

## Health Consumers Queensland submission

### COAG Health Council

### Proposed reforms for mandatory reporting by treating practitioners

## Health Practitioner Regulation National Law

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## About us

Health Consumers Queensland is the peak organisation representing the interests of health consumers and carers in the state. Health Consumers Queensland is a not-for-profit organisation and a registered health promotion charity and we believe in improving health outcomes for people in Queensland.

*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.*

Our priority focus is on consumer engagement that influences and leads improvements and delivers better health outcomes for all Queenslanders. We achieve this through our Queensland-wide health consumer network, tailored training and skills development programs, and maximising opportunities for consumer representation at all levels of the health system.

*Consumer engagement is when health consumers actively participate in their own healthcare and in health policy, planning, service delivery and evaluation at service and agency levels.*

## OUR MISSION, VISION AND STRATEGIC DIRECTION

### OUR MISSION

Health Consumers Queensland empowers consumers to lead and drive better health outcomes.

### OUR VISION

Consumers and community partnering with the health system to get the healthcare we want.

### STRATEGIC THEMES

- 1 Build capacity towards consumer-focused co-design and transformation of the health system**
  - Education for consumers and health service staff.
  - Building systemic advocacy skills that enables consumers to take leadership in co-design.
- 2 Growing a strong, responsive and sustainable organisation**
  - Develop, strengthen, build, measure, learn.
  - Utilise the passion, energy and vision of our people.
  - Strong governance, culture, accountability and compliance.
  - Sustaining diverse income sources.
- 3 Building profile and research**
  - Research excellence and partnering with universities nationally to inform policy and practice.
- 4 Sought after source of strategic advice to key influencers**
  - Long term relationships to promote development of a consumer-centred health system.
- 5 Partnership with sister organisations and networks**
  - Building effective and efficient networks of health consumer organisations to leverage engagement with key influencers and decision makers.
  - Working alongside sister organisations to strengthen the consumer voice.
  - Shared development of consumer advocacy.

### VALUES



## Introduction

Our organisation welcomes the opportunity to provide an organisational response to the targeted consultation process for amendments to mandatory reporting requirements by treating practitioners.

Our response is aimed at protecting public safety, while ensuring that legislation is not a barrier to health professionals seeking health care when they need it. These two need not be mutually exclusive, as healthy practitioners (who are also health consumers) are better placed to provide us with good, safe care.

As always, our submissions are focused on these consumer-focused principles of person-centred, integrated health care:

- Accessibility - safe, affordable and high quality services, treatments, preventative care and health promotion activities.
- Respect - healthcare that meets consumers' unique needs, preferences and values
- Choice – a responsive health system which ensures consumer choices in treatment and management options
- Participation - patient involvement in health policy to ensure that they are designed with the patient at the centre<sup>1</sup>.

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<sup>1</sup> International Alliance of Patients' Organizations (2006) Declaration on Patient-Centred Healthcare (IAPO: London)  
<https://www.iapo.org.uk/sites/default/files/files/IAPO%20Declaration%20on%20Patient-Centred%20Healthcare%20Poster.pdf>

## Consultation questions

**Question 1: Does the proposed legislation reflect the key principle agreed by Health Ministers that the National Law must ensure health practitioners can seek help when needed and protect the public from harm?**

The intent of the legislation appears to be to make it easier for practitioners to seek the care they need, whilst protecting the public.

Evidence must be provided on the impact of mandatory reporting laws in Australia to date:

- Does mandatory reporting happen?
- At what rate is AHPRA identifying and sanctioning treating practitioners who don't mandatorily report?
- Is APRA systemically identifying why they didn't report, and tackling these barriers?

Our organisation strongly asserts that any changes to hard-won mandatory reporting legislation aimed at protecting the public, must be informed by evidence (not just anecdotal):

- Does mandatory reporting prevent health professionals from seeking health care?
- What research or experience in other similar jurisdictions proves that legislative changes such as those proposed do make it 'easier' for health practitioners to seek care?
- Further, if increased access cannot be assured, or even if it can be, at what cost does this come? What is the impact of this on public safety? Is it improved or endangered? Balancing the risks of health practitioners not seeking care against the risk of those same health practitioners providing care to their patients when they shouldn't be, at potentially no greater access to health care for themselves.

If legislation change were to occur, it's successful implementation would rely upon an often disconnected web of regulatory, complaints and clinical governance systems, which are not infallible or transparent to the public. It is often the consumer experience that the health system doesn't work in the way in which it was designed to.

Over and above legislation, regulation, policy guidelines, and procedural changes is the cultural context of a health system: too often set up around the needs of the system and health

professionals, whilst at the same time fostering a culture of blame and stigma towards health practitioners who need help.

- What would a system look like that can assist practitioners to get the help they need, and ensure the community is protected from potentially unsafe treating practitioners *before* there is a risk of substantial harm?

With any change, we need to ensure that the system can and will work in a way we think it will to protect the needs and interests of the public/patients.

If change occurs, implementation must ensure that consumers are absolutely embedded through this process to assure us that it is robust, transparent and is working to serve both dual interests (of health practitioners and consumers). Consumers must:

- be involved in co-designing the regulations, policy guidelines, procedures and educational material.
- sit on the ongoing governance/implementation committee overseeing this work

This work also needs to recognise that this proposed legislation change is for registered practitioners who have identified that they have a problem and are reaching out for help. There must still be robust processes, such as mandatory supervision, for practitioners who don't have self-awareness of issues which impair their ability to provide safe, high quality care.

**Question 2: Does the proposed legislation give appropriate guidance to treating practitioners about factors they may take into account when considering a registered health practitioner's impairment?**

Whilst the intent of changes to the threshold for reporting is understood (see q 1), we are concerned that language between the two thresholds is very similar and could cause confusion for health practitioners:

**What is the difference between 'substantial risk of harm' and 'risk of substantial harm'?**

**Placing the public at substantial risk of harm** is a higher threshold than currently applies to mandatory reporting and is intended to encourage health practitioners to seek help for impairment and health issues.

The table below summarises the differences between the thresholds for reporting under the proposed reforms for treating practitioners and current mandatory reporting provisions.

<b>Proposed threshold: Substantial risk of harm</b> (see proposed sections 141B(1) and (3))	<b>Current threshold: Risk of substantial harm</b> (see current section 140(c) of the National Law)
Focuses on the likelihood of harm being caused to the public. A 'substantial risk' is a much higher threshold of risk for reporting.	A 'risk' of substantial harm is <u>any</u> level of risk of harm to the public, however unlikely or remote the risk is. This is a much lower threshold of risk for reporting.

*(from Mandatory Reporting – Consultation Paper, 2018)*

We also think that it could be difficult for treating practitioners such as GPs, psychologists or psychiatrists, to know what may constitute a substantial risk of harm, in specialist or sub-specialist areas eg. obstetrics.

There should also be clarity on who is a "treating practitioner". There must be no gray area between who is considered a treating practitioner (higher threshold) and colleague/co-worker/supervisor (lower under current section 141).