# Health and Other Legislation Amendment Bill 2016

# Explanatory Notes

## Short title

The short title of the Bill is the Health and Other Legislation Amendment Bill 2016 (the Bill).

## Policy objectives and the reasons for them

The Bill amends the Criminal Code and three health portfolio Acts to support policy initiatives of the Government and to improve the effective operation of the Acts. In particular, the Bill amends:

- the Criminal Code to standardise the age of consent for sexual intercourse to 16 years and replace references to *sodomy* with *anal intercourse*
- the *Hospital and Health Boards Act 2011* (the Hospital and Health Boards Act) to facilitate general practitioners (GPs) having access to the Queensland Health database, The Viewer; and enable more efficient disclosure of confidential patient information for research purposes
- the *Public Health Act 2005* (the Public Health Act) to allow health information relating to deceased patients to be disclosed for research purposes; enable schools to share student information with school immunisation and oral health service providers to improve the uptake of the School Immunisation Program and School Dental Program; and make consequential amendments to reflect changes to the Australian Childhood Immunisation Register, and
- the *Queensland Institute of Medical Research Act 1945* (the Queensland Institute of Medical Research Act) to facilitate the payment of bonuses to successful discoverers or inventors.

### The Criminal Code

There is currently a disparity in the Criminal Code between the age of consent for anal intercourse, which is 18 years, and the age of consent for all other sexual activity, which is 16 years. With the exception of Queensland, all Australian states and territories provide an equal age of consent for all sexual activity.

While the discrepancy in the age of consent does not directly target young people on the basis of their sexual orientation, in practice, the law discriminates on this basis against young same-sex attracted men under 18 years. Some in the community have identified the inconsistent age of consent for anal sex in the Criminal Code as a barrier to young people accessing safe sex education regarding anal intercourse, with gay and bisexual youth being denied peer acceptance and community support. Unprotected anal intercourse is the highest risk behaviour for transmission of human immunodeficiency virus (HIV).

The draft *Queensland Sexual Health Strategy 2016–2021* (the Sexual Health Strategy), which was released for public consultation in May 2016, aims to support healthy and safe sexual experiences based on respect and consent and to provide Queenslanders with the knowledge required to maintain optimal sexual and reproductive health. The Sexual Health Strategy is the first of its kind in Australia and fulfils a government election commitment. A key action of the Sexual Health Strategy is to improve sexual health outcomes for specific population groups, including reducing barriers to testing and treatment for sexually active young people and those who identify as same-sex and gender questioning. The final Sexual Health Strategy is expected to be released later in 2016.

The Government made a general election commitment to establish an expert committee consisting of key health experts, to consider the implications of legislating to making the 'age of consent' in Queensland uniform, as is the case in the other States in Australia, and make recommendations. A panel of health experts and relevant organisations met in May 2016, and advised the Minister for Health and Minister for Ambulance Services that the current laws may have adverse implications for young Queenslanders. The panel noted that young people in same sex relationships may feel compelled to withhold information about their sexual history from their health practitioner for fear of the possible legal consequences, whether for themselves or their partner. This may have implications in terms of the young person's access to appropriate medical treatment and also has the impact of stigmatising their relationship. With research indicating the average age for young people's first sexual experience is now below 16 years, the panel recommended the age of consent for all forms of lawful sexual intercourse be standardised to 16 years.

The expert panel considered that using the term sodomy may stigmatise this form of intercourse, and homosexual relationships in particular. The panel therefore recommended the Criminal Code be amended to replace references to sodomy with anal intercourse.

The Bill amends the Criminal Code to standardise the age of consent to 16 years and to replace references to *sodomy* with *anal intercourse*, supporting the release of the Sexual Health Strategy and implementing the expert panel's recommendations.

***Hospital and Health Boards Act 2011***

- **Access to information systems by general practitioners**

Queensland Health collects information about patients and stores it in several information systems. The Viewer is a read-only, web-based application that displays patient information consolidated from other information systems. The information accessible using The Viewer includes the patient's name, address and demographic information, admission and discharge history, pathology and medical imaging reports, and other information relating to their medical history. The Viewer is currently available to authorised Queensland Health clinical and support staff. Each user has individual user logins and their activity in The Viewer is recorded and audited.

The duty of confidentiality in section 142 of the Hospital and Health Boards Act prohibits a designated person from disclosing patient information to another person, except in prescribed circumstances. *Designated person* is defined in part 7 and includes, for example, public service employees employed in the Department of Health and employees of a Hospital and Health Service. A designated person would be in breach of section 142 if they disclosed confidential information by permitting persons to have access to a Queensland Health information system, unless the disclosure is required or permitted under the Act. A number of exceptions to the duty of confidentiality are provided for in part 7 of the Act. However, these exceptions are not considered sufficient to allow access by a patient's GP to The Viewer.

Queensland Health's *My health, Queensland's future: Advancing Health 2026*, the 10 year Vision and Strategic Framework for health in Queensland, was developed in response to the ongoing challenges facing the health system and launched by the Minister for Health and Minister for Ambulance Services on 19 May 2016. The Vision and Strategic Framework identifies connecting care as one of four strategic directions. To improve health outcomes, it is important that the entire health system works together, including a focus on improving collaboration between parts of the health system to enable better continuity of care for patients.

The headline measures of success in the Vision and Strategic Framework include increasing availability of electronic health data to consumers and to have the majority of clinical activities supported by a digital platform. Enabling GPs to access The Viewer will support the headline measures of success and provide GPs with a more comprehensive view of the patient's clinical history, contributing to connected healthcare for the benefit of the patient.

Giving GPs access to The Viewer will facilitate information-sharing and collaboration, ensuring patients receive consistent, timely and better coordinated care. For example, where a patient attends an emergency department after hours and is instructed to follow up with their GP for further treatment or care, the GP will be able to access the relevant admission and discharge, pathology and imaging reports to ensure appropriate care is provided and only appropriate outpatient referrals are made. GPs will be able to see the results of pathology and other tests already performed at the hospital and avoid unnecessarily repeating tests.

- **Disclosure of patient data for research purposes**

To undertake medical research, researchers are required to meet a number of requirements, including that the research project is submitted for review by a Human Research Ethics Committee or, in the case of low and negligible risk research, a Human Research Ethics Committee or another review body. Once the project is approved, a research governance review is undertaken within the Department of Health or Hospital and Health Service where the project is to be carried out. This ensures the regulatory, budgetary, and contractual requirements have been addressed, that the appropriate head of department and heads of supporting departments have indicated their awareness of and support of the project, and that any other site specific issues are dealt with. Once the research governance review is complete, the research project is authorised to commence at that site by the relevant chief executive.

Researchers require access to patient information to inform their research. In most instances, the patient can consent to their information being disclosed. However, the Australian Medical Association Queensland has identified a legislative barrier to researchers' ability to efficiently gain access to patient information for research purposes where patients do not have capacity to consent. This may arise, for example, where researchers are undertaking a clinical trial in an intensive care unit or dementia unit. Substitute decision-making frameworks apply, including the Queensland Civil and Administrative Tribunal under the *Guardianship and Administration Act 2000* (the Guardianship and Administration Act), and a statutory health attorney for an adult's health matter under the *Powers of Attorney Act 1998* (Powers of Attorney Act), to obtain consent to a patient's participation in research. However, it is not clear that the substitute decision-maker can consent on the patient's behalf to confidential patient information being disclosed.

A complex legislative framework currently exists for gaining access to patient information in these circumstances. The duty of confidentiality in section 142 of the Hospital and Health Boards Act prohibits *designated persons* from disclosing patient information to another person, except in prescribed circumstances. The circumstances currently prescribed under part 7 do not specifically include disclosing patient information for research purposes.

Under the current framework, researchers may apply to Queensland Health under chapter 6, part 4 of the Public Health Act for approval to obtain a patient's confidential information. Section 281 of the Public Health Act provides that the chief executive may give health information held by a health agency despite any other provisions dealing with confidentiality, including section 142 of the Hospital and Health Boards Act. A person is required to apply in writing to the chief executive under section 282 to obtain health information for research conducted by them or an entity of which they are a member, with a range of particulars required to be included in the application. The chief executive can also require further information or documentation to support the application under section 283. The chief executive may only grant the application if satisfied that the giving of the information is in the public interest having regard to, among other things, the privacy of individuals to whom the health information relates, and the identification of any person by the information is necessary for the research.

This application process is an unnecessary burden in instances where a patient is unable to provide consent for researchers to access their information but the research project has met a number of other requirements, including that:

- the research has ethics approval
- commencement of the project has been authorised by the relevant chief executive in accordance with administrative requirements within Queensland Health, and
- the patient's participation in the research has been approved under a substitute decision-making framework.

The Australian Medical Association Queensland has raised concerns that the Public Health Act application process may delay or temporarily suspend research projects.

The Bill amends the Hospital and Health Boards Act to enable more efficient disclosure of patient information for research purposes. The amendments remove the need for researchers to undertake the Public Health Act application process to obtain a patient's confidential information in the above circumstances, while ensuring other appropriate approvals and authorisations in relation to the research have been obtained.

***Public Health Act 2005***

- **Deceased patient data**

Researchers seek access to historical patient information, including information relating to deceased patients for research purposes including, for example, studies requiring information relating to factors contributing to causes of death. Section 142(3) of the Hospital and Health Boards Act provides that the duty of confidentiality in relation to patient information applies even if the patient is deceased.

The definition of *health information held by a health agency* under the Public Health Act, however, does not clearly relate to both living and deceased patients as it refers to 'a person'. *Person* is defined in the *Acts Interpretation Act 1954* to include an individual and a corporation, with an *individual* defined to mean a natural person. The term natural person is generally understood to relate only to living persons. As a result, it is unclear whether a researcher is able to obtain information relating to deceased patients through the Public Health Act application process outlined above.

The Bill makes a minor amendment to the Public Health Act to clarify that the definition of *health information held by a health agency* includes the information of both living and deceased persons. This supports the above amendment to the Hospital and Health Boards Act to enable more efficient disclosure of patient information for research purposes.

- **Disclosure of student information**

The School Immunisation Program provides free immunisations to secondary students across Queensland. Hospital and Health Services are responsible for ensuring delivery of the School Immunisation Program; it can either be delivered by Hospital and Health Services themselves or by external providers under contract with Hospital and Health Services.

Queensland children are also eligible for publicly funded oral health services through Queensland Health's School Dental Program. These services are either provided at school dental clinics or at dental clinics located within Hospital and Health Services.

To be vaccinated as part of the School Immunisation Program or to receive oral health services through the School Dental Program, students must return a signed parental consent form to the school. A substantial number of consent forms are not being returned, despite Queensland Health providing schools with a resource kit that includes sample letters to parents, school newsletter articles, school staff flyers, and advice on parental reminders using various communication mediums such as SMS and email. Immunisation and oral health are not part of a school's core business and not all schools possess the administrative capacity to seek parental consent and follow up on student involvement in what is a non-educational extra-curricular activity.

A goal of the *Queensland Immunisation Strategy 2014-2017* is to ensure that 85 per cent of Queensland adolescents are fully immunised through the School Immunisation Program. However, it is falling well short of this target. In 2015, the vaccination uptake for Year 8 students in the School Immunisation Program was 74 per cent for dTpa vaccine (whooping cough) and 61 per cent for human papillomavirus (HPV) dose 3 (complete vaccine course). Hospital and Health Services have reported declining consent rates for the School Dental Program for many years.

To improve uptake of the School Immunisation Program and School Dental Program, the Bill amends the Public Health Act to authorise school principals and their delegates to disclose student information to an immunisation or oral health service provider (school health program provider), enabling providers to:

- follow up with the parents of students who have not returned their consent form
- reconcile returned consent forms against eligible students, and
- make informed decisions on future strategies to improve consent form return rates for Indigenous children, and children from culturally and linguistically diverse backgrounds, if required.

This direct relationship may assist families to resolve any concerns or questions they may have about their child's immunisation or oral health needs and enables a clinical-oriented service that cannot be provided by schools.

- **Consequential amendments for the Australian Childhood Immunisation Register**

The Bill makes minor amendments to the Public Health Act as a result of changes to the *Australian Immunisation Register Act 2015* (Cwlth).

***Queensland Institute of Medical Research Act 1945***

Under the Queensland Institute of Medical Research Act, the QIMR Berghofer Medical Research Institute is required to obtain Governor in Council approval for the payment of bonuses to successful discoverers or inventors working as officers and employees of QIMR or under the auspices of QIMR. This impedes QIMR's ability to remunerate discoverers of intellectual property in a timely manner and to attract high-performing discoverers or inventors.

QIMR is committed to improving the translation of medical research discoveries into treatment, diagnosis and prevention strategies. To do so, QIMR must be able to attract and retain world leaders in medical research.

The Bill amends the Queensland Institute of Medical Research Act to remove the requirement for Governor in Council approval for the payment of bonuses, up to an aggregate annual limit of $10 million in a financial year. Governor in Council approval will be required should the annual limit exceed $10 million. This amendment gives QIMR autonomy to manage bonuses as they determine up to the $10 million cap, providing QIMR with a competitive edge for attracting and remunerating discoverers or inventors.

# Achievement of policy objectives

## The Criminal Code

The Bill will amend the Criminal Code to standardise the age of consent for sexual intercourse to 16 years. The Bill achieves this by removing the offence of unlawful sodomy in section 208 and amending the offences of unlawful carnal knowledge in sections 215 and 216 to extend the definition of *carnal knowledge* in those provisions to include anal intercourse.

The Bill will also make consequential amendments to a range of other Acts to support these amendments.

### *Hospital and Health Boards Act 2011*

- **Access to information systems by general practitioners**

The Bill amends part 7 of the Hospital and Health Boards Act to provide that a prescribed health practitioner may access a prescribed information system.

The Bill inserts definitions for part 7, to provide that a *prescribed health practitioner* is a relevant health practitioner who is prescribed by regulation, or a person who was formerly a relevant health practitioner mentioned above. A prescribed health practitioner does not include an individual who is currently a designated person under new section 139A(1). *Prescribed information system* is defined to mean an information system prescribed by regulation. It is intended that GPs will be prescribed in the Hospital and Health Boards Regulation, to enable their access to The Viewer. The amendment will also enable further categories of health practitioners and information systems to be prescribed in future, where access is to facilitate a patient's care or treatment.

To ensure appropriate protection of individuals' health information, the Bill provides that it is an offence for a prescribed health practitioner to:

- access information contained in a prescribed information system unless the information is necessary to facilitate the care or treatment of an individual or accessed incidentally
- access a prescribed information system and any information contained in the system contrary to any conditions prescribed by regulation, or
- disclose confidential information to another person, directly or indirectly, unless the disclosure is required or permitted under the Hospital and Health Boards Act.

These offences carry a maximum penalty of 600 penalty units, which is broadly equivalent to the civil penalty for the unauthorised collection, use or disclosure of health information under the Commonwealth My Health Record system. Conditions on accessing the information system to be prescribed in the Hospital and Health Boards Regulation may include, for example, that the health practitioner must not access information for persons to whom the health practitioner has not provided care or treatment and access being subject to a direction by the patient to whom the information relates that no health practitioner can access the information.

To further safeguard against the health practitioner accessing information for persons to

whom they have not provided care, the system will require the health practitioner to search by a unique identifier, such as the patient's Medicare number.

To ensure that prescribed health practitioners may disclose confidential information for appropriate purposes, for example, where disclosure is required for care or treatment of a person, the Bill provides that exceptions to the duty of confidentiality under sections 143-148, 154-157 and 159 of the Hospital and Health Boards Act apply to a prescribed health practitioner as if they were a designated person under the Act.

The amendment to section 143(2) provides that giving a prescribed health practitioner access to a prescribed information system under section 161C is a disclosure permitted by an Act. This makes clear that a designated person does not commit an offence under section 142 by enabling a prescribed health practitioner to access a prescribed information system.

The Bill inserts additional requirements for prescribed health practitioners seeking to disclose confidential information under section 148. The section allows disclosure for the protection, safety or wellbeing of a child. Section 147 provides for disclosure in similar circumstances, relating to lessening or preventing serious risk to life, health or safety and includes a requirement that the relevant chief executive must believe on reasonable grounds that the disclosure is necessary to lessen or prevent serious risk to life, health or safety and to authorise the disclosure in writing. The Bill inserts similar requirements for section 148 in relation to disclosure by prescribed health practitioners, as it is expected that information accessed by a prescribed health practitioner through a prescribed information system which raises issues relating to the protection, safety or wellbeing of a child is information available to Queensland Health staff that may have already been actioned internally. To ensure prescribed health practitioners do not unnecessarily disclose information relating to a situation already being actioned by Queensland Health staff, it is appropriate for the relevant chief executive to exercise oversight over disclosure by a prescribed health practitioner and consider the request for disclosure in the first instance. It is not expected that these requirements would significantly delay disclosure by a prescribed health practitioner in these circumstances.

- **Disclosure of patient data for research purposes**

The Bill amends the Hospital and Health Boards Act to provide a new exception to the duty of confidentiality for the disclosure of a patient's information for research purposes, removing the need for the researcher to obtain an additional approval under the Public Health Act for disclosure of patient information.

The amendments provide that if the relevant chief executive (that is, the chief executive of the department or a Hospital and Health Service chief executive) gives a researcher written approval to carry out the research, a designated person as defined for part 7 of the Hospital and Health Boards Act may disclose a person's confidential information to a researcher for the purpose of conducting the research. The researcher need not be another designated person. This section only applies where the participant is an adult who has impaired capacity for consenting to participation in the research and a tribunal under the Guardianship and Administration Act or another person authorised under a law to make decisions for the person, for example, where applicable, a statutory health attorney for an adult's health matter under the Powers of Attorney Act, consents to their participation in the research.

***Public Health Act 2005***

- **Deceased patient data**

The Bill amends the Public Health Act to clarify that the definition of *health information held by a health agency* includes information about both living and deceased persons.

- **Disclosure of student information to support the School Immunisation Program and School Dental Program**

To improve uptake of the School Immunisation Program and the School Dental Program, the Bill amends the Public Health Act to authorise school principals and their delegates to disclose student information to a school health program provider for the purposes of administering the School Immunisation Program or School Dental Program.

The Bill provides that the school health program provider may ask the school principal to provide information, including the name and date of birth of a student, the name, telephone number, email address and postal address of a parent or guardian of a student, and any other information prescribed by regulation about a student. It is expected that information prescribed by regulation may include the gender of the student, which class or group they are attached to, the languages spoken at the student's home and the student's indigenous status.

The Bill requires the school principal to disclose the information within a reasonable period, if requested.

To ensure school principals know who the information can be disclosed to, the Bill includes a requirement for the relevant Hospital and Health Service chief executive to give the school principal written notice identifying the school health program provider for the school. The Bill allows the Hospital and Health Service chief executive to delegate this function to an appropriately qualified employee of the Hospital and Health Service or health service employee employed in the department and working for the Hospital and Health Service. This will ensure that disclosure is limited to approved providers who are either a Hospital and Health Service or an entity engaged by a Hospital and Health Service to carry out a school health program.

As school health program providers do not currently have access to information about the student cohort beyond the estimated number of students in the cohort, they are not able to identify which of the students in the cohort have not returned their consent form. The Bill therefore enables the disclosure of information about all students enrolled in a relevant cohort. This approach will minimise the administrative burden on schools, as they will be able to send the information relating to a cohort rather than having to identify specific students in a cohort who may not have returned their consent form.

To provide sufficient flexibility for the school principal to refuse to disclose information about vulnerable students, for example, where students are under a protection order, the amendment provides that the school principal may refuse disclosure where they consider disclosure is not in the best interests of the student. The Bill includes a requirement for the school principal to advise the school health program provider if they have refused to disclose any student information and if so, the number of students they have refused disclosure for, for reconciliation purposes.

Some school health program providers, such as Hospital and Health Services and local councils, are agencies or health agencies required to comply with the privacy principles in the *Information Privacy Act 2009* (the Information Privacy Act). Other providers may be bound to comply with the privacy principles through their service contract with the Hospital and Health Service. However, to ensure that all student information is protected, the privacy principles in the Information Privacy Act are deemed to apply to a school health program providers provide, if the provider is not already an agency or a health agency for the purposes of the Information Privacy Act.

- **Consequential amendments for the Australian Childhood Immunisation Register**

The Bill amends the Public Health Act to replace references to *recognised immunisation provider* with *recognised vaccination provider* and to amend the definitions of *immunisation history statement* and *immunisation status "up to date"* to reflect changes to the Commonwealth legislation that deals with the Australian Childhood Immunisation Register.

***Queensland Institute of Medical Research Act 1945***

The Bill amends the Queensland Institute of Medical Research Act to enable QIMR to make payments to successful discoverers or inventors working, or who have worked, as officers and employees of QIMR or under the auspices of QIMR. The amendments provide that QIMR has discretion to make payments to successful discoverers or inventors up to an aggregate amount $10 million in a financial year. Should the aggregate value of the payments exceed $10 million in a given financial year, Governor in Council approval of the payment of any further bonuses is required.

**Consequential amendments**

The Bill makes minor amendments to the *Child Protection (Offender Reporting) Act 2004, Corrective Services Act 2006, Criminal Organisation Act 2009, Criminal Practice Rules 1999, Disability Services Act 2006, District Court of Queensland Act 1967, Evidence Act 1977, Penalties and Sentences Act 1992, Police Powers and Responsibilities Act 2000, Private Employment Agents Act 2006, Transport Operations (Passenger Transport) Act 1994, Vicious Lawless Association Disestablishment Act 2013, Working with Children (Risk Management and Screening) Act 2000* and *Youth Justice Act 1992* as a consequence of the changes to the Criminal Code.

# Alternative ways of achieving policy objectives

There are no alternative ways of achieving the policy objectives of the Bill.

# Estimated cost for government implementation

The costs to government associated with implementation of amendments in the Bill will be minimal and met from existing budget allocations.

# Consistency with fundamental legislative principles

- **Disclosing confidential information**

Clauses 25, 31 and 36 may be seen as breaching the principle that legislation must have sufficient regard to individual's rights and liberties as they enable disclosure of personal information in limited circumstances. However, appropriate safeguards have been included to safeguard personal information.

Clause 25 inserts new section 150A to the Hospital and Health Boards Act to enable more efficient disclosure of confidential patient information for research purposes. Mechanisms will remain in place to ensure confidential information is dealt with appropriately. The designated person under the Hospital and Health Boards Act must only release confidential information if the relevant chief executive has approved the research, the disclosure is for research purposes, the disclosure is to a researcher, the patient has impaired capacity for consenting to participation in the research and the researcher has obtained consent for the patient's participation in the research from the tribunal under the Guardianship and Administration Act or another person authorised under a law to make decisions for the patient, for example, where applicable, a statutory health attorney for an adult's health matter under the Powers of Attorney Act.

Clause 31 inserts new division 4 into part 7 of the Hospital and Health Boards Act to facilitate GPs accessing The Viewer. This provision will enable GPs to access confidential patient information and allow further categories of health practitioners and information systems to be prescribed in future.

The Bill provides that it is an offence for a prescribed health practitioner to access information about an individual contained in a prescribed information system unless the information is necessary to facilitate care or treatment of the individual or accessed incidentally. The inclusion of the reference to incidental access ensures that prescribed health practitioners do not inadvertently commit an offence by accessing information in the patient record that while not strictly related to the patient, is incidental to information necessary to facilitate care or treatment of the individual, for example, the patient's family history.

The Bill further provides that it is an offence to access a prescribed information system contrary to any conditions prescribed by regulation. Conditions prescribed by regulation may include, but not be limited to, the health practitioner not accessing information relating to a person to whom the health practitioner has not provided care or treatment and access being subject to a direction by the patient to whom the information relates that no health practitioner can access the information. GP activity in The Viewer will be recorded and audited to ensure these conditions are met. The system will also require the health practitioner to search by a unique identifier, such as the patient's Medicare number.

The amendment also provides that it is an offence for prescribed health practitioners to disclose confidential information, either directly or indirectly, unless the disclosure is required or permitted under the Hospital and Health Boards Act.

Clause 36 inserts new chapter 5, part 4 to the Public Health Act to support the School Immunisation Program and School Dental Program by enabling school health program providers to access the information of all students enrolled in a cohort.

The type of information being disclosed under the provision is, for the most part, the same information included on the consent form, which the provider would have access to. Hospital and Health Services who deliver the programs directly are considered a *health agency* under the Information Privacy Act and are therefore bound to comply with the National Privacy Principles in discharging their obligations in relation to disclosure of information by schools. Some external immunisation providers, such as Brisbane City Council, may be an *agency* under the Information Privacy Act, and therefore bound to comply with the Information Privacy Principles. Others may be bound to comply with the Information Privacy Act by virtue of their contract with the Hospital and Health Services. However, to ensure that all external providers, as contracting agencies to Hospital and Health Services, are bound to comply with the privacy principles in discharging their obligations, the Information Privacy Act will be deemed to apply to a school health program provider that is not an *agency* under section 18 of the Information Privacy Act or a *health agency* under schedule 5 of the Information Privacy Act.

The Department intends to update the consent forms for the 2017 school year to clearly advise parents that their information may be disclosed to the approved provider. The consent process will also be updated to enable parents to indicate that they do not want their child immunised or to attend the oral health clinic; Hospital and Health Services will direct providers not to follow up these families.

- **Matters to be prescribed in regulation**

Clauses 14, 31 and 36 may be seen as breaching the principle that legislation must have sufficient regard to the institution of Parliament as they enable matters to be prescribed by regulation.

The amendments made by clauses 14 and 31 enable relevant health practitioners and information systems to be prescribed under a regulation for the purpose of granting access to an information system. It is initially intended to prescribe GPs under the Hospital and Health Boards Regulation for the purposes of accessing prescribed information systems. It is intended to prescribe The Viewer as an information system.

The Bill provides that a prescribed health practitioner must comply with all conditions prescribed by regulation in relation to accessing a prescribed information system. Conditions prescribed by regulation may include, but not be limited to, the health practitioner not accessing information relating to a person to whom the health practitioner has not provided care or treatment and access being subject to a direction by the patient to whom the information relates that no health practitioner can access the information.

Prescribing relevant health practitioners, information systems and related conditions in a regulation is justified in this instance. Prescribing health practitioners in the Hospital and Health Boards Regulation will provide sufficient flexibility to grant access to additional categories of health practitioners in the future, if this is identified as being necessary to facilitate further information-sharing between Hospital and Health Services and external health practitioners. Prescribing information systems in the Hospital and Health Boards

Regulation will ensure that this provision can be used for other information systems in the future, if it is identified that health practitioners require access to other Queensland Health information systems.

Prescribing conditions of access in the Hospital and Health Boards Regulation will allow conditions to be amended or added to ensure that access is managed appropriately. This approach will allow the Government to respond promptly and flexibly if changes are needed to the framework in future, while ensuring any changes to the matters prescribed under the Hospital and Health Boards Regulation are subject to Ministerial oversight and also tabled and subject to parliamentary scrutiny.

Clause 36 provides that for carrying out a function under the school health program, the school health program provider may ask the school principal to provide information, including the name and date of birth of a student, the name, telephone number, email address and postal address of a parent or guardian of a student, and any other information prescribed by regulation about a student. It is expected that information prescribed by regulation may include the gender of the student, which class or group they are attached to, the languages spoken at the student's home and the student's indigenous status.

It is appropriate for further student information to be prescribed by regulation, as this is a matter of detail that may be subject to change. Allowing information to be prescribed by regulation will allow additional types of information to be added in future if it is identified that different information is required by providers to support the school health programs.

- **New offences**

Clause 18 provides that a prescribed health practitioner must not directly or indirectly disclose confidential information to another person unless required or permitted under the Hospital and Health Boards Act. The maximum penalty for committing an offence under this provision is 600 penalty units.

Clause 31 provides that it is an offence for a prescribed health practitioner to access information about an individual unless the information is necessary to facilitate care or treatment of the individual or accessed incidentally. The maximum penalty for committing an offence under this provision is 600 penalty units.

Clause 31 also imposes conditions on the prescribed health practitioner's access of the prescribed information system, which are prescribed by regulation.

The maximum penalty for a designated person breaching the duty of confidentiality under part 7 of the Hospital and Health Boards Act is 100 penalty units. The higher penalties for prescribed health practitioners are justified on the basis that prescribed health practitioners such as GPs are not subject to equivalent control or oversight by Queensland Health as designated persons. For this reason, greater incentive to comply is thought to be required to ensure private information is protected. The penalties are also comparable to the civil penalties in section 59 the *My Health Records Act 2012* (Cwlth) for unauthorised collection, use and disclosure of health information included in a healthcare recipient's My Health record. These offence provisions will ensure appropriate protection of individuals' health information.

While prescribed health practitioners will be subject to a penalty for breaching a prescribed condition, as outlined above, any changes to the conditions prescribed under the Hospital and Health Boards Regulation will be subject to Ministerial oversight and also tabled and subject to parliamentary scrutiny. Prescribed health practitioners will be required to accept terms and conditions of use each time they access a prescribed information system, ensuring that they are aware of their legal obligations, including the conditions of access and penalties for misusing the system. If conditions are added or amended in future through the Hospital and Health Boards Regulation, prescribed health practitioners would receive notification of the change in conditions and be required to confirm that they have accepted the new/amended conditions before accessing the system.

# Consultation

- **Criminal Code**

A panel of health experts and relevant organisations met on 16 May 2016 to consider the implications of amending the Criminal Code to standardise the age of consent for sexual intercourse to 16 years. The panel recommended standardising the age of consent to 16 years and replacing references to sodomy with anal intercourse.

The Legal Aid Queensland Public Defender, Queensland Law Society, Bar Association of Queensland, Aboriginal and Torres Strait Islander Legal Service, Lesbian Gay Bisexual Trans Intersex Legal Service Inc, Director of Public Prosecutions, the Chief Magistrate, the Chief Judge of the District Court, the Chief Justice of the Supreme Court and the President of Court of Appeal were consulted on the draft amendments to the Criminal Code. No issues were raised with the proposed amendments.

- **Access to information systems by general practitioners**

Requests to enable GPs to access to The Viewer have been received via the General Practice Liaison Officers, the Queensland Clinical Senate (the peak representative body of health clinicians across Queensland) and by Primary Health Networks on behalf of GPs.

A Wait Times Summit was held on 29 April 2015 and reconvened on 7 October 2015 to address the issue of wait times through the patient journey. The proposal to provide GPs with access to The Viewer was considered as part of the Summit. Summit participants included representatives from Health Consumers Queensland, The Royal Australian College of General Practitioners – Queensland Faculty, the Australian Medical Association Queensland and various Primary Health Networks including Greater Metro South Primary Health Network and Brisbane North Primary Health Network. Participants of the Wait Times Summit endorsed the recommendation to provide GP access to The Viewer. The Queensland Clinical Senate was consulted further in relation to this proposal and was strongly supportive.

Hospital and Health Services were consulted in relation to this proposal. The feedback received was supportive of the amendments.

The Office of the Information Commissioner (OIC) was consulted in relation to the privacy aspects of the proposal. OIC supports the policy intent of the proposal, while noting that it

will create a privacy vulnerability that did not exist previously. OIC supports the proposed safeguards to ensure patients' personal information is protected.

- **Disclosure of patient data for research purposes**

The amendments to facilitate disclosure of patient data for research purposes have been progressed at the request of the Australian Medical Association Queensland. The Australian Medical Association Queensland and researchers have been consulted and their feedback has been reflected in the Bill.

Hospital and Health Services were consulted in relation to this proposal. The feedback received was supportive of the amendments.

OIC was consulted in relation to the privacy aspects of the proposal. No significant privacy implications were identified.

- **Deceased patient data**

Hospital and Health Services were consulted in relation to this proposal. No feedback was received in relation to this proposal.

OIC was consulted in relation to the privacy aspects of the proposal. OIC noted that care should be taken when handling the information of the deceased, as it may also be the personal information of the living, for example, a family member. The disclosure of this information will continue to be subject to the stringent requirements of the Public Health Act, including privacy considerations.

- **Disclosure of student information to support the School Immunisation Program and School Dental Program**

Targeted consultation with Independent Schools Queensland, the Queensland Catholic Education Commission and state school principal and school administrator associations has been undertaken in relation to the disclosure of student information.

No feedback was received from the state school sector. Independent Schools Queensland and the Queensland Catholic Education Commission support the proposal in-principle, but explained that disclosure of student information would be a shift in practice for school principals. The Department of Health will work with schools to ensure implementation issues are addressed.

Hospital and Health Services were consulted in relation to this proposal. The feedback received was supportive of the amendments.

OIC was consulted in relation to the privacy aspects of the proposal. No significant privacy concerns were identified.

- ***Queensland Institute of Medical Research Act 1945***

QIMR has been consulted and supports the amendments to the Queensland Institute of Medical Research Act.

- **Minor and consequential amendments**

There was no consultation external to Government on the other amendments in the Bill as they are technical or consequential in nature.

# Consistency with legislation of other jurisdictions

- **The Criminal Code**

With the exception of Queensland, all other Australian states and territories provide an equal age of consent for all sexual activity. In New South Wales, Victoria, Western Australia, the Northern Territory and the Australian Capital Territory the age of consent for all sexual activity is 16 years of age. The standard age of consent for sexual activity in Tasmania and South Australia is 17 years. The amendments to the Criminal Code standardising the age of consent to 16 years will therefore provide greater consistency with legislation in other Australian jurisdictions.

- **Access to information systems by general practitioners**

It is understood Queensland will be the first Australian jurisdiction to legislate to enable GPs to access patient information via a public sector health database. The amendments will also enable further categories of health practitioners and information systems to be prescribed in future, where access is to facilitate the care or treatment of an individual. The amendments will improve health care in Queensland by facilitating information-sharing, ensuring patients receive consistent, timely and better coordinated care.

- **Disclosure of patient data for research purposes**

The amendments to enable more efficient disclosure of confidential patient information for research purposes will address an issue specific to Queensland's legislative framework, and are not uniform with or complementary to legislation of the Commonwealth or another state or territory.

- **Deceased patient data**

The amendment to the Public Health Act to clarify the meaning of *health information held by a health agency* addresses an issue specific to the State of Queensland.

- **Disclosure of student information to support the School Immunisation Program and School Dental Program**

It is understood a number of other jurisdictions allow immunisation and oral health providers to access student information.

In 2013, Victoria amended the *Public Health and Wellbeing Regulations 2009* to enable secondary school principals to share student information with school immunisation providers which, in Victoria, is undertaken by local councils. Information able to be disclosed includes the student's name, the name of their parent or guardian and the parent or guardian's

telephone number, email address and postal address.

In Tasmania, local councils deliver school based immunisation programs under the *Public Health Act 1997* (Tas), which provides that a local council may require a person to provide information relating to public health which is reasonably needed for the purposes of the Act. This enables local councils to require schools to provide student information for the purposes of a school based immunisation program.

In Western Australia, the Department of Health and Department of Education share the information of state school students for the purposes of providing school immunisation services, with the Department of Education electronically downloading enrolment data for the Department of Health to use. Non-state schools share their class lists directly with nurses. The Department of Education also shares student information with the Department of Health for the purposes of the school dental program.

The Northern Territory has administrative arrangements in place for the sharing of student information for the school immunisation program. Schools share student information with school nurses, who are employed by the Department of Health to work in schools.

New South Wales, South Australia and the Australian Capital Territory have no legislation in place to provide for sharing of student information to support immunisation or school dental programs.

- ***Queensland Institute of Medical Research Act 1945***

Research institutions in other jurisdictions are able to make distributions to inventors without Governor in Council approval. Under the *Garvan Institute of Medical Research Act 1984* (NSW), Board approval is not required irrespective of the size of the payment to inventors. Any distributions that do occur are reported to the Finance, Risk and Audit committee for noting.

The Walter and Eliza Hall Medical Research Institute has an internal royalty policy that mandates the distributions to inventors. Distributions are uncapped. Any distribution to staff requires board approval and the Walter and Eliza Hall Medical Research Institute has a commercialisation committee to oversee key activities.

# Notes on provisions

## Part 1 Preliminary

### Short title

*Clause 1* provides that, when enacted, the short title of the Act will be the *Health and Other Legislation Amendment Bill 2016.*

## Part 2 Amendment of Criminal Code

### Code amended

*Clause 2* provides that part 2 amends the Criminal Code.

### Amendment of s 6 (Carnal knowledge)

*Clause 3* amends section 6(2) to omit the term *sodomy* and replace it with the term *anal intercourse*. The change of terminology from sodomy to anal intercourse is not intended to alter in any way the existing meaning or effect of section 6.

### Omission of s 208 (Unlawful sodomy)

*Clause 4* omits section 208 (Unlawful sodomy).

### Amendment of s 213 (Owner etc. permitting abuse of children on premises)

*Clause 5* makes consequential amendments to section 213 (Owner etc. permitting abuse of children on premises). Section 213 subsections (1) and (3)(a) are amended to omit reference to section 208 and update the provision to acknowledge that 16 years is the age of consent for all sexual conduct.

Subsections (4) and (6) are omitted from section 213 to reflect that 16 years is the age of consent for all sexual conduct.

Subsection (5) is renumbered as subsection (4) as a consequence of the omission of subsection (4).

### Amendment of s 215 (Carnal knowledge with or of children under 16)

*Clause 6* makes a consequential amendment to section 215 (Carnal knowledge with or of children under 16) to omit subsection (6), which defines *carnal knowledge* for the purpose of the section to exclude sodomy. This amendment ensures that carnal knowledge takes the meaning set out in section 6, that is, that it includes anal intercourse.

### Amendment of s 216 (Abuse of persons with an impairment of mind)

*Clause 7* makes consequential amendments to section 216 (Abuse of persons with an impairment of the mind).

Subclause (1) inserts the words *with or* into subsection (1) to extend the section 216 offence to persons who have or attempt to have unlawful carnal knowledge *with* a person with an impairment of the mind in addition to persons who have or attempt to have unlawful carnal knowledge *of* a person with an impairment of the mind. This will ensure that the section 216 offence encompasses conduct in relation to a person with an impairment of the mind, previously captured under section 208(1)(c) and (d) where the offender sodomises a person or permits the person to sodomise him or her.

This amendment also corrects an anomaly in section 216 with regard to the abuse of persons with an impairment of the mind by ensuring that where a person has or attempts to have unlawful carnal knowledge *with* a person with an impairment of the mind, that person is culpable under section 216(1). This ensures that section 216(1) is consistent with other provisions that have the effect of criminalising sexual conduct against persons with an impairment of the mind, including sections 215(1) and (4A); 216(2)(c) and 222.

Subclause (2) omits subsection (5), which defines *carnal knowledge* for the purpose of the section to exclude sodomy. This amendment ensures that carnal knowledge takes the meaning set out in section 6, that is, that it includes anal intercourse.

## Amendment of s 219 (Taking child for immoral purposes)

*Clause 8* makes consequential amendments to section 219 (Taking child for immoral purposes). Section 219 subsections (1) and (3)(a) are amended to omit reference to section 208 and update the provision to acknowledge that 16 years is the age of consent for all sexual conduct.

Subsections (4) and (6) are omitted from section 219 to reflect that 16 years is the age of consent for all sexual conduct.

Subsection (5) is renumbered as subsection (4) as a consequence of the omission of subsection (4).

## Amendment of s 229B (Maintaining a sexual relationship with a child)

*Clause 9* makes consequential amendments to section 229B (Maintaining a sexual relationship with a child). Section 229B subsections (1), (5) and (10) are amended to omit reference to section 208 and update the provision to acknowledge that 16 years is the age of consent for all sexual conduct.

## Amendment of s 578 (Charge of offence of a sexual nature)

*Clause 10* makes consequential amendments to section 578 (Charge of offence of a sexual nature). Subsections (1), (1A) and (4) reflect the omission of section 208.

## Amendment of s 636 (Evidence of blood relationship)

*Clause 11* makes a consequential amendment to section 636 (Evidence of blood relationship) to omit reference to section 208.

### Amendment of new pt 9, ch 95

*Clause 12* inserts new part 9, chapter 95 into the Criminal Code, which provides the transitional provisions for the *Health and Other Legislation Amendment Act 2016.*

## Part 3 Amendment of Hospital and Health Boards Act 2011

### Act amended

*Clause 13* specifies that this part amends the *Hospital and Health Boards Act 2011*.

### Amendment of s 139 (Definitions for pt 7)

*Clause 14* omits existing definitions of *confidential information* and *designated person* and inserts definitions for *confidential information, prescribed health practitioner*, *prescribed information system* and *relevant health practitioner* for the purposes of part 7 of the Act.

*Confidential information* is defined to include information accessed by a prescribed health practitioner under section 161C(2). This ensures that information accessed by a prescribed health practitioner under section 161C(2) is treated as confidential information for the purposes of part 7 of the Act.

*Prescribed health practitioner* is defined to mean a relevant health practitioner, other than an individual who is currently a designated person under new section 139A(1), who is prescribed by regulation, or a person who was formerly a relevant health practitioner mentioned above. *Relevant health practitioner* is defined as an individual who is registered under the Health Practitioner Regulation National Law to practise a health profession, other than a student. These definitions mean that the categories of health practitioners who can access prescribed information systems can be limited through regulation. The provision will enable GPs to be prescribed under the Hospital and Health Boards Regulation.

*Prescribed information system* is defined to mean an information system prescribed by regulation. This will allow The Viewer to be prescribed under the Hospital and Health Boards Regulation, and allow other information systems to be prescribed in future as necessary.

Clause 14 also inserts a reference to the definition of *designated person* under section 139A.

### Insertion of new s 139A

*Clause 15* inserts new section 139A, which moves the definition of *designated person*. The existing definition is restructured to clarify at subsection (2) that a designated person includes a person who was formerly a person under subsection (1).

### Insertion of new pt 7, div 2, sdiv1, hdg

*Clause 16* inserts a heading for new part 7, division 2, subdivision 1 (Prohibited disclosure of confidential information).

## Amendment of s 142 (Confidential information must not be disclosed)

*Clause 17* amends section 142 to insert 'by designated persons' into the heading and to insert 'or a prescribed health practitioner' in section 142(2) after 'designated person', to separate the duty of confidentiality for designated persons from the new duty of confidentiality for prescribed health practitioners in new section 142A.

## Insertion of new s 142A and pt 7, div 2, sdiv 2, hdg

*Clause 18* inserts new section 142A, which provides a duty of confidentiality for prescribed health practitioners. Subsection (1) provides that a prescribed health practitioner must not directly or indirectly disclose confidential information to another person unless the disclosure is required or permitted under the Hospital and Health Boards Act. This offence carries a maximum penalty of 600 penalty units.

Subsection (2) provides that the duty not to disclose confidential information to another person includes another prescribed health practitioner or a designated person.

Subsection (3) further provides that the duty of confidentiality remains in place even if the person who could be identified from the disclosure of confidential information is deceased.

Clause 18 also inserts a heading for new part 7, division 2, subdivision 2 (Permitted disclosure of confidential information).

## Amendment of s 143 (Disclosure required or permitted by law)

*Clause 19* inserts section 143(2)(e) to provide that giving a prescribed health practitioner access to a prescribed information system under section 161C is a disclosure permitted by an Act. This makes clear that a designated person does not commit an offence under section 142 by enabling a prescribed health practitioner to access a prescribed information system.

Clause 19 also inserts new subsection 143(3), which provides that a prescribed health practitioner may disclose confidential information if the disclosure is required or permitted by an Act or law.

## Amendment of s 144 (Disclosure with consent)

*Clause 20* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 144.

## Amendment of s 145 (Disclosure of confidential information for care or treatment of person)

*Clause 21* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 145.

### Amendment of s 146 (Disclosure to person who has sufficient interest in health and welfare of person)

*Clause 22* inserts 'or prescribed health practitioner' after 'designated person' in section 146(1) to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 146.

### Amendment of s 147 (Disclosure to lessen or prevent serious risk to life, health or safety)

*Clause 23* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 147.

### Amendment of s 148 (Disclosure for the protection, safety or wellbeing of a child)

*Clause 24* amends section 148 to allow prescribed health practitioners to disclose confidential information if the disclosure is to a person for the protection, safety or wellbeing of a child and the confidential information relates to someone other than the child.

The Bill inserts additional requirements for prescribed health practitioners seeking to disclose confidential information under section 148. Existing section 147 provides for disclosure in similar circumstances, relating to lessening or preventing serious risk to life, health or safety, and includes a requirement that the relevant chief executive must believe on reasonable grounds that the disclosure is necessary to lessen or prevent serious risk to life, health or safety and must authorise the disclosure in writing.

Clause 24 inserts similar requirements for section 148 in relation to disclosure by prescribed health practitioners. It is expected that information accessed by a prescribed health practitioner through a prescribed information system that raises issues relating to the protection, safety or wellbeing of a child will be information available to Queensland Health staff and is likely to have already been actioned internally. To ensure prescribed health practitioners do not unnecessarily disclose information relating to a situation already being dealt with by Queensland Health staff, it is appropriate for the relevant chief executive to exercise oversight over disclosure by a prescribed health practitioner and consider the request for disclosure in the first instance. It is not expected that these requirements would significantly delay disclosure by a prescribed health practitioner in these circumstances.

### Insertion of new s 150A

*Clause 25* inserts new section 150A, which provides an exception to the duty of confidentiality in section 142 where disclosure of confidential information will support a research project, and an adult patient is unable to consent to the disclosure of confidential information because of their impaired capacity.

New section 150A(1) provides that the section applies where the relevant chief executive gives a researcher written approval to carry out research, to ensure that authorisation to commence the project has been obtained by the relevant chief executive (that is, the chief executive of the department or a Hospital and Health Service chief executive) in accordance

with the administrative requirements within Queensland Health outlined under 'Policy objectives'. The reference to the relevant chief executive's written approval to carry out the research does not relate to ethics approval by a Human Research Ethics Committee or another review body—this is a separate approval process that must be satisfied by the researcher before the relevant chief executive considers and, by way of the 'written approval' referred to in the section, authorises the project as part of the research governance review.

Subsection (2) provides that a designated person may disclose confidential information about a person, the participant, for the purpose of conducting research if:

- the disclosure is to the researcher—that is, the disclosure does not have to be to another designated person
- the participant is an adult who has impaired capacity for consenting to participation in the research, and
- the tribunal under the Guardianship and Administration Act or another person authorised under a law to make decisions for the participant consents to the participant's participation in the research.

The Bill provides an example of a statutory health attorney for an adult's health matter under the Powers of Attorney Act as another person authorised under a law to make decisions for the participant. Section 63 of the Powers of Attorney Act sets out the statutory health attorney framework, by providing that a statutory health attorney for a *health matter* (defined in schedule 2 of the Guardianship and Administration Act) includes, generally, a spouse, carer, close friend or relation, or if none of these people are readily available and culturally appropriate to exercise power for a matter, the public guardian. This framework does not apply in every instance—section 72 of the Guardianship and Administration Act applies where research is considered a *special health matter*, and provides that only the tribunal may consent to the person's participation in special medical research or experimental health care.

Subsection (3) defines the terms *impaired capacity* and *research* for the purposes of new section 150A. *Impaired capacity* is defined by reference to the Guardianship and Administration Act definition, and *research* is defined by reference to the definition in section 280 of the *Public Health Act 2005*.

### Amendment of s 154 (Disclosure to or by relevant chief executive)

*Clause 26* inserts 'or prescribed health practitioner' after 'designated person' in subsection (1) to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 154.

### Amendment of s 155 (Disclosure to health practitioner registration board)

*Clause 27* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 155.

## Amendment of s 156 (Disclosure to health ombudsman)

*Clause 28* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 156.

## Amendment of s 157 (Disclosure to person performing functions under Coroners Act 2003)

*Clause 29* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 157.

## Amendment of s 159 (Disclosure to Australian Red Cross Society)

*Clause 30* inserts 'or prescribed health practitioner' after 'designated person' to allow prescribed health practitioners to disclose confidential information in the circumstances outlined in section 159.

## Insertion of new pt 7, div 4

*Clause 31* inserts new part 7, division 4, which provides for an exception to the duty of confidentiality in new section 142A for access by prescribed health practitioners to confidential information.

New section 161C(1) provides that a prescribed health practitioner may access a prescribed information system.

Subsection (2) provides that a prescribed health practitioner must not access information contained in a prescribed information system unless the information is necessary for the prescribed health practitioner to facilitate the care or treatment of an individual or accessed incidentally. A maximum penalty of 600 penalty units applies to this offence. This requirement is in place to ensure that prescribed health practitioners do not inappropriately access information contained in a prescribed information system where the information is not necessary to facilitate the care or treatment of their patient. However, to ensure that prescribed health practitioners do not inadvertently commit an offence by accessing information in the patient record that while not strictly related to the patient, is incidental to information necessary to facilitate care or treatment of the individual, for example, the patient's family history, the offence provides for incidental access to information.

Subsection (3) provides that a prescribed health practitioner must comply with all conditions prescribed by regulation in relation to accessing a prescribed information system and any information contained in the system. A maximum penalty of 600 penalty units applies. This enables conditions on accessing the information system to be prescribed in the Hospital and Health Boards Regulation including, for example, that the health practitioner must not access information for persons to whom the health practitioner has not provided care or treatment and access being subject to a direction by the patient to whom the information relates that no health practitioner can access the information.

### Amendment of sch 2 (Dictionary)

*Clause 32* inserts cross-references to the definitions of *prescribed health practitioner*, *prescribed information system* and *relevant health practitioner* into the dictionary, to provide that these definitions can be found at section 139 for part 7 of the Act.

## Part 4 Amendment of Public Health Act 2005

### Act amended

*Clause 33* specifies that this part amends the *Public Health Act 2005.*

### Amendment of s 158 (Definitions for ch 5)

*Clause 34* amends section 158 to replace the definition of *recognised immunisation provider* with *recognised vaccination provider.*

### Amendment of s 160A (Definitions for div 1AA)

*Clause 35* amends section 160A to replace the definition of *recognised immunisation provider* with *recognised vaccination provider*.

Clause 35 also amends the definitions of *immunisation history statement* and *immunisation status "up to date"* to reflect changes in terminology under the *Australian Immunisation Register Act 2015* (Cwlth).

### Insertion of new ch 5, pt 4

*Clause 36* inserts new chapter 5, part 4, which provides for the disclosure of information to support school health programs.

New section 213AA provides for definitions in relation to part 4.

*Health service* is defined by reference to section 15 of the Hospital and Health Boards Act.

*Health service chief executive* is defined by reference to section 33 of the Hospital and Health Boards Act.

*School health program* is defined in relation to students of a school, to mean a program carried out for the purpose of providing a dental health service or an immunisation health service for the students. This definition captures the School Dental Program and School Immunisation Program.

*School health program provider* is defined in relation to a school health program, to mean a Hospital and Health Service, or an entity engaged by a Hospital and Health Service that carries out the school health program. This definition provides that only a Hospital and Health Service or an entity engaged by a Hospital and Health Service is a school health program provider for the purposes of disclosure of student information under part 4.

*School principal* is defined to include a delegate of the school principal.

*Service* is defined to mean a Hospital and Health Service established under section 17 of the Hospital and Health Boards Act.

*Student* is defined in relation to a school to mean a child who is enrolled in the school.

New section 213AB provides that part 4 applies in relation to a school health program provider carrying out, or preparing to carry out, a school health program for students. A school health program is carried out not only where a program is physically carried out on the students' school grounds, for example, by way of a mobile dental van parked at the school, but also where students are provided with a dental health service or an immunisation health service at a neighbouring school or at a clinic located within a Hospital and Health Service.

New section 213AC provides requirements for the health service chief executive to identify the relevant school health program provider.

Subsection (1) provides that if the school health program provider is a Hospital and Health Service, the health service chief executive of the Hospital and Health Service must give the school principal a written notice stating that the Hospital and Health Service is the school health program provider. Subsection (2) provides that if the school health program provider is an entity engaged by a Hospital and Health Service, the health service chief executive of the Hospital and Health Service must give the school principal a written notice stating that the entity is the school health program provider. These requirements will ensure that a school principal knows who the school health program provider is for the purposes of disclosing student information.

New section 213AD provides that for carrying out a function under the school health program, the school health program provider may ask the school principal to provide information, including the name and date of birth of a student, the name, telephone number, email address and postal address of a parent or guardian of a student, and any other information prescribed by regulation about a student. It is expected that information prescribed under a regulation may include the gender of the student, which class or group they are attached to, the languages spoken at the student's home and the student's indigenous status.

Subsection (2) provides that the school principal must, within a reasonable period, disclose the information requested by the school health program provider if the school principal receives, or has received, a written notice under section 213AC stating that the Hospital and Health Service or entity that requested the information is the school health program provider.

Subsection (3) provides that a school principal may refuse to disclose any information about the student if the school principal considers the disclosure is not in the best interests of the student. This will provide sufficient flexibility for the school principal to refuse to disclose information about vulnerable students (for example where students are under a protection order).

Subsection (4) provides if under subsection (3), the school principal refuses to disclose information about one or more students, the school principal must give the school health program provider a written notice stating how many students have had information withheld

for the school health program. This information will be used by school health program providers for reconciliation purposes.

New section 213AE provides that this section applies to a school health program provider that is not an agency under section 18 of the Information Privacy Act or a health agency under schedule 5 of the Information Privacy Act. To ensure that all student information is protected through application of the privacy principles, subsection (2) provides that for the purposes of the Information Privacy Act, chapter 2, part 4:

- the school health program provider is taken to be a bound contracted service provider, and
- the agreement to provide a school health program between the Hospital and Health Service and the school health program provider is taken to be a service arrangement, and
- the Hospital and Health Service is the contracting agency.

New section 213AF provides that a health service chief executive may delegate their functions under part 4 to an appropriately qualified employee of the Hospital and Health Service or health service employee employed in the department and working for the Hospital and Health Service.

### Amendment of sch 2 (Dictionary)

*Clause 37* amends schedule 2 to omit the definitions of *health service*, *health information held by a health agency* and *recognised immunisation provider*.

A new definition of *health information held by a health agency* is inserted to clarify that a reference to a person for the definition includes both living and deceased persons.

Clause 37 also inserts references to the definitions of *health service*, *health service chief executive, recognised vaccination provider, school health program*, *school health program provider, school principal, Service* and *student*.

## Part 5 Amendment of Queensland Institute of Medical Research Act 1945

### Act amended

*Clause 38* specifies that this part amends the *Queensland Institute of Medical Research Act 1945*.

### Replacement of s 19 (Bonuses to discoverers)

*Clause 39* amends section 19 to provide that the Queensland Institute of Medical Research Council may pay an amount, called a bonus, to successful discoverers or inventors working, or who have worked, as officers and employees or under the auspices of the Council. This provision enables the QIMR to pay bonuses to successful discoverers or inventors after they cease to work with, or under the auspices of the QIMR, including to their estates after they are deceased.

Subsection (2) makes clear that the bonus does not include salary or allowances, if any have been paid to the discoverer or inventor.

Subsection (3) provides that if the Queensland Institute of Medical Research Council intends to pay a bonus and the total amount of bonuses paid in the financial year is more than $10 million before the payment is made or will be more than $10 million because of the payment, then subsection (4) applies.

Subsection (4) provides that before the Queensland Institute of Medical Research Council pays the bonus, they must obtain the approval of the Governor in Council.

## Part 6 Minor and consequential amendments

*Clause 40* specifies that schedule 1 amends the legislation it mentions.

## Schedule 1 Legislation amended

Schedule 1 makes consequential amendments to other legislation necessary to give effect to the changes to the Criminal Code.