Speech By

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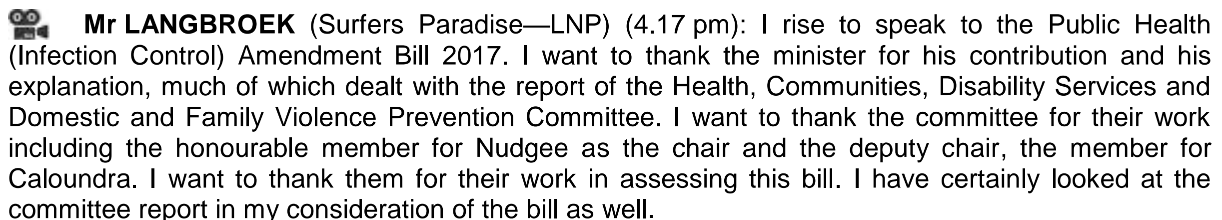
PUBLIC HEALTH (INFECTION CONTROL) AMENDMENT BILL



Mr LANGBROEK (Surfers Paradise—LNP) (4.17 pm): I rise to speak to the Public Health (Infection Control) Amendment Bill 2017. I want to thank the minister for his contribution and his explanation, much of which dealt with the report of the Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee. I want to thank the committee for their work including the honourable member for Nudgee as the chair and the deputy chair, the member for Caloundra. I want to thank them for their work in assessing this bill. I have certainly looked at the committee report in my consideration of the bill as well.

There is an interesting background to the bill and the situation in which we find ourselves in that I come from the profession of dentistry. I am a registered non-practising dental surgeon and I see that the infection control framework is being extended to areas that have not necessarily been held over in legislation before. It is probably good to consider the history of infection control as it has been applied especially in dentistry.

Talking about the background to the bill I see the committee report mentions the declared health services that are going to be covered by this bill: public hospitals and ambulance services, dental clinics, medical practitioners' private rooms, acupuncturists and Chinese medicine practitioners, sexual health services, home nursing services, midwifery services outside the hospital environment, pathology and blood collection services, retrieval services and vaccine services.

In terms of procedures that dentists perform all the time, dental surgeries provide treatments for people in what is pretty much a day theatre. They are not in a hospital facility, but they are in the equivalent of a day theatre because they are often having procedures such as minor oral surgery. Members would be aware of procedures such as having wisdom teeth removed, which is sometimes done under a general anaesthetic in a day theatre situation but which is often performed in a dental surgery. There are other minor oral procedures such as pedodontics, which is working on children; endodontics, which are root canal treatments; and periodontics, which is treatment of the gums. The point is that many of the procedures which are performed by dental practitioners in general practice situations are the sorts of things that are more commonly done in a hospital situation.

In the years since I began practising we have become increasingly aware of the need for infection control. I first started at university in the 1970s and through the 1980s when the rise of HIV, human immunodeficiency virus, first became evident. Dental practitioners and dental students—as we were at the University of Queensland—suddenly became acutely aware of the situation because the concern was that if someone contracted HIV it could then develop into AIDS. Dental students in the 1980s felt it was almost inevitable we would contract HIV from the aerosol mist that results when a dentist uses the drill. We were concerned that we would contract HIV if that aerosol got in our eyes because, importantly, we did not know how it was transmitted. We now know that it is usually transmitted through blood-to-blood contact or through sexual fluids, but back then in the 1980s we did not know.

The bottom line is that up to then sterilisation procedures were really quite minimal in dental practice situations. I clearly remember talking about glass bead sterilisation, but there was no routine use of autoclaves to sterilise everything that went in or near a patient's mouth. We did not sterilise the triple syringe, which is the instrument that a dentist uses to mix air and water to blow around and clear the visual field they are inspecting. Dentists did not necessarily wear gloves and they did not wear masks. We practised what was called 'wet finger' dentistry. Many patients will recall going to the dentist and having a predominantly male dentist leaning over you—sometimes with pretty bad breath, halitosis—with his moist fingers in your mouth. It really was not a particularly pleasant situation, but I grew up wanting to be a dentist!

The important issue is that we changed our sterilisation processes and procedures as a result of what was happening around the world during the rise of HIV. At dental school at the University of Queensland I clearly remember the way we sterilised dental drill bits between patients. Back then a dental nurse in the clinic would just wipe it over with a cotton bud dipped in methylated spirits, and that was what we did between patients. Now if you go to a dental surgeon you normally find that everything—all the drills and syringes—are covered in disposal plastic and there is once-only local anaesthetic, which is designed to be used only once and then disposed of. It is very important to make sure those things are done. The autoclaving or sterilisation of instruments should now be routine. There has been a significant increase in the number of dental schools since I was at university when there were only five in the whole country, and now we have three in Queensland alone: James Cook, Griffith University and the University of Queensland, so of course we have an increasing number of dental graduates.

I have been referring specifically to dentistry because the changes that the minister has referred to have come about as a result of a situation that happened at Carina in Brisbane a couple of years ago which necessitated the changes to the Public Health Act we are now considering. The important issue is that things have progressed a long way since our initial concern as practitioners with regard to contracting HIV, hepatitis B or hepatitis C. We received recommendations from the Australian Dental Association during those years and one such recommendation was, 'If you know that a patient has a particular disorder like hepatitis B, hepatitis C or HIV, treat them at the end of the day and throw out most of the equipment that you have used on them.' We found that that was not particularly successful, because then patients were loath to tell practitioners that they may have had hepatitis B, hepatitis C or HIV, or they may not have known that they had it. As a profession we then began to treat everyone as though they had everything, and that meant that we had more stringent infection control procedures. That has now led to the situation where a particular surgery may have put thousands of patients at potential risk, even though we know that generally speaking it is very unlikely someone is going to get one of these disorders or diseases from a dental surgeon.

As the minister has mentioned, the incident in Carina has led to a reassessment of the Public Health Act and that is why we are considering the bill before us today. As I said, this kind of breach is rare because dental surgeons and all of the other practitioners mentioned in these facilities would have had infection controls mentioned to them during their education processes, but because of patients coming and going and the need to get changeover happening quite quickly there can be pressure at times. If you have a busy practice, suddenly it can be tempting to cut corners on some of these infection control procedures. That is why it is imperative that we have very high standards so that Queenslanders can be confident the health services they receive are safe and sanitary.

The first part of the bill will make changes to further enable guidance to be provided to the operators and staff of healthcare facilities, HCFs, to minimise infection risks. By the way, I can point out that the HCFs mentioned in this bill should not be confused with a health fund which is called HCF. I think that may confuse some of our speakers later this afternoon or anyone who is reading this later. The healthcare facilities are the things that are referred to in the bill. While the act already provides an infection control framework for HCFs across the state, including over 600 dental practices, the bill before us allows for appropriate adjustments to be made to the regulation-making head of power in the act supported by amendments to the Public Health Regulation 2005 that will allow for mandatory training, competency and infection control standards to be prescribed by regulation.

The second part of the bill will expand the ability of the Department of Health to monitor compliance of the operators and staff of HCFs with their infection control obligations and, where necessary, investigate possible breaches. Heads of power will also be inserted into the framework to allow Queensland Health to require the operator of an HCF to produce a copy of their infection control management plan, the ICMP, or to amend an ICMP. Authorised persons will be empowered to enter premises to investigate infection risks without prior notice.

I note the minister's reassurance that this will not be done lightly. I can report that, if I were to ask most of my dental colleagues whether they have ever had an investigation or a visit from some of those 145 Queensland Health inspectors, I would guess that very few of my colleagues would report that they

have ever had a visit from Queensland Health inspectors. I note that the committee raised questions regarding the ability of inspectors to get around to all of the facilities that are mentioned in 2.1 of the committee report, which is all of the various services that are covered.

Public health facilities such as publicly controlled hospitals and ambulance services will usually have their own processes in place because they are often covered by a different regime and inspectors may well have been inspecting those, but as I understand it there have not been many inspections of private dental practices performed by those 145 Department of Health inspectors.

The third part of the bill will increase the power of Queensland Health to enforce compliance by the operators and staff of HCFs with the infection control framework and to prosecute breaches. I note that the minister has assured us, and we are aware of the fact, that these breaches are in the minority, but with an increasing amount of proactive dentistry being done—in other words, a lot of dentists are now offering more commercial type products, whether it is bleaching teeth or crown and bridge cosmetic type dentistry—there will be more procedures being done. It is important to make sure that everyone within the profession understands their responsibilities.

The bill imposes penalties for noncompliance and enables Queensland Health to direct the operator of an HCF to take particular corrective actions or to cease performing a particular health service where that service involves a risk to public health from poor infection control practices. I note that these are the improvement notices and the directions notices to which the minister referred.

I turn now to the reservations as expressed by committee members. I acknowledge the submissions made by the Australian Dental Association Queensland, ADAQ, the Australian Lawyers Alliance and my colleagues on the committee which highlight their concerns about the practical implications of this bill. The ADAQ raised a number of concerns. The first regarded the resourcing of appropriately qualified persons for the task of providing mandatory training, competency and infection control standards that will be prescribed by as-yet-unseen regulation.

The ADAQ is also concerned that the proposed changes would amount to conflicting regulations between the Australian Health Practitioners Regulation Agency—dentists are registered with AHPRA—and its Queensland notification boards, the Office of the Health Ombudsman and now Queensland Health. I understand and accept the committee's report that shows that there is increasing corporatisation in dental practices and that AHPRA and OHO do not cover specifically those corporations and that is why it has been necessary to bring it forward in this form.

The ADAQ also raised the fact that the act only provides for a right of review to the Supreme Court. The minister referred to the amendments I will move subsequent to the second reading debate. The concern is that it is expensive and time consuming for affected registrants. If a power is to be exercised by a senior person in Queensland Health then there needs to be a right of review of that decision because of the catastrophic effect of a directions notice, which can result in the closure of a practice. If a dental practitioner or dental surgeon is directed that their practice is going to close, it is imperative, as the minister has reassured us, that the directions notice and any appeal that might come from the dental surgeon should be dealt with in a timely manner. We are not looking to water down any of the provisions; we are simply saying that an appeal to the highest court in this state would seem to be a rather tough measure for a private practitioner to have to take. That is why the amendment proposes that QCAT could deal with this type of matter.

The ADAQ suggested that a right of review via QCAT should be an option. I note that the committee asked for the minister's clarification and the minister has given a clarification. I will leave the rest of my comments on that matter to the appropriate time. I reassure the minister that any amendment we have foreshadowed is not with a view to watering down what the bill is trying to do. It simply addresses the fact that a process involving the Supreme Court would be more onerous and expensive. I look forward to debating that at the appropriate stage. I will move an amendment which provides a right of appeal or review to QCAT where Queensland Health issues notices under the new provisions.

Concerns have also been raised by the ADAQ and reinforced by my colleagues the members for Caloundra, Cleveland and Gaven regarding the implications of the word 'involved' in clause 5, section 151. Clause 5 provides that a person involved in the provision of a declared health service who fails to take reasonable precautions and care to minimise the risk of infection commits an offence which attracts a maximum penalty of 1,000 penalty units. They rightly pointed out that the word 'involved' is ambiguous and could implicate anyone who is working under the ICMP and could also result in employers shifting the blame to employees. An example provided in the bill is that a nurse collecting blood in a blood bank could be liable for not complying with the ICMP. The question under the bill is: would the individual be liable or would vicarious liability apply? We look forward to clarification of the intent of the word 'involved' in section 151.

My colleagues also raised concerns about the issue of workload, as I have already mentioned, for the 145 authorised officers to effectively enforce the new regime to a level that would justify the changes. We are not clear that they will be able to manage, given that healthcare facilities are numbered in the thousands.

The statement of reservation also raises concerns about the wording of clause 9, proposed new section 156B(b), which deals with the power of an authorised person giving notice that requires the operator to amend the ICMP. Proposed new subsection (3)(b) provides that the notice must state 'the way the ICMP must be amended'. The Australian Lawyers Alliance, ALA, advised that this may be interpreted to suggest that the authorised person must rewrite the ICMP. They propose that it be altered to say 'the reasons the authorised person considers the ICMP does not comply with this part'.

The ALA also recommended providing clarity with regard to clause 13, section 390, which contains the phrase 'an imminent risk of infection to a person at the health care facility'. The organisation believed that this poses a difficult threshold and proposed a lower one before allowing entry to a healthcare facility without notice. I note the minister's reassurance that these sorts of rights of entry will not be taken lightly and will not be just done in an ad hoc fashion.

The LNP will not be opposing the bill. As I have mentioned, we will be moving one amendment, which provides a right of appeal or review to QCAT where Queensland Health issues notices under the new provisions.

In conclusion, as a former dental practitioner I reassure Queenslanders that it is imperative that we have faith in the provisions to do with infection control. In a world where viruses are becoming increasingly difficult to treat, it is important that people who are providing health care maintain the standards they were educated to meet. We need to be able to give confidence to Queenslanders, or people who visit Queensland and are seeing someone they do not know—people from different jurisdictions often visited my practice in Surfers Paradise—that infection control procedures are being carried out to the highest level and that ethical responsibility is taken very seriously. I know that most practitioners do, but those involved in dentistry or in professions in the other fields that are mentioned do not have the same level of oversight as happens in our public hospital system and in our clinics, which are oversighted by different authorities.

These are matters that were often raised through the Health Quality and Complaints Commission, which succeeded the Health Rights Commission. Many of the agencies that were covered by the then Health Quality and Complaints Commission felt frustrated about the duplication of regulation, given that they were already complying with regulation from other authorities. In private practice, these sorts of regulations have often been determined by the individuals themselves and making sure they are complying. I can understand and support the need for more oversight, given what has happened with a plethora of other practices opening medical and quasi-medical type operations. As a population and as legislators, we need to make sure that everyone going to these types of facilities can be confident in the type of infection control that is being carried out by the practitioners.