomes in remote areas and elsewhere, it is very important that a 'whole-of-workforce' perspective is brought to bear. To date, reactionary policies have focused heavily on the medical workforce. While medical practitioners are integral to the provision of quality care, some participants suggested that nursing and allied health have often been the 'poor cousin' in policy deliberations.

The bill also amends the Dental Practitioners Registration Act. In the course of my research for this bill, I spoke to some very experienced dentists who finished their careers in the public health dental service and who commented that they felt that they did not get the same work satisfaction or were not as valued by members of the public and the bureaucracy for the work provided as they had been in private practice or, indeed, in public dental health provision some years before. This can lead to problems of motivation for hardworking professionals who may then decide to practise elsewhere or end up regarding it as 'just a job' and may explain why Queensland Health has trouble attracting more than the 300 dentists mentioned in the Forster review who attempt to treat the approximately one million Queenslanders who are eligible for public dental health services.

The crisis of available dental care in rural and regional areas seems intractable. The numbers are alarming and the causes are quite varied: lack of funding for public clinics, poor salaries for those working in them, lack of educational initiatives, affordability of services, availability of fluoridation, the cost of training and so on. But really it boils down to one thing: there are not enough dentists. The public dental sector is completely overwhelmed and will continue to be for the next few years until extra graduates come out.

One cannot underestimate the dental health crisis. The October 2006 report from the Australian Council of Social Services identified 40 per cent of Australians are unable to get help when they need it, with more than half a million people waiting for more than two years for public dental services. In June 2002, the waiting time for a Queenslander on average was 17 months.

Ms Struthers: Why was that? Because they scrapped the federal dental assistance scheme.

Mr LANGBROEK: I take that interjection. The program was introduced during the last term of the Keating government. It then expired. Many programs expire after one term.

With the increasing number of people seeking dental care and the shortage of dentists becoming more critical, it is frightening to speculate on the length of time that Queenslanders will be waiting in 2006. One can safely say that Queensland Health is unable to meet the demand for oral health services and is having problems recruiting and retaining dentists. Again, the changes that this bill seeks to bring in need to be seen for what they are: a reactive approach to a crisis situation that has been coming for many years.

How did we get to this? Why have there not been workforce analyses done sooner to identify the current workforce climate in this state? I remind the minister of one of the basic recommendations of the Forster review: there needs to be better workforce planning and monitoring of workforce trends. Increasing

places at universities will not have an impact on the workplace for at least 10 years, yet the workforce problem exists now. Today in Queensland, the crisis we have in health, and specifically oral health, has everything to do with a lack of planning and checks carried out by those opposite.

The amendments in the bill will give effect to a national—not a Queensland government—initiative established by the Australian Health Ministers Conference in November 2003 to address the shortage of dentists in the public sector. The national initiative is called the Public Sector Dental Workforce Scheme. Like changes to the area of need registration, the scheme was introduced with the intention of alleviating workforce shortages in the public sector, including in rural, regional or remote areas of the country.

Under the Public Sector Dental Workforce Scheme, graduates from approved overseas dental programs in Canada, Hong Kong, Malaysia, Singapore, South Africa and the US may be granted an exemption from the Australian Dental Council preliminary examination. Eligible practitioners will be given a form of restricted conditional registration, enabling them to practise in the public sector for a period of up to three years, during which time the ADC final examination must be undertaken, as well as an occupational English test. Upon passing the final examination, practitioners will be entitled to full registration and will be able to practise in both the public and private sectors. In essence, it is a scheme to streamline into Australia the entry of dentists with comparable qualifications to Australian trained dentists to work in the public sector. Our overseas trained practitioners are valued members of the health profession and enrich our multicultural society. However, the failure of past medical workforce policies, particularly to accommodate public hospital and rural medical workforce needs, has led to Queensland becoming increasingly reliant on overseas trained doctors and dentists to sustain our medical force.

The bill implements the scheme by creating a new category of special purpose registration for those dentists. Applicants will be assessed by the Dental Board of Queensland in accordance with the fitness to practise criteria outlined in the act. Having an advisory body on board to assess qualifications stands us in good stead. The Dental Board will keep close tabs, but I am sceptical about getting overrun with dentists. Many of the countries we will be recruiting from do not have an oversupply of dentists. They will have to have a written offer of employment and be supervised by a dentist who, after a certain period, will have to fill out ongoing reports and will have to register every year. The Dental Board has been asked to draft a supervision program similar to that which applies to graduating students now. Graduates are reassessed after a month and then there are increasing periods when they are reassessed as an assessment of progress.

We need to ask: how will supervision programs affect dentists? In November 2005 the Dental Board of Queensland released a document providing guidelines for supervised practice. The board outlined four levels of supervision: direct supervision, contemporaneous supervision, broad supervision and distant supervision or mentoring. The board has noted that level 2 supervision is the most likely to occur in circumstances of initial employment in the Public Sector Dental Workforce Scheme. With level 2 supervision, the supervisor shares with the registrant responsibility for the individual patient. Thus, the supervisor should be in the workplace at all times. The supervised registrant is responsible for ensuring that he or she practises within the confines determined by the supervisor, and that the supervisor is informed of the management of individual patients. Are the supervising dentists being taken away from serving the public and do we have enough dentists to supervise without plunging the waiting list times into further crisis?

I am also aware of the attractive packages we can offer overseas trained dental graduates because many of the countries that we have approved are also in the grip of dental staff shortages. When the Premier went to the UK, he was obstructed by Ken Livingstone, the Mayor of London, from trying to pinch graduates when the UK is also in the midst of a health workforce crisis. Is this to occur again? All I am saying—as I have said before—is that not all of those countries have an oversupply of dentists. Those countries may not be particularly enamoured with us taking their graduates when they need them.

The bill will also change the Dental Practitioners Registration Act to allow interstate and New Zealand dentists to provide professional services in Queensland in an emergency or while a patient is being transported, giving effect to the request of the Dental Board of Queensland that section 270 of the Medical Practitioners Registration Act be replicated in the dental provisions. This is a good practical provision and a good change achieved by inserting new section 230A under clause 45 of the bill. With regard to replication, under the remaining 11 health practitioner registration acts all boards will have the ability to approve short-term registration and will have expanded delegation powers regarding their registration functions.

I turn back to the Public Sector Dental Health Workforce Scheme. Like other initiatives to engage overseas trained professionals, this scheme is now needed to meet the demand on Queensland's public health system which has been put into crisis. However, we have to keep this solution in perspective. It is a short-term solution. These amendments are needed because the registration boards have been ill equipped through legislation to cope with the change that recruiting overseas trained professionals has brought. The needs of overseas trained graduates in terms of entry standards, induction, professional support and ongoing education and training have to be properly recognised.

I think that this is an appropriate time to revisit the Forster review, which recommended a change in the workforce to better retain health professionals. The review noted the need for immediate short-term solutions to recruit more professionals, but also noted the need for long-term measures. The review said that a long-term plan should include reforms to improve organisational culture, the provision of staff amenities, removing frustrations, providing safe working environments, peer support for isolated practitioners, just salary arrangements, more efficient work practices and simplified industrial awards. The review also said that we need to show a strong commitment to education and training, better workforce planning and monitoring of trends and, to enable the improved provision of equitable, timely and sustainable oral health services, an increased interaction with the private sector, including outsourcing and mixed public/private models.

Outsourcing is an idea that the Beattie government has not yet cared to acknowledge as sound. Despite the fact that we have an oral health crisis in this state, I do not foresee those opposite coming to their senses on this point after they so loudly condemned the coalition's plan to outsource health services as recommended in several reports during the latest election campaign.

Before moving on, I acknowledge that clause 46, regarding the protection for persons involved in supervising special purpose registrants, confers immunity from proceedings or prosecution on supervisors who honestly and on reasonable grounds give information to the board on request and that this raises issues of possible fundamental legislative principles.

Section 129 states that if a special purpose registrant is registered on condition that they carry out their practice under supervision, the board may ask a person involved in the supervision to give information to the board about the supervised practice. Clause 46 of the bill provides that supervisors are not liable civilly, criminally or under an administrative process for giving this information. The conclusion of this clause raises the question of whether or not conferring this sort of immunity from proceedings or prosecution is being made with the appropriate level of justification.

I agree with the drafters of the explanatory notes, which state that the provision is defensible on the grounds that supervisors have a vital role in protecting the public through the effective supervision and assessment of special purpose registrants. Without this immunity, there is a risk that they would be less likely to provide candid and comprehensive reports and information about the registrants whom they supervise.

I turn now to the Pharmacists Registration Act 2001. Clauses 191 and 192 of the bill seek to clarify the intent of the Pharmacists Registration Act 2001 in relation to pharmacy businesses owned and controlled by registered pharmacists with some exceptions, one of which is the dealing with the business by trustees in bankruptcy, liquidators, receivers or administrators if the business or pharmacist becomes insolvent under administration. It explicitly states that these situations do not offend against section 139B of the act. Several lenders had previously expressed disquiet to the Pharmacy Guild of Queensland about the legal status of the types of security, mortgage, bill of sale et cetera that they sought from pharmacists borrowing to set up or purchase pharmacy businesses.

The amendments will address these concerns to the benefit of a pharmacist's choice of lenders while not derogating from the principle that ownership and control of pharmacy businesses should virtually always be vested in registered pharmacists. So the bill will clarify that a person, such as a mortgagee, who has an interest in a pharmacy business arising out of a mortgage, bill of sale or other security does not own the business. Section 139G, which currently specifies that the trustee in bankruptcy and liquidators do not commit an offence against section 139B, also applies to administrators and receivers. Mortgages, bills of sale or other securities in relation to a pharmacy business are not void to the extent that they give rights to administrators, receivers or receivers and managers. In summary, the lack of this legislation has been an issue for some lenders up until now. If a business goes, security is compromised by uncertainty. They will now lend with confidence. So this is a commendable change.

So, too, are the changes to the Radiation Safety Act 1999. The bill seeks to achieve consistency with the National Directory for Radiation Protection, endorsed by the Australian Health Ministers Conference in July 2004. In effect, it is achieving better uniformity in radiation protection practices between jurisdictions. The act is to be amended to expressly provide as one of its objectives the protection of the environment. These are very good changes. The bill does this by amending sections 4, 140 and 210 of the act. The act will also be amended to allow the more timely acquisition of certain radiation sources that are used to carry out diagnostic and therapeutic procedures.

The amendments in this bill that relate to the Transplantation and Anatomy Act 1979 are seemingly operational. They simplify the requirements governing the taking of skeletal muscle or oral tissue for research purposes and clarify that matters, such as tissue biopsies, may be taken only from adult donors.

I turn now to the amendments to the Tobacco and Other Smoking Products Act. I would like to take this opportunity to remind the minister that, no matter how tough the laws, without enforcement tough laws are as effective as having no laws at all. Recently, in a media release the minister claimed that Queenslanders had embraced the new smoking laws after an enforcement blitz conducted in the two

weeks following the grace period of the laws' introduction resulted in only two Queenslanders between the Gold Coast and Cairns being issued with on-the-spot fines. I believe that most people try to do the right thing and have been obeying the laws, but I find it hard to accept that a targeted police blitz on licensed venues over two weeks resulted in only two infringements between Cairns and the Gold Coast being issued. In particular, with this bill we are clarifying definitions of non-smoking areas, from which I infer that people have been confused and subsequently caught when it was not the intention of the legislation.

After the smoking bans came into force, up until 30 September 2006, 1,016 fines were issued. Allegations had been circling that Queensland Health officers who were assigned to conduct the blitz were not happy with the burden that had been placed on them by the Beattie government. In this context, it may be the case that the blitz was not conducted as thoroughly as reported and more infringements would have been recorded had people been targeted as much as the government suggested that they were going to be. I am more than happy to discuss and support the amendments to the act that this bill seeks to make. However, I ask the minister to keep in mind that laws that are not enforced are worse than no laws at all.

The bill clarifies the intent of a number of provisions in the act concerning the advertising, display and promotion of smoking products. Clause 290 of the bill inserts a new section 26W, which establishes a broader criteria for the meaning of an outdoor eating or drinking place, including sporting fields, shopping centre food courts, and festivals or other events held in parks. I appreciate that the government says that it is going to continue educating businesses and operators about what the changes will mean to them.

Smoking is prohibited within four metres of any entrance to an enclosed space, including temporary structures such as a circus tent and at all entrances, not just the main entrance. But the clarification needs to go further. A gap in the current Tobacco and Other Smoking Products Act 1998 allows for a lack of buffers preventing smoke from a designated outdoor smoking area entering an enclosed part of a licensed premises. Currently, section 26ZA of the act provides only for the requirement to have a buffer along the perimeter of a designated outdoor smoking area where the area is adjacent to other outdoor areas. The gap in this approach is that licensees are not required to have any buffer between a designated outdoor smoking area and an enclosed area when they are directly connected. Although usually there would be a wall separating an enclosed area from any outdoor area, this is not the case in many modern establishments. Typically, the enclosed area flows to the outdoor area, with the two areas only occasionally separated by a series of connecting folding doors. Another common occurrence is to have large connected windows that may open up to remove up to 60 per cent of a wall. As buffers are required only between designated outdoor smoking areas and adjacent outdoor areas, a licensee may have a smoking area directly connected to an enclosed area without any buffer, thus without any barrier preventing the smoke from entering the enclosed areas.

These connecting folding doors and window arrangements can be seen at many licensed premises throughout Brisbane, as folding doors and windows have been popular since the end of the 1990s. An example of the problem can be seen at the Shelter Bar in the Story Bridge Hotel at Kangaroo Point. One of the two smoking areas designed by this licensee has no buffers at all. Smoke from the area flows directly into the enclosed area with a bar being less than five metres from the smoking area. One perimeter of the smoking area is directly in front of an enclosed area and the two areas may be separated by a wall of folding doors. However, these doors are left open during normal licensed hours. Two of the other perimeters of the smoking area do not have any buffers. Occasionally, a two-metre buffer is used for one end. The third perimeter is along the street and so does not require a buffer as it is not adjacent to another outdoor area of the premises.

Another area that is not covered by section 26ZA of the act is entrances to a smoking area. A gap left as an entrance to a smoking area would be a breach of the current section if a screen impervious to smoke was used as a buffer under section 26ZA. An example of this problem can be seen at the designated outdoor smoking area of the Victory Hotel in Brisbane's CBD. Yesterday afternoon I attended the Victory Hotel with the member for Kawana to do some research. I can say that I was rigorous in my research.

Although the hotel makes considerable efforts to comply with the legislation, its designated outdoor smoking area would still breach the current section owing to the two open entrances to the area. Although there may be a level of understanding in enforcement regarding entrances, it serves to bring the law into disrepute to place something in the statute book that must involve a degree of disobedience or leeway to be workable and which encourages licensees to have a room-to-move approach to their statutory obligations. Any successful attacks on this legislation will greatly undermine public confidence in the policy, encourage licensees not to be compliant and greatly disadvantage any licensee who seeks to comply with the legislation versus a licensee who seeks to take advantage of any gaps. This issue is not fully addressed in this bill by its amendments to section 26ZA.

New section 26W, which is inserted by this bill, defines what is an outdoor eating or drinking area for the purposes of where a person may not smoke outdoors. The effect of the new greatly expanded definition in proposed section 26W is attempted to be mitigated by subsection 4 of that section. The proposed new section 26W(4) is a new way to designate a smoking area in an outdoor eating or drinking

place. The proposed new section 26W(4) and the proposed addition of a new subsection to 26ZA in the bill adds to the confusion about the effect of the proposed section 26W(4) and again encourages licensees to believe that they may designate a smoking area under section 26W(4), thus avoiding their obligations under sections 26ZA to 26ZC of the act.

However, only after a detailed look at the legislation can it be seen that even if a licensee designated a smoking area under section 26W(4) would this area be caught by the definition of 'designated outdoor smoking area' as an area in which smoking is allowed and the obligations under sections 26ZA to 26ZC would need to be complied with. The chances of this being contested in court are high. The consequences of a win to a licensee would render sections 26ZA to 26ZC redundant.

To remove any doubt or encouragement to a licensee to try to avoid their obligations under sections 26ZA to 26ZC, a further subsection should be added to the proposed new section 26W that could prevent a licensed premises from having a designated outdoor smoking area under section 26W(4) and to not include the proposed new subsection to section 26ZA, or at least remove the word 'licensed' from the reference to 'licensed outdoor area of the premises'.

Despite this bill's amendments, I would seek clarification from the minister with regard to golf courses. The Gold Coast is littered with golf courses, as many would be aware. But since the introduction of the smoking laws some members and staff at some of the Gold Coast licensed golf courses have been perplexed by the application of the laws. At one course, pursuant to a smoking management plan created in lieu of the tough new smoking laws, signs had been placed around the golf course stating that food is not allowed to be eaten in the rough.

When the new laws were introduced the laws made the whole golf course a licensed area. As 50 per cent of outdoor licensed areas must be nonsmoking the club has had to measure its holes and make 50 per cent of the golf holes non-smoking holes. This is what happens. On non-smoking holes members cannot smoke but can eat and drink. On smoking holes members cannot eat but can smoke and drink. In the rough between all holes on the course, meaning the buffer zones between smoking and non-smoking holes, members may not smoke, drink or eat. Members are ostensibly not even allowed to have food in their possession on smoking holes as food is not supposed to be taken into smoking areas.

The application of the laws on licensed golf courses is quite ludicrous. I understand the minister was advised of the difficulties in applying these regulations to golf clubs but that he refused to grant exemptions. Again we see no development with this bill except to broaden the criteria and potentially confuse club members and staff more.

I appreciate the provisions of clause 288. The clause amends section 26U to clarify that a person contravening section 26R(1) by smoking in an enclosed place must comply with a direction to stop the contravention. The clause also amends section 26U(2) to clarify that a person conducting an on-site food service commits an offence if this person continues to provide food or drink to another person who has not complied with a direction to stop. This is a good change. A new subsection 3 makes it an offence if the person conducting the food business was not aware that the contravention was happening.

The bill also seeks to ban the supply of smokeless tobacco products such as nasal snuff and chewing tobacco. These changes are worthy of consideration as Queensland Health has reportedly received a number of inquiries from retailers interested in selling these products. Retailers would only be inquiring if a possible market seemed apparent to them. I notice that the member for Darling Downs is not here to give a passioned defence for the practice.

My theme today has been that the changes this bill seeks to make are reactive changes. But the Beattie government's attempt to outlaw smokeless tobacco products before they become a major problem is a move made with foresight and worthy of bipartisan support. Smokeless tobacco products are highly addictive. The nicotine delivery capabilities are very high, increasing the potential for nicotine dependence in users. There is also evidence that the use of these products also increases the risk of developing oral or throat cancer, other oral diseases and cardiovascular disease. Let us get rid of these threats to the health of Queenslanders as our counterparts in New South Wales, the ACT, Victoria, Tasmania and Western Australia have already done.

A bill to ban smokeless tobacco in Australia was introduced into federal parliament at the end of the 1980s. This was an Australia-wide piece of legislation and meant that smokeless tobacco could only be brought in for personal use. Smokeless tobacco products include chewing tobacco and what is commonly known as snuff or powdered tobacco used for nasal or oral ingestion. In the US the public health community's campaign against smokeless tobacco dates back to the 1980s, starting with a landmark *New England Journal of Medicine* study showing that women and young people who used snuff had a risk of mouth cancer four times as great as nonusers.

I have had representations from people telling me that smokeless tobacco is a safer alternative to cigarettes and wanting us not to support these amendments. As I have indicated when I contacted the people advocating opposition to this part of the bill, individual importing and the cost thereof are matters for the federal jurisdiction. I do note, however, that the federal customs tariff has been raised from $2.33 to

$290.74 per kilo, making smokeless tobacco financially unobtainable to most users, but I have no issues with this either as this whole practice is a scourge. The Queensland coalition cannot and will not be party to legislating a less dangerous form of commercial tobacco sale. Whilst I am sympathetic to those who have contacted me, we agree with the government's stance on this.

The bill also makes amendments to the Mental Health Act 2000. It is quite an interesting change and will enable the classified patient scheme under chapter 3 of the Mental Health Act to be applied to persons who are lawfully held or detained in custody, but not yet charged under prescribed state and Commonwealth legislation. This sort of change is to stop a repeat of the bizarre Cornelia Rau case. Had this clause been in effect and Ms Rau were able to be treated, it probably would have led to her identity being revealed before she was detained at the Baxter Detention Centre—a detention that has now led to a compensation claim against the government. This move is a good one and considers the health interests of a detainee pending charge by allowing them to receive possible appropriate mental health services.

Minor amendments are being made by this bill to the Private Health Facilities Act 1999, including rectifying an operational deficiency relating to the disclosure by another party of information provided under the act. Clause 227 amends section 147, which imposes a duty of confidentiality on persons who obtain information in the course of their function under the act. However, section 147(4)(c) enables information to be given to the Commonwealth, another state or an entity of the Commonwealth or state under specified conditions, including that the entity must not give that information to anyone else. This provision has been creating operational barriers for the Commonwealth and other state governments which engage independent researchers and contractors to conduct specific tasks on their behalf. So, to address this situation, the restriction imposed by section 147(7) is to be modified by this bill to specify that if an entity is given information under section 147(4)(c) it must not give this information to anyone else unless the disclosure is permitted by the relevant prescribed agreement or is permitted by the chief executive in writing.

Amending the Health Services Act to enable the appointment of inspectors with appropriate powers to investigate alleged breaches of the confidentiality clauses under sections 33 and 57, and not just section 62A, is needed. I will unashamedly admit that I am still in the process of contacting the many health related boards and associations in the state to introduce myself as the new shadow minister for health in Queensland. Many were kind enough to offer their thoughts on this latest bill and I thank them for that. In conclusion, I think the Forster review put it best—it can no longer simply continue doing what it is currently doing. This bill starts to acknowledge this conclusion.