Health Legislation Amendment Bill (No. 3) 2025

Consultation Paper

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Purpose

Queensland Health is seeking stakeholder feedback on proposed amendments to the:

- *Assisted Reproductive Technology Act 2024;*
- *Transplantation and Anatomy Act 1979*; and
- *Private Health Facilities Act 1999*.

This document is for **consultation purposes only** and does not represent Queensland Government policy.

Please provide any feedback on the proposed amendments by **5pm Thursday 11 September 2025**.

Your views are valuable and may be referred to in material provided to Government in considering the proposals and, if legislative amendments are progressed, may be referred to in public documents such as the explanatory notes for the Bill or material provided to a Parliamentary Committee.

If you have any questions or require further information about the proposed amendments, please send your queries to the email address below.

Feedback can be provided via email to legislationconsultation@health.qld.gov.au

Terms used in this paper

Term	Explanation
Ante-mortem intervention	A medical procedure that is carried out on a person to determine, maintain or improve the viability of tissue for transplantation.
ART	Assisted reproductive technology (services and procedures associated with procuring pregnancy).
ART provider	A business that provides ART services.
Australian Health Service Safety and Quality Accreditation Scheme (AHSSQAS)	The AHSSQAS sets out the responsibilities of accrediting agencies in relation to implementation of safety and quality standards, which includes (relevant to this paper) the: • National Safety and Quality Health Service Standards; and • National Safety and Quality Cosmetic Surgery Standards.
Designated Officer	The medical superintendent of a hospital and their appointed nominees (being medical practitioners), or appointed nominees of a person in charge of a hospital.
Donated embryo	An *embryo* that is donated after its creation for use by someone other than the *gamete* provider or their spouse.
Donated gamete	A *gamete* that is donated for use by someone other than the *gamete* provider or their spouse.
Donor-conceived	Refers to a person born as a result of a *donated gamete* or *donated embryo*.
Embryo	A human egg fertilised by human sperm.
Gamete	Human sperm or a human egg.
Life-sustaining measure	Health care intended to sustain or prolong life, for example assisted ventilation or artificial nutrition and hydration.
National Safety and Quality Health Service (NSQHS) Standards	The NSQHS Standards were developed by the Australian Commission on Safety and Quality in Health Care in collaboration with the Australian Government, states and territories, the private sector, clinical experts, patients and carers. The NSQHS Standards are available here: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition
Senior available next of kin	Defined in section 4 of the *Transplantation and Anatomy Act 1979* to mean: (a) in relation to a child—the first of the following persons who in the following order of priority, is reasonably available— 1. the spouse of the child; 2. a parent of the child; 3. a sibling, who has attained the age of 18 years, of the child; 4. a guardian of the child; and (b) in relation to any other person—the first of the following persons who, in the following order of priority, is reasonably available— 1. the spouse of the person; 2. a child, who has attained the age of 18 years, of the person; 3. a parent of the person; 4. a sibling, who has attained the age of 18 years, of the person.

Overview of proposed changes

It is proposed the Health Legislation Amendment Bill (No. 3) 2025 (Bill) will amend the:

- *Assisted Reproductive Technology Act 2024* to support the implementation of the regulatory framework for assisted reproductive technology services in Queensland by clarifying the application of certain provisions, promoting equitable outcomes and where appropriate, introducing a pathway for case-by-case decision-making so the administration of the Act does not result in undue hardship;
- *Transplantation and Anatomy Act 1979* to maximise opportunities for organ donation by providing clear authority for a person's next of kin to consent to interventions being undertaken before life-sustaining measures are withdrawn in certain cases, to better determine suitability and matching of organs for donation, and to improve viability of organs for transplantation; and
- *Private Health Facilities Act 1999 to:*
    - support the safe delivery of cosmetic surgery in Queensland by clarifying the head of power in the Act to allow a regulation to specify types of facilities or health services that must be accredited to relevant standards, such as the National Safety and Quality Cosmetic Surgery Standards; and
    - enable information sharing agreements with Queensland Government departments and entities about information collected under the Act.

Proposed changes to the *Assisted Reproductive Technology Act 2024*

Assisted reproductive technology (ART) refers to treatments or procedures that give people the possibility to have children when they may not otherwise have been able to, including those with fertility issues, genetic risks, and diverse genders and sexualities.

The *Assisted Reproductive Technology Act 2024* (ART Act) was passed by Queensland Parliament to protect the welfare and interests of the people who will use ART, and the people born as a result. The ART Act establishes a regulatory framework to provide greater oversight, transparency, and safeguards and prohibit certain unacceptable practices.

The regulatory framework is commencing in stages:

Stage one

- Has been in effect since **September 2024**.
- Introduced information collection and record keeping obligations alongside key prohibitions.

Stage two

- Proposed to commence on **1 March 2026**.
- Will implement remaining aspects of the regulatory framework, including licensing, event notification obligations, consent requirements, and additional prohibitions.

Donor conception information register

- Proposed to commence in stages in **2026**.
- Will establish the Donor Conception Information Register which will hold information about donors, donor-conceived people and the parent/s of donor-conceived people.

Since implementation of the ART Act started in September 2024, Queensland Health has received feedback from affected stakeholders and identified opportunities to improve the ART Act and better align the legislation with its objectives.

Broadly, the proposed changes seek to clarify the policy intent of the Act, promote equitable outcomes and where appropriate, introduce a pathway for case-by-case decision making so the administration of the ART Act does not result in undue hardship.

Information collection requirements

Background

The ART Act currently requires ART providers (fertility clinics) to collect a variety of information when obtaining gametes or before using gametes in an ART procedure. For all gametes, the following information is required in relation to the gamete provider:

- full name;
- date and place of birth;
- residential address;
- phone number;
- email address.

Donated gametes will require additional information, including:

- donor's ethnicity and physical characteristics;
- relevant medical history;
- sex and year of birth of each offspring, whether donor-conceived or not.

These collection requirements reflect the central importance of ART providers' role as a source of information, particularly for donor-conceived people, and will support the Donor Conception Information Register. It is for this reason that breach of these requirements is an offence with a maximum penalty of 200 penalty units ($33,380 for an individual, and five times that for a corporation).

Proposed changes

Streamline the contact information required, provide Queensland Health with the ability to give a case-by-case approval for use of gametes and clarify the application of the information collection and record keeping requirements.

Contact information requirements

It is proposed to replace the existing requirement to obtain a gamete provider's residential address, phone number, and email address under section 33 of the ART Act with a requirement to collect 'contact information.' For consistency, contact information will be defined to align with the existing definition for the Donor Conception Information Register outlined in section 40 of the ART Act, which refers to the person's residential address, phone number, email address, or any other way the person may be contacted.

ART providers, patients, and advocacy groups have raised concerns with the specific requirements in section 33, citing examples of where particular contact information, such as an email address, may be missing, prohibiting the use of the gamete in an ART procedure. This is creating unintended and harsh consequences for patients, particularly for those seeking to continue their family.

The above proposed change seeks to ensure ART providers' central role in collecting information about gamete providers, including contact information, continues, while balancing the impacts on patients where information is unavailable. Additionally, to support any change to the contact information

requirement, Queensland Health will develop detailed guidance for ART providers on minimum expectations of the types of information collected under section 33.

For consistency, the information collection requirements relating to people undergoing ART procedures (section 35) and the record keeping requirements relating to information about children born as a result of ART procedures (section 36) will also be amended to replace references to residential address, phone number, and email address with a requirement to collect contact information.

Case-by-case approval

In addition to amending the requirements for contact information, it is proposed to give the chief executive (Director-General of Queensland Health) the power to approve use of gametes where the information collection requirements cannot be met if satisfied there are reasonable grounds for using the gamete. This will balance the need to have appropriate information for people born as a result of ART against instances where administration of the ART Act may result in harsh consequences.

Some examples of exceptional cases raised by ART providers, patients, and advocacy groups include:

- a missing email address precluding a family from creating a genetic sibling for their child;
- a missing phone number preventing a person from starting their family using embryos created using their eggs and donor sperm 10 years ago; over that time their advanced reproductive age dramatically changed meaning fewer and lower quality eggs can be collected.

It is anticipated an approval would only be provided in limited circumstances and that the chief executive will consider the following types of factors, in addition to the individual context of the application:

- whether the ART provider has taken reasonable steps to collect the information;
- the information that has been collected, and where donor gametes are used, whether there is sufficient information to support the Donor Conception Information Register;
- whether being unable to use the chosen gametes would result in unfairly harsh outcomes for a person.

Clarification of application of information collection and record keeping requirements

Gametes are often obtained well in advance of the treatment or procedure they will be used in. Most of the genetic material in storage in Queensland is made up of gametes, or embryos created with gametes, obtained before the ART Act commenced. Donated gametes are also often obtained through overseas donor banks.

While Queensland Health advised ART providers to update their policies and processes to ensure compliance with the Act for gametes or embryos already in storage, it is necessary to put this requirement beyond doubt. It is also important that genetic material transferred between ART providers, including from overseas donor banks, is captured by the information collection requirements. These matters are particularly important in relation to donor gametes to support donor-conceived people.

It is proposed to amend the ART Act to explicitly reinforce the intent of the information requirements by stating these obligations apply to gametes or embryos in storage prior to the commencement of the ART Act and gametes or embryos transferred between ART providers.

Family limit – Case-by-case approval

Background

The family limit is one of the key restrictions in the ART Act which protects the welfare and interests of donor-conceived people. Once Stage 2 of the ART Act commences, it will be an offence where both of the following apply:

- an ART provider uses donated gametes or donated embryos in an ART procedure resulting in more than 10 donor-related Australian families; and
- the provider knew this would be the result or did not carry out the appropriate checks to determine whether the limit would be breached.

A maximum penalty of 400 penalty units ($66,760) applies for non-compliance.

The intent of the family limit is to protect donor-conceived people, particularly from the risk of consanguineous relationships and the psychosocial impacts of having many genetic siblings. This intent is not changing, and the 10-family limit will remain in place.

Status quo

The ART Act provides that for the purposes of the family limit, a *family* is defined as a parent, their spouse (if any), and their children. If a couple separates and one of the partners wishes to use the same donor in future, the effect of the Act is this would be counted as a separate family for the purposes of the family limit.

This may disproportionately impact female same sex couples because both partners can be a birth parent. For example, a same sex couple may have a child using donor sperm. Following a breakdown of the relationship, if one of the parents wished to have a further child using the same donor but the 10-family limit had been reached, the definition of *family* would result in this being treated as a separate family which would prohibit the parent from using this donor again, despite the potential psychosocial benefits to the existing donor-conceived child of having a sibling.

Proposed change

Provide the ability for Queensland Health to give a case-by-case approval for the use of gametes or embryos beyond the 10-family limit in exceptional circumstances.

It is proposed to give the chief executive the power to approve the use of donated gametes beyond the 10-family limit on a case-by-case basis, if satisfied there are reasonable grounds for doing so. All decisions will be underpinned by a robust decision-making process, including consideration of key matters outlined in the Act, to ensure the chief executive appropriately considers the circumstances of the individual application, differing perspectives on the family limit, and the impact of any approved use beyond the limit (including for existing and future donor-conceived people, prospective parent/s, and the donor).

In considering the application, the chief executive must be satisfied that the gamete provider has consented to the making of the application by the ART provider. Alternatively, if the ART provider has been unable to contact the gamete provider, the chief executive must be satisfied that the ART provider has taken reasonable steps to contact them.

Where a donor has explicitly withdrawn their consent, or only given consent to a lower family limit (for example, they have only consented to their gametes being used to create five families) a provider will need to demonstrate their attempts to contact the donor. Any refusal by the donor or inability to contact them will be a consideration in the decision-making process.

Providing a case-by-case approval will allow Queensland Health to exercise discretion if presented with a particular case where the application of the 10-family limit would result in unreasonable hardship. It is anticipated approvals would be by exception and only for cases of significant hardship.

Existing chief executive approvals

Background

There are existing powers in the ART Act for the chief executive to provide case-by-case approvals:

- section 27 enables the chief executive to approve the use of donated gametes or embryos beyond the 15-year time limit if satisfied there are reasonable grounds to do so;
- section 37 provides for the chief executive to authorise destruction of records on application by an ART provider;
- section 148 is a transitional provision which allows the chief executive to authorise the use of a donated embryo created before the ART Act if the use of that embryo is considered reasonable.

These approval powers provide an avenue for flexibility to exercise discretion and limit undue hardship that may occur in the administration of the ART Act while maintaining appropriate oversight of the use of genetic material and management of records.

Proposed change

Refine existing case-by-case approval powers to ensure the provisions align and operate effectively.

Noting the new case-by-case approval powers being introduced for information collection and the family limit, amendments are proposed to the existing case-by-case approval powers to ensure the provisions align where possible and to clarify the decision-making process. This includes setting out the relevant factors that must be considered when determining whether an approval should be granted for the use of donated gametes or embryos beyond the 15-year time limit. Further changes are being considered to section 27 during drafting of the Bill to ensure it operates effectively.

Consent requirements

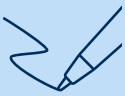
Background

Informed consent is an important part of healthcare. To reflect this, the ART Act sets out consent requirements that ART providers must comply with before undertaking a range of activities associated with ART. This includes requirements relating to the consent of gamete providers, including donors.

The existing consent provisions for donors additionally require the consent to include the maximum number of families that may be created with the donor's genetic material within the legislated 10-family

limit, and the maximum period of time that the donor's genetic material may be stored within the legislated 15-year time limit.

Proposed changes



Require ART providers to collect a gamete provider's written consent to obtain, or attempt to obtain, gametes.

Clarify that donor consent is not needed to the extent that case-by-case approval to use donated genetic material beyond the 10-family limit or 15-year time limit has been given.

It is proposed to amend the ART Act to specifically require a gamete provider's consent for obtaining or attempting to obtain their gametes. This will ensure there is a legislated requirement for consent to be obtained in writing before an ART provider carries out this important step in the ART process. By requiring this consent under the ART Act other protections will also apply, including record keeping requirements (section 36).

It is also proposed to clarify the consent requirements to support the case-by-case family limit approval process and the existing approval process for the time limit on use of donated gametes or embryos. Noting that these chief executive approval processes are for individual cases where there are reasonable grounds to go beyond the legislated limits, it is proposed to clarify that donor consent is not required to the extent the chief executive has given an approval relating to the family limit or time limit. This clarification will ensure these chief executive approvals operate as intended and can be granted if required to prevent undue hardship.

Clarification of transitional provisions

Background

The ART Act creates a new framework for an industry that was previously self-regulated in Queensland. 'Transitional provisions' were included in the Act to facilitate the transition to the new framework, noting there would be people who had already started their ART treatment prior to the Act commencing.

The transitional provisions were designed to enable this group to continue their ART treatment using their chosen donor, even if it would breach the family limit (section 25), time limit on use of donated gametes or embryos (section 27), or donor consent requirements (part 2, division 3).

Section 146 of the ART Act states that a 'person' who has been allocated donor gametes before commencement of the Act and had become pregnant with them may use the remaining donor gametes in future ART procedures. This reflects the fact that the person may already have a donor-conceived child using their chosen gamete donor, and that there may be psychosocial benefits to enabling that person to have another child using the same donor. Similarly, section 147 allows a 'person' to use a donated embryo if it was allocated to them before the Act's commencement.

The wording used in section 146 could exclude some people from completing their family by limiting its application to only the 'person' who was pregnant previously and excluding the person's spouse at the time the donated gametes were allocated. This creates a barrier for some couples, including a same sex couple where Person 1 carried the first pregnancy and Person 2 wishes to carry a subsequent pregnancy. Similarly, this could exclude a family using a surrogate, where they need to use a different surrogate for the subsequent pregnancy.

The unintended exclusion means that some people would face barriers to, or be potentially prevented from, completing their intended family using the same donor as any donor-conceived children or previous pregnancies.

Proposed change

Clarify the scope of the transitional provisions to better reflect diverse family structures and enable people who had started their ART treatment before commencement of the ART Act to complete their intended family.

It is proposed to amend the transitional provisions to broaden the wording to include family structures where the same person may not give birth each time. To achieve this, the application of the transitional provisions will be extended to the person's spouse at the time the donated gametes or donated embryos were allocated and to person's surrogate, where relevant…. This will make the application of these transitional provisions more inclusive and ensure equality of treatment.

Broader consideration is also being given during drafting of the Bill to the transitional provisions in the ART Act. New transitional provisions are being drafted to ensure the regulatory scheme operates as intended for ART services, procedures, and records that occurred or were created before the Act. The type of further transitional provisions being considered are listed in the working draft of the Bill. This list represents areas where it has been identified during implementation that the policy intent described during development of the ART Act may not be operating as expected or is not sufficiently specific. For example, under section 36, the policy intent was for all records, those created before 19 September 2025 and since, are required to be maintained. However, the Act may not be operating to achieve so further drafting is being considered.

Minor and technical amendments

Make minor and technical amendments to ensure the ART Act operates effectively.

Terminology

It is a requirement of Commonwealth legislation that all ART providers must be accredited under the Reproductive Technology Accreditation Committee's (RTAC) *Code of Practice for ART Units* (RTAC Code of Practice). The ART Act includes references to concepts in the RTAC Code of Practice to ensure consistency and alignment between the regulatory and accreditation frameworks. It also ensures Queensland Health can maintain appropriate regulatory oversight of key requirements under the RTAC Code of Practice.

Serious adverse events

The RTAC Code of Practice includes a list of serious adverse events that must be reported to RTAC by an ART provider if they occur. It includes technical and clinical matters including any event which:

- causes a significant medical or surgical condition that occurs as a result of ART treatment;
- results in the hospitalisation of a patient due to a complication of ART treatment;

- arises from a systemic failure in the validation or verification of a diagnostic test or technology that resulted in misdiagnosis or significant potential harm or loss to patients, their gametes or their embryos.

To align with this concept and ensure Queensland Health has appropriate oversight of serious adverse events, section 61 of the ART Act requires ART providers to notify Queensland Health of particular events, including serious adverse events. For the Act, *serious adverse event* is currently defined, for a licensed provider, as an event that is prescribed by regulation, or by the conditions of the provider's licence, as a serious adverse event.

To streamline the regulatory framework, it is proposed to update the definition of *serious adverse event* in the ART Act to refer to the relevant code of practice prescribed by regulation. The RTAC Code of Practice is intended to be prescribed by regulation. This will ensure transparency by requiring any events notified to RTAC to also be notified to Queensland Health. Although RTAC is currently the sole accrediting body recognised in Australia, this amendment also ensures that an equivalent code from an alternative accrediting body may be prescribed if one was established in future.

Personnel

The RTAC Code of Practice also requires ART providers to appoint personnel. This includes 'key personnel' such as a medical director, scientific director, nurse manager, and 'additional personnel' such as a clinical director, laboratory manager, and counsellor.

Key personnel are referred to in the ART Act for the licensing requirements, and the Act provides for key personnel to be prescribed by regulation.

It is proposed to replace references in the Act to 'key personnel' with references to 'personnel' as described within the relevant code of practice prescribed by regulation. This change will reflect the important on-site role of additional personnel while better reflecting the policy intent and aligning with accreditation requirements. As above, it is intended to prescribe the RTAC code of practice by regulation while providing flexibility if another accrediting body was established in future.

Cross-referencing error

Section 138 of the ART Act provides that in some cases, an offence committed by an ART provider will also be taken to have been committed by an executive officer within the corporation if they authorised or permitted the conduct or were knowingly concerned in the conduct. Relevant offences in which executive officers may be held responsible for their role are called 'deemed executive liability provisions.'

One of the offences which was intended to be a deemed executive liability provision is section 139(1) which prohibits a person from providing an official under the ART Act with false or misleading information. Due to a cross-referencing error, section 138 incorrectly references section 139(2) as a deemed executive liability provision even though it is not an offence.

It is proposed to make a minor correction to include section 139(1) of the ART Act as a deemed executive liability provision, allowing Queensland Health to hold chief executives accountable if they play a role in providing false or misleading information. To ensure the original policy intent of the provision is reflected, it is intended to include a transitional provision in the ART Act to clarify that section 138 as amended applies to any conduct that occurred between commencement of the original provision in September 2024 and the amendment being made.

Proposed changes to the *Transplantation and Anatomy Act 1979*

Background

Organ and tissue donation saves and improves lives, but it is only possible in about two percent of cases where a person dies in hospital, because specific criteria must be met for transplantation. In 2024, 96 people in Queensland donated their organs, with 273 Australians receiving a transplant as a result. It is critical to maximise every opportunity for organ donation.

The *Transplantation and Anatomy Act 1979* provides the legal framework for the donation of organs and tissue for use in transplantation. It provides the legal authority and consent processes that are necessary to enable donation of tissue, which includes organs for use in transplants.

Under the Transplantation and Anatomy Act, a person's next of kin (referred to in the Act as the *senior available next of kin*) can consent to removal of tissue from a deceased donor. For the purposes of organ donation, a person is considered deceased if their brain has irreversibly stopped functioning (brain death) or their heart has stopped beating and the blood has irreversibly stopped pumping around the body (circulatory death).

What is circulatory death?

Circulatory death usually occurs when a person is in an intensive care unit following a severe illness or injury they are unable to recover from, and the doctors, family and, in rare cases, the person, agree it is in the person's best interests to remove life-sustaining measures. Examples include:

- a person who has suffered a severe spinal injury where they cannot move or breathe unassisted;
- a person with terminal heart and lung failure;
- a person who suffers a severe brain injury resulting in a serious, permanent disability, but the person does not meet the definition of brain death.

Once there is medical consensus about end of life for a person through circulatory death, consent to withdraw life sustaining measures is obtained from a substitute decision-maker under the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. Following this, the possibility of organ donation is raised and further consent to organ donation can be obtained.

To facilitate organ donation, certain treatments and investigations (known as 'interventions') may need to be carried out on a potential donor to determine suitability for donation, enable organ matching with suitable recipients and maintain or improve organ function and viability.

Examples of interventions to support organ donation

- taking blood tests for organ function, matching tissue and screening for diseases;
- conducting x-rays, ultrasounds or CT imaging;
- administering medications to maintain blood pressure or to prevent blood clots;
- conducting specialised tests to examine the lungs.

For organ donation following brain death, because the potential donor is legally deceased but remains on life-sustaining measures, these interventions can be carried out after the certification of death.

For organ donation after circulatory death, the person remains legally alive until life-sustaining measures are withdrawn and their heart stops beating. Because organ donation is time sensitive, and the quality and viability of organs can rapidly deteriorate once life-sustaining measures are withdrawn, it is important that testing and supporting interventions are carried out before the withdrawal of life-sustaining measures and prior to the certification of death, to ensure the organs are as viable for transplantation as possible. As these interventions must occur while the person is still alive (**ante-mortem**), there is currently no clear legislative authority for consent to be given for these interventions.

Proposed changes

Enable consent to be given for ante-mortem interventions to be conducted on a potential donor to support suitability testing and organ viability for donation following circulatory death.

It is proposed to amend the Transplantation and Anatomy Act to provide a clear framework for consent to be given to conduct ante-mortem interventions on a potential donor to support organ donation following circulatory death.

Under the Transplantation and Anatomy Act, the *designated officer* (medical superintendent of a hospital or their nominee) can authorise the removal of tissue for donation after death. The proposed amendments will provide that the designated officer of a hospital can authorise ante-mortem interventions be conducted on a potential donor if:

- consent has been given by the appropriate decision-maker to withdraw life-sustaining measures; and
- consent to conduct ante-mortem interventions has been given either by the potential donor, if they have capacity, or the senior available next of kin.

Who is the senior available next of kin?

For an adult, in order of priority:

1. spouse;
2. child (if 18 years or older);
3. parent; or
4. sibling (if 18 years or older).

For a child, in order of priority:

1. spouse;
2. parent;
3. sibling (if 18 years or older); or
4. guardian.

It is important to note that the discussion and decision to withdraw life-sustaining measures occurs before, and is independent of, discussions about organ donation and possible ante-mortem interventions. The decision to withdraw life-sustaining measures must be made in accordance with Queensland legislation and good medical practice. Once this decision has been made, and the appropriate consent obtained, organ donation can then be discussed with the next of kin and consent to ante-mortem interventions sought. The potential donor would remain on life-sustaining measures while ante-mortem interventions are carried out.

Proposed changes to the *Private Health Facilities Act 1999*

Accreditation requirements for facilities providing cosmetic surgery

Background

The *Private Health Facilities Act 1999* provides the framework for protecting the health and wellbeing of patients receiving health services at private health facilities. In Queensland, private health facilities are referred to as private hospitals or day hospitals (section 8 of the Private Health Facilities Act).

All private health facilities are required to be licensed and hold accreditation under the Australian Health Service Safety and Quality Accreditation Scheme (AHSSQAS), which incorporates the National Safety and Quality Health Service (NSQHS) Standards (section 48 of the Private Health Facilities Act and section 8 of the *Private Health Facilities Regulation 2016*).

The Private Health Facilities Regulation lists a significant number of cosmetic surgery procedures that must be performed in a licensed and accredited facility, including abdominoplasty, breast augmentation or reduction, facelift, facial implants and rhinoplasty (section 3(2) of the Private Health Facilities Regulation).

In September 2022, Australian Health Ministers agreed to a range of actions to strengthen the national regulation of cosmetic surgery. As part of the reforms, the Australian Commission on Safety and Quality in Health Care (Commission) was asked to develop national standards for the safe delivery of cosmetic procedures. In December 2023, the Commission released the National Safety and Quality Cosmetic Surgery Standards (National Cosmetic Surgery Standards) to ensure patients receive safe, high-quality care in facilities where cosmetic surgery is performed.

It is proposed to require all private health facilities where cosmetic surgery is performed in Queensland to also be accredited to the National Cosmetic Surgery Standards. This will be achieved through future changes to the Private Health Facilities Regulation. However, before that can be done, it is necessary to ensure the Private Health Facilities Act contains the necessary head of power to apply the National Cosmetic Surgery Standards to those facilities that provide cosmetic surgery. The definition of what constitutes 'cosmetic surgery' will be set out in the Private Health Facilities Regulation. Stakeholders and industry will be separately consulted about the definitions of what will constitute 'cosmetic surgery' as part of the process for making changes to the Private Health Facilities Regulation.

Proposed changes

Clarify the head of power in the Act to allow the Private Health Facilities Regulation to specify types of facilities that must be accredited to relevant standards, such as the National Cosmetic Surgery Standards.

Currently, the Private Health Facilities Act and Private Health Facilities Regulation require all private health facilities to be accredited against the NSQHS Standards through compliance with the AHSSQAS. However, there is no head of power to provide that certain private health facilities that provide specific types of

procedures, such as cosmetic surgery, must be accredited to agreed standards, such as the National Cosmetic Surgery Standards.

It is proposed to amend the Private Health Facilities Act to clarify the head of power to ensure private health facilities that provide cosmetic surgery can be required to be accredited to the National Cosmetic Surgery Standards.

Information sharing agreements with Queensland Government entities

Background

The Private Health Facilities Act protects confidential information obtained under the Act and sets out when the information may be shared (section 147 of the Private Health Facilities Act). These requirements apply to information that:

- is personal health information, which is information about a person's health that identifies, or is likely to identify, the person; or
- would be likely to damage the commercial activities of the person to whom the information relates; or
- is contained in a written report about the person's criminal history under section 16 of the Private Health Facilities Act.

The Private Health Facilities Act provides that confidential information can be disclosed to the Commonwealth or another State under a prescribed agreement, if the chief executive is satisfied the giving of the information is in the public interest (section 147(4)(c) of the Private Health Facilities Act).

However, the Private Health Facilities Act does not allow the chief executive to disclose information to another Queensland government department or entity under a prescribed agreement. Instead, to give information to a Queensland government entity, the chief executive must authorise the disclosure of information if they believe the disclosure is in the public interest (section 147(3)(g) and (6) of the Private Health Facilities Act). If the chief executive authorises information being given to a Queensland government department or entity, the nature of the information and the purpose for which the information was given must be included in the Department of Health's annual report (section 147(9) of the Private Health Facilities Act). This imposes an administrative burden on the sharing of information and creates delays for disclosure of information to other Queensland government departments or entities.

Examples of information that has previously been shared with another Queensland government entity, as published in the annual reports of the Department of Health, includes:

- Queensland Police Service – for patients with firearm injuries in private hospitals, to assist in a strategic intelligence assessment product relating to illegal firearms in Queensland;
- Maritime Safety Queensland, Department of Transport and Main Roads – to undertake analysis of water transport injuries; and
- Department of Transport and Main Roads – to analyse clinical outcomes for patients with serious road crash injuries.

Other Queensland Health legislation allows for the sharing of information with a Queensland government entity under a prescribed agreement, for example:

- under the *Hospital and Health Boards Act 2011*, confidential information can be shared with an entity of the State under a prescribed agreement (section 151(1)(b) of the Hospital and Health Boards Act); and
- under the *Public Health Act 2005*, confidential information can be shared with an entity of the State under a prescribed agreement (sections 84(1)(b), 226(1)(b), 2280(1)(b), 224(1)(b), 279AO(1) of the Public Health Act).

In some cases, data about public health care can be provided to a Queensland government entity more quickly than data about health care provided in the private system. This can lead to incomplete health data being shared and limits analysis of relevant information.

Proposed changes

Allow for the sharing of information, with a Queensland government entity, under a prescribed agreement.

It is proposed to amend the Private Health Facilities Act to provide that information may be disclosed to an entity of the State under an agreement prescribed by regulation. Before an agreement is prescribed, the chief executive will have to be satisfied the giving of the information is in the public interest.

The proposed approach will be consistent with the sharing of confidential information with the Commonwealth or another State under the Private Health Facilities Act. The approach will also more closely align with the approach that applies under the *Public Health Act 2005* (sections 84, 226, 228O, 244 and 279AO) and the *Hospital and Health Boards Act 2011* (section 151(1)(b)).

Prescribed agreements, for the disclosure of information, are drafted to ensure that each agreement contains appropriate obligations for continued compliance with the *Information Privacy Act 2009* and Queensland privacy principles. This ensures that confidential and personal information is stored, handled, accessed, amended, managed, transferred, used and disclosed appropriately.

Section 147(7) of the Private Health Facilities Act also contains limitations about information shared under a prescribed agreement for section 147(4)(c), including that:

- the information can only be used for the purpose for which it was given; and
- it must not be given to anyone else, unless authorised under the agreement or with the written consent of the chief executive.

Unauthorised disclosure is also an offence with a maximum penalty of 50 penalty units ($8,345 for an individual).