

# HEALTH CONSUMERS QUEENSLAND

## SUBMISSION TO

### The Exposure Draft of the *Health Practitioner Regulation National Law 2009*

17 JULY 2009

#### Health Consumers Queensland

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Submission - Exposure Draft *Practitioner Regulation National Law 2009*

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Friday 17 July, 2009

## **ABOUT HEALTH CONSUMERS QUEENSLAND (HCQ)**

HCQ was established to contribute to the continued development and reform of health systems and services in Queensland, by providing the Minister for Health with information and advice from a consumer perspective and by supporting and promoting consumer engagement and advocacy. HCQ's aim is to strengthen the consumer perspective in health services policy, systems and service reform and improvement.

HCQ comprises a Ministerial Consumer Advisory Committee and a Secretariat supported by the Division of the Director-General, Queensland Health. HCQ's statewide Ministerial Committee was appointed in August, 2008 and is comprised of a mix of health consumers from a broad range of health populations and social groupings.

HCQ launched its *Strategic Plan 2008-10* in March 2009, focusing on the key priority areas of quality and safety; equitable access and targeted responses; and participation and engagement.

In line with its priority area of quality and safety, HCQ provided formal responses to the National Registration and Accreditation Scheme's *Consultation Paper 1: Proposed Registration Arrangements* and *Consultation Paper 3: Proposed Arrangements for Handling Complaints, and Dealing with Performance, Health and Conduct Matters*.

HCQ has developed this formal submission within the context of its terms of reference which include the provision of timely, high level strategic advice on government health policies and proposals, from a consumer perspective, and recommending priority areas of action to improve the quality and responsiveness of health services.

## **ABOUT THIS SUBMISSION**

To inform this submission, HCQ uses the term 'consumer' to identify a patient or end user of health services. Further, HCQ acknowledges the Queensland Health definition of consumers, as:

*Consumers are people who use, or are potential users, of health services including their family and carers. Consumers may participate as individuals, groups, organizations of consumers, consumer representatives or communities. (1)*

This submission responds to the Exposure Draft of the *Health Practitioners Regulation National Law 2009* (Bill B). The exposure draft builds upon previous legislation (Bill A) and has been informed by feedback from a series of consultation papers on the implementation of a national accreditation and registration scheme for health care professionals, agreed to by the Council of Australian Governments (COAG) in March of 2008.

It reflects discussion between HCQ, Consumers Health Forum of Australia and other State and Territory health consumer organisations. In line with our priority area of quality and safety HCQ has been working closely with Consumers Health Forum and other state and territory consumer bodies around some key issues in the implementation of the national

scheme and this Exposure draft, to ensure consumers' voices are heard at the state and national level and the proposed legislation reflects the rights and interests of Australia-wide health consumers and their representatives.

Importantly, this submission also specifically reflects feedback provided by Queensland health consumers, gathered through HCQ's Consumer Network, two targeted focus groups and its advisory committee.

It is intended that this submission provide direct feedback to the Australian Health Workforce Ministerial Council on matters raised in the exposure draft. In line with HCQ's Term of Reference One this submission has also been provided to the Deputy Premier and Queensland Minister for Health for his information and consideration.

The submission will be available can be accessed on HCQ's website at [www.health.qld.gov.au/hcq](http://www.health.qld.gov.au/hcq) to inform health consumers and other stakeholders in relation to HCQ's position on matters in the draft exposure legislation.

## 1. OVERVIEW AND GENERAL COMMENTS

HCQ supports the notion that Australia's health workforce underpins the way consumers experience and use the health system. HCQ commends COAG and the State and Territory Ministers for taking the important and necessary steps in implementing a national approach to accreditation and registration of health care practitioners. It also commends the leadership demonstrated by the Queensland Government and the Deputy Premier in progressing the implementation of the scheme and the passing of 'Bill A' in the Queensland Parliament.

HCQ further commends State, Territory and the Australian Governments for their commitment to further legislation that provides an opportunity for the implementation of a more user-friendly, coordinated and robust accreditation, registration and complaints process for health professionals.

We agree that the national health scheme needs to ensure a high degree of public protection and transparent and accountable policies, practices and services to engender public confidence in the Australian health system.

HCQ believes the implementation of a national framework offers the best ever opportunity to achieve ongoing, safe and quality health services in Australia. According to the *Australian Charter of Healthcare Rights*, patients and other people who use the Australian health system have a right to receive safe and high quality care, to comment on their care and have their concerns addressed.

From a health consumer perspective, the infrastructure implemented to deliver the proposed centralised functions needs to deliver timely outcomes in a cost effective and user-friendly manner. It needs to facilitate easy assess by consumers to raise concerns and/or complaints around individual or systemic health practitioner issues. It needs to be transparent and accountable. HCQ supports a structure which delivers on these components.

Amongst other matters, HCQ's previous submissions recommended that Aboriginal and Torres Strait Islander Health Workers be included in the professions covered by the legislation; the adoption of a mandatory reporting framework for health professionals; a single point for consumers lodging complaints and formalised support for consumers around lodging and processing complaints, and commends the adoption of these matters in the national scheme. This submission includes some further issues around the implementation of some of these matters as detailed in the exposure draft of this legislation.

HCQ has focused upon key issues from a consumer perspective in providing feedback on the exposure draft of the *Health Practitioner Regulation National Law 2009*. These key issues include the role and functions of the Public Interest Assessor, accreditation, registration and health complaints, performance and conduct at national and state/territory levels.

Overall HCQ commends the intent of the draft legislation, especially specific components being implemented towards a more robust process around the overall management of complaints.

Feedback to HCQ around complaints management and the role of the Public Interest Assessor indicates the need for greater detail and clarity in the final legislation around the role and responsibilities of the national agency, the Public Interest Assessor and other state and territory agencies and commissions in managing all aspects of the complaints process in regard to a health professional's performance and conduct.

HCQ supports the creation of the Public Interest Assessor (PIA) as an additional positive safe-guard for consumers around complaints management. HCQ also recommends that the PIA is clearly detailed in the legislation to be an independent, statutory appointee reporting to the Ministerial Council and that the office should be independent of the agency structure and be sufficiently resourced to carry out its role and functions. HCQ believes this would strengthen consumer confidence in the ability of this body in working independently yet collaboratively with the national boards and national agency around complaints management.

HCQ also supports the inclusion of a systemic role for the PIA in the legislation in reporting on trends in concerns and complaints at a national level across the 10 national boards. This additional function would value-add to safer, higher quality health services and outcomes for Australian health consumers and could build upon the work of other complaints bodies at the national and state/territory levels.

HCQ further supports the implementation of effective strategies to develop the language and cultural competencies of newly immigrating professionals. HCQ also identifies the potential language and cultural competency issues for those trained in other English speaking countries, who may be unfamiliar with the unique cultural aspects and professional language of Australia.

HCQ will continue to monitor and engage with any future process of consultation around

the implementation of legislation relating to the National Registration and Accreditation Scheme.

***Overall Recommendations (specific recommendations are contained in specific sections of HCQ's submission)***

- HCQ strongly recommends that structures and mechanisms exist at all levels to allow for consumer input and representation in all components of the national scheme, whether these are implemented at a state or national level.
- That the legislation contains principles that reflect the intent of the Australian Charter of Healthcare Rights, endorsed by all state/territory Health Ministers.

## **2. FOCUS OF HCQ'S SUBMISSION**

HCQ has decided to focus upon some key matters, from a consumer perspective, contained in the draft legislation. These matters include:

- Public Interest Assessor;
- Accreditation;
- Registration;
- Complaints, performance and health conduct; and
- National and State/Territory law for handling complaints.

### **2.1 PUBLIC INTEREST ASSESSOR (PIA)**

#### ***Recommendations***

- The legislation includes a principle that a rights based framework such as the Australian Charter of Health Care Rights, underpin and inform the role, functions and culture of the PIA. The Charter has been endorsed by all state and territory Health Ministers to guide health service delivery across Australia.
- The PIA is legislated to be an independent, statutory appointee reporting to the Ministerial Council and that the office should be independent of the agency structure and that the legislation have "in-built" guarantees that the PIA will be sufficiently resourced to effectively carry out its role and functions. HCQ believes this would strengthen consumer confidence in the ability of this body in working independently yet collaboratively with the national boards and national agency around complaints management.
- The national legislation reinforces a nationally consistent approach to complaints management. As such, the PIA and the Independent Assessor roles need to be consistent across Australia and their relationship to each other be made clear.
- Additionally, rather than states and territories being able to choose their legislative frameworks for investigations, prosecutions and the definitions of offences and contraventions of the legislation it needs to encompass a nationally consistent framework for complaints handling and management.

- The framework to be based upon current “best practice” or highest industry standards rather than minimum standards.
- A systemic function needs to be written into the legislation around the role of the PIA to facilitate the identification and actioning of patterns and trends of complaints received nationally across the 10 Boards. This higher level, strategic function of the PIA would ensure patterns of concerns as well as complaints are identified pro-actively in a timely manner and recommendations made to address these matters. As such, the role could significantly inform policy changes or policy development.
- The legislation to detail that the PIA independently reports to the Ministerial Council on its activities and outcomes on a quarterly basis. This reporting to include tabling and publishing an Annual Report with the Ministerial Council.
- The description of the role of the PIA be significantly expanded to include detail around:
  - Its scope/responsibilities
  - Resources to support its activities
  - Reporting structure
  - The authority/enforcement powers the PIA has and how these are to be actioned within state and territory jurisdictions.
- A clear pathway (map) for consumers to follow when lodging a complaint is developed and published. Various print and electronic mediums be utilised to inform consumers of the role of the PIA, the national agency and state/territory bodies in receiving and actioning complaints.
- Legislation/regulations to include the development of clearly articulated memorandums of understanding/protocols between the PIA, the national agency and state/territory commissions. This would reduce the possibility of overlap and duplication between bodies and actively promote a user-friendly and consistent approach for consumers.
- Legislation/regulations to facilitate transparent processes around stages of management re complaints so consumers are kept informed at all stages. HCQ believes that decision-making powers should reside with the PIA.
- Serious consideration should be given to ensuring that the PIA is value adding to providing a better system – it needs to be robust and responsive.
- The legislation to detail consumers having access to an advocate and that the definition of advocate includes family members, friends as well as advocates remunerated through organizations. HCQ recognises that there is a perceived power differential between a consumer and any bureaucratic structure and advocates serve to equalise this balance differential.
- An independent review and appeal process for consumers is developed, rather than the legislation only covering health professionals in relation to this. Provided the PIA is clearly constituted as an independent appointee/body it could undertake this function.

The recommendations above have been informed by the following overall feedback received by HCQ around the Public Interest Assessor.

### **Role of the PIA**

- The scope of the work, including its role and responsibilities are unclear in the current draft. HCQ reinforces that the detail of the PIA role, its scope and its

limitations (what it does and doesn't do) needs to be clearly delineated in the legislation, including the parameters of the authority of the role.

- The role has the potential to duplicate other existing mechanisms such as the Health Commissions in all states and territories. This could result in confusion for consumers around the appropriate body to address their complaints and cause unnecessary and distressing delays in progressing consumer complaints.
- Reporting procedures would be more easily understood by a 'mapping' process which details the roles and responsibilities of the PIA and other relevant state/territory complaints bodies. Consumers could then ascertain which office or person to whom they could make contact, processes of referral between the bodies, and the timelines for bodies dealing with complaints referral timelines, including referral timelines.
- The term 'reasonable support' needs to be more clearly defined, making it clear exactly what would be considered within the scope of reasonableness, even if this is defined through regulation. Consumers would like to see support provided to them throughout the whole course of the complaint. Making a complaint can be a daunting and often intimidating process for consumers unused to bureaucratic structures. The support would need to be appropriate to the person's needs, for example: interpreters for people who are deaf or from culturally and linguistically diverse backgrounds; support for people who are illiterate (consumers will often abandon a complaint because of requirements that the complaint be put in writing) and those experiencing mental health issues. Even if the person does not have special needs, it is still reassuring for them to know that assistance will be made available to them, should they request it, at any point throughout the process. It is not enough to offer information: for full and meaningful participation adequate resourcing is required.
- It is important for people to be able to have a family member or advocate with them to speak on their behalf. This needs to be clearly defined in the legislation.
- It is highly recommended that in developing the complaints processes, groups such as Aboriginal and Torres Strait Islander, CALD and disability bodies need to be consulted.
- All complaints promotional material to be made accessible to diverse health consumer and community groups.

### **Independence and funding of PIA role**

- If the PIA is funded by the national boards, HCQ is concerned that even if this is not a direct conflict of interest, it could be 'perceived' as one by consumers.
- The PIA should be an independent statutory body with investigative powers and should be well resourced to perform its role (not just 'a person').
- A protocol for the clear understanding of the relationship between the independent statutory body and the national and state bodies would need to be developed
- To be truly independent, funding should come from government.

## 2.2. REGISTRATION

### Recommendations

- Health professionals who are registered under the 'limited registration' criteria perform work only in that registration status.
- That supervision and professional support of health professionals practicing in an area of need with 'limited registration' is a *requirement*.
- The legislation to include clear safeguards should be put in place to ensure that rigour in medical and health standards is maintained when health professionals with 'limited registration' are appointed in areas of need.
- Where practical and where needing to respond to the cultural sensitivities of a community, that the Minister consults with the community about placement of a person with 'limited registration' in their area.
- Regulations are developed and monitored for those who do not call themselves 'practitioners'. This would provide a measure of protection for the consumer.

The recommendations above have been informed by the following overall feedback received by HCQ around limited registration.

#### Limited registration

- The term 'limited registration' in Bill B, s.86, is very broad. Clarification of this may ameliorate the confusion expressed by consumers about the term. For example, because of the shortage of health professionals (mainly doctors) in rural and remote areas this could lead to communities accepting health professionals with 'limited registration'. It was argued that if a doctor wants to work in an 'area of need' then maybe limited registration is desirable. This was perceived by some as being preferable to not having any medical care. Other consumers were concerned that if a person is not competent, then they shouldn't be able to practice anywhere and argued that why should rural and remote areas get 'second best'.
- In s85, the relevant State Minister makes the decision about whether a person with 'limited registration' is allowed to practice in an 'area of need'. This authority can be exercised without any consultation with the particular community.

#### Consumer protection

- Under this draft legislation it is not possible to take action against a person for malpractice if that person is not registered and does not call themselves a 'practitioner'. There is no protection for the consumer
- Person who set themselves up as 'counselors' or 'alternative therapies' don't have to be registered and are not regulated.

For a comprehensive submission on the registration of health professionals, please refer to HCQ's submission – Response to Consultation Paper 1 *Proposed Registration Arrangements*.

## 2.3 ACCREDITATION

### Recommendations

- The legislation mandates for consumers to be given a significant role in the development and implementation of standards of accreditation across the 10 health professional groups covered in the national scheme.
- Accreditation standards should reflect current best practice and as such, high industry standards rather than minimum standards of practice.
- There is consistent application of the standards to all health professionals, including students.
- The legislation to state that accreditation standards include evidence of training in relation to particular health populations and social groupings. This would cover cultural diversity/sensitivity, disability, mental health, chronic disease and rural and remote health populations.
- The standards adopt a common, rather than profession specific terminology, and a broad framework to enable a robust system that is applicable across a variety of professionals.
- An ongoing monitoring and review process is legislated as part of the accreditation system.
- Guidelines/indicators for each standard are developed as part of the legislation or by regulation.
- Appropriate criminal history screening be mandatory across each of the 10 health professional groups – refer to HCQ formal submission to Consultation Paper 1 *Proposed Registration Arrangements* which can be accessed at [www.health.qld.gov.au/hcq/submissions](http://www.health.qld.gov.au/hcq/submissions)

The recommendations above have been informed by the following overall feedback received by HCQ around accreditation.

### **Consumer participation**

- Consumer participation in the accreditation process is necessary in order for it to be transparent and accountable and ultimately to the benefit of the end user of health services. However, to enable consumers to fully participate the following is necessary:
  - Consumers should have access to training to develop the skills necessary to engage meaningfully – planning, monitoring and evaluation (the curriculum design).
  - A process is needed to facilitate consumer participation and it needs to be well resourced.
- A consumer ‘pool’ of people who can have input into areas of university curriculum, continuum of care, registrars in training etc needs to be developed.

### **Development of accreditation standards**

- Research on international and national ‘best practice’ standards should be taken into account.
- Professional Boards will already have set standards and these would need to be taken into consideration.

- Consultation with peak bodies, consumers and others should be considered. Any groups consulted with, particularly consumer groups, must be budgeted for and reported against.
- A diversity of consumers, health professionals or their representatives and community representatives need to have input.
- Concerns have been expressed that the implementation of national accreditation standards could result in the adoption of standards that are “lower” than current state/territory standards. HCQ reinforces that the legislation needs to reflect best practice and highest current standards.

### **Curriculum**

- The development of curriculum for health professionals to include:
  - Courses teaching awareness of the needs of people with chronic disease. These particular patients report difficulty in accessing medical assistance – one of the reasons being that ‘they take up too much time’.
  - Cultural awareness/sensitivity training for those newly immigrating professionals.
  - Awareness of the impact of disability, not only the person themselves, but on their family.
  - Particular issues for rural and remote communities.

### **Monitoring**

- On-going monitoring and review of standards is not included
- Guidelines/indicators to assess if standards have been met by bodies need to be developed.
- Current requirements and arrangements for criminal history screening of health care professionals are inconsistent and inadequate.
- Disciplinary actions, for example, against health professionals are kept on the data base, but do not remain there for any length of time.

## **2.4. COMPLAINTS, PERFORMANCE AND HEALTH CONDUCT**

### **Recommendations**

- All aspects of complaints management in this legislation should be built upon and support the principles contained in the Australian Charter of Health Care Rights, recently endorsed by all state and territory Health Ministers.
- The legislation must include a Review/Appeals mechanism for consumers, not just health professionals.
- The legislation needs to clearly define a complaint, including what would not be covered within the scope of this definition.
- Provision needs to be covered in the legislation for consumers to have access to ‘witness’ support whilst processing their complaint.
- The process of lodging a complaint and subsequent steps need to be clearly outlined, including the capacity to resolve complaints ‘informally’ through mediation prior to activating a formal complaints process.

- Complaints against de-registered persons should be pursued, finalised and if proven, publicly recorded against the de-registered person, in case the person applies for registration at a future date.
- Representatives of people from various groups, e.g. Aboriginal and Torres Strait Islanders should be included when assessing relevant complaints.
- The perception by consumers that their complaints 'don't go anywhere' needs to be addressed via the new structure and its administration cultivating a culture that 'listens' to complainants and tries to find solutions – either through dialogue or mediation – before the complaint starts to escalate.
- Timeframes for the handling and investigation of complaints needs to be made consistent throughout the document and penalties for exceeding timeframes need to be included in the legislation.
- Quality control mechanisms which include a component of continuous improvement need to be included in the legislation around complaints management process.
- The legislation details data collection around the recording of complaints and this data is used to identify systemic issues with the purpose of addressing a recurring pattern of complaints at the root cause – at policy or procedural levels.
- Nationally consistent Whistleblower protection is legislated and available to complainants in all states/territories.
- A clear definition of what constitutes 'reasonable support' (clause 154) to make a complaint needs to be clearly defined in the legislation and to cover the provision of personal care; disability; language and interpreter support for specific health groupings as well as family members and advocates.
- A clear definition of 'substantial harm' and 'significant harm' is included in this legislation to support nationally consistent practice in line with the mandatory reporting requirements.

The recommendations above have been informed by the following overall feedback received by HCQ around complaints.

### **Complaints processes**

- A Review/Appeals mechanism is not included for consumers regarding decisions made.
- Only practitioners have access to a Review or Appeal (s210 and s243), with the exception being NSW.
- Consumers do not have access to 'witness' support the same as practitioners are offered legal representation.
- There is no explanation of the process/steps to be taken when a complaint is made, e.g. opportunities to negotiate or mediate before the complaint gets out of hand, with further steps to escalate the complaint if resolution is not reached at this level.
- It is not clear who assesses the complaint after the complaint has been lodged at the single point of contact. It raises the question does the PIA assess every single complaint or only those where the state does not investigate the complaint and refers it to the PIA?
- Complaints about de-registered persons are not required to be pursued.
- Reporting obligations (s42 and s43) are not inclusive of consumers only of health practitioners.

- There needs to be some flexibility around the inclusion of representatives of people from different groups, e.g. Aboriginal and Torres Strait Islanders, CALD when assessing relevant complaints.
- There is a perception by consumers that their complaints 'don't go anywhere' because doctors look after 'their own'. Most complaints 'fail', i.e. they are not taken up because the 'threshold' of what will be addressed is too high and very specific. This serves to reinforce the perception.
- It is not clear what type of complaints will be accepted.

### **In the public interest**

- A clear definition of "public interest" as contained in clause 167 needs to define more clearly the term "in the interests of the public" as this can be perceived differently to "public interest" by various health stakeholder groups.
- It needs to be clear who decides what is in the 'public interest'.
- Mechanisms to assist decisions about what constitutes "public interest" could include regular forums/consultations – these need to be factored into any budget and well resourced so that people are able to attend - "Funded participation". Times of consultations should be convenient to consumers.
- There needs to be timely and transparent reporting on any feedback from consultation processes and it needs to be clear who receives the reports.
- Transparent consultation and communication mechanisms – accessibility and affordability.
- It needs to be made clear who decides what is in the 'public interest'.

### **Timeframes**

- Timeframes appear to be inconsistent and confusing throughout the document.
- There is no timeframe for the lodging of a complaint.
- Penalties for exceeding timeframes are not clearly defined.

### **Quality Improvement**

- The national scheme needs to be supported by a quality control mechanism to facilitate quality, safety, consistent decision making and continuous improvement.
- There is no reporting process included in s42 and s43.
- Systemic issues need to be embedded in any reporting process.

### **Safeguards**

- There are no safeguards around support and protection for consumers to lodge and pursue a complaint: consumers can feel threatened or intimidated by bureaucratic processes.
- Whistleblower protection should extend to cover all states/territory and needs to be strengthened.
- The term 'reasonable support' for people lodging a complaint needs to be explained. Support for health consumers is required in a variety of ways to ensure that the complaint is properly understood.
- Provision for education and information programs for consumers about the reforms and complaints processes and their rights as health consumers is not considered.
- A commitment to education and information programs for consumers to be aware of the new systems, what they can expect and have their rights outlined.

## 2.5 OTHER MATTERS

### Recommendations

- HCQ believes that everyone has the right to make a complaint. If there are impediments for any group of people to this right, then appropriate resources should be provided to remove such barriers.
- The reference to an 'entity' or 'unincorporated body' in the legislation does not make it clear if this is intended to apply to young people under 18 years, particularly those 15-18 years old who live independently of family, maybe in foster care or maybe those with a disability who have a carer. These groups may wish to make complaints.
- There are no explanations given why speech pathology, social workers, occupational therapies are not covered by the legislation.

## 3. CLOSING STATEMENTS

HCQ supports COAG's moves to implement a coordinated and standardized approach to the accreditation and registration of health care professionals. HCQ supports the commitment of the Health Ministers to consultation with stakeholders including consumers around the detailed implementation of the national scheme.

HCQ commends COAG for its commitment and priority given to safety, quality and effectiveness of health services, in the public interest and supports these principles being upheld in every facet of the national scheme.

HCQ will continue to be involved with the implementation of the scheme, through monitoring the impact of the legislation on health delivery to consumers. HCQ will continue to encourage health Ministers and others to move from a framework of 'consultation' to a framework of 'participation' by consumers in their health care.

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