RESPONSE TO AUSTRALIAN HEALTH MINISTERS ADVISORY COUNCIL (AHMAC) ON NATIONAL CODE OF CONDUCT FOR HEALTH CARE WORKERS

Carol O'Donnell, St James Court, 10/11 Rosebank St. Glebe, Sydney 2037, www.Carolodonnell.com.au

This submission responds first to Section 2.2 of the AHMAC consultation paper on the proposed terms of the National Code of Conduct for Health Care Workers, mainly about key definitions and issues for quality management. It later addresses questions on service provider behaviour, insurance and enforceable standards.

It is vital for quality management to be sustained by a very broad, openly questioning culture, rather than many narrow or blaming ones, operating behind closed doors or not. This does not mean emotion or judgment can or should be extracted from language to reduce it to ticks, drugs, and bland politesse posing as empathy. It means instead that we must try to understand more of each other's drivers, and those of significant others. These drivers are not purely financial, nor purely spiritual or caring without financial constraints – much as we might like ourselves to be. The best we can hope is that we learned from any encounter. This is why I love SBS. Its Charter and Code of Practice is so good anybody could be guided by it, unless they thought otherwise, as I pointed out that I did in spots. (So sue me?)

The regional planning and fund management direction is one with which the Draft National Code of Conduct for Health Care Workers often appears consistent in regard to its approach to quality management of services to improve them in general and in the particular case. However, its relationships to courts, industry and funding require clarification for good data driven management of services and the funds for related policy setting purposes. Nevertheless, one applauds the apparent potential of the Code, as applied in the context of the National Disability Insurance Scheme and in place based service provision in the workplace, home or community. Related issues are discussed in attached submissions on public infrastructure and housing.

Q. How should the class or classes of person that are to be subject to this National Code be identified?

A. With primary reference to the key stakeholders in good health care provision

Equitable, accessible, high quality, cost-effective delivery of health services depends on prior identification of the stakeholders and **key** stakeholders in national and regional environments. Key stakeholders are those for whom health care services have ideally been established and those who have funded the health service operations. In this context the term '**health practitioner'** is not favoured because the concept of **service** appears too easily lost or reduced to past ideas of 'noblesse oblige' and to courts with partial and aggressive notions of evidence, driven by focus on the rule, rather than on the experience of persons in particular environments.

The commonly used concept of '**a minimum enforceable standard'** needs to be clarified beyond the Code statements themselves. When state Occupational Health and Safety Acts were passed with the aim of providing safer workplaces, the point of

codes, as distinct from standards, was that codes of practice were considered recommended ways of acting, which could and should be varied to meet the conditions of the particular grounds and case. Standards, on the other hand, were called up in law and treated prescriptively. They had to be followed to the letter. How is the National Code of Conduct for Health Care Workers and the concept of **a minimum enforceable standard'** being administered to achieve related goals?

In this context one also questions the definition of a health care worker as '***a natural person'*** who provides a health service' (p. 54). The term '**natural'** appears also to be a veiled reference to an organization – (e.g. a company, government or charitable body) which may have a relationship with the health care worker, so determining her behaviour, or not. One wonders what the term **'natural'** is expected to imply in a context of the National Code of Conduct for Health Care Workers or in others. Are a person or an organization to be treated the same in court – according to the rule?

(Get this! I am an owner in the body corporate, which I assume is the body of Christ. See attached submission to the Financial Services Inquiry based on experience at St James Court. Encourage George Pell, the Pope and Murdoch to take it from here.)

The related strengths of the NSW workers compensation insurance, Medicare and Wran administrations took up many of the crosses of the Whitlam government approach and tried to repair its weaknesses. Didn't we almost have it all? Wran states at the beginning of the book 'A Decade of Change: Women in NSW 1976-86':

> Our administration coincided with the United Nations Decade for Women, and the second wave of feminism. Our achievements for women in NSW are acknowledged throughout the world. This book records the transformations which occurred in New South Wales in the decade. I am proud to have been Premier during this period. I urge you all to consolidate and extend the gains made. (Neville Wran)

(These are His words from the grave. My grandson was born and the next day Barry O'Farrell stood down. Could this mean my grandson will be the next Dalai Llama, as I fear we're loving Catholicism to death in NSW. It's basically a losing strategy which ideally needs a lot of direction. You buggers who know what you are doing should hurry up and explain it so that the rest of us can get a vague idea where we can fit in. The Catholic Society of St Peter has recently lifted a lot more scales from my eyes.)

Related non-profit underwriting and funding models are noteworthy for their equitable and effective service delivery and cost-effectiveness in comparison with service models in US arenas driven for profit and with many more incentives to hide or treat dissatisfactions in court. They tell almost nothing but lies on US TV in many races to the bottom. I argued on related regional planning themes to Patricio Campos, ADP Manager, World Vision Equador, and to Sister Mary Magdalene, the Catholic Society of St Peter and a crowd related to Mental Awareness and Health Society (MAHSOC) in Health and Wellbeing Week. (See correspondence attached). Related potential of the Westpac Bicentennial Foundation for strategic planning is addressed later. The brain and the other developing mind and life are confused at one's peril in my book.

Superficially, however, the National Code of Conduct for health care workers appears part of a promising new approach to professional indemnity and fund management consistent with NSW government views of ideal planning directions related to living and working in particular places. This ideal quality management model was begun with state workers compensation and Medicare schemes which Whitlam tried to get before. He also failed in national disability insurance. Wilenski drove the equal opportunity culture in the bureaucracy in NSW to help it happen. There is no intelligent alternative to planning, with competition to assist it as openly and broadly as possible. We wish to move beyond a blaming culture, without being told to shut up. This has many implications for the improvement of related planning, development, research and fund management which should be better understood.

Women interviewers on ABC TV appear particularly good. Who needed O'Brien? If you really want to tap an intelligent woman's understanding instead of seeking to put them in a more feminine box called 'popular culture' I bet many could give a lot of suggestions few men would want to hear in Dubai or anywhere else. Try this out if you genuinely seek greater financial literacy or legal understanding. I doubt it.

More financial stability than markets can deliver appears crucial for healthier, more equitable and effective treatment across the board. The first NSW Government Strata and the Community Title Law Reform Position Paper (2013) is instructive in this regard. A related submission to the Financial Services Inquiry is attached.

Q. Is the proposed scope of application of the National Code acceptable?

A. Follow the broader Queensland definition of health services

The ideal quality management aim for the national code is for it to be broadly and openly inclusive of service providers, so that service outcomes may be more effectively and broadly compared and changed if there appears good reason to do so. The practices related to certification of competence to practice can also be made more clearly related to the comparative outcomes of treatment through vocational education in the workplace or community. Ideally, the risks related to these provider/practitioner/client relationships are addressed broadly and comparatively in relation to particular situations and environments, rather than according to fixed rules which may often be under comparatively narrowly specialised scrutiny. Give up ticking boxes and try expressing your views instead so we know what we are doing.)

From global, national and related regional planning perspectives, Queensland legislation appears likely to have the more inclusive and therefore the more efficient, equitable and comparable definition of 'health services'. It captures Queensland services for 'maintaining, improving, restoring and managing people's wellbeing' (p. 36). This usefully supports the World Health Organization (WHO 1946) definition of health as '***a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity'***. The broadest possible open reach is highly desirable in the context of global and related regional planning and research

for improved and flexible treatments to meet individual and related community need and choice. One assumes the concept of **need** is more likely to be related to concepts of **minimum standards**, rather than consumer choice, however defined. This is so whether these services are delivered in family, private, government, charitable or related institutions and however their provision is designed and funded.

The concept of **'a minimum enforceable standard'** is ideally addressed in related contexts. In any judgment, it is usually necessary to recognise that community standards are cultural, economic and region specific, whereas standards in legislation are prescriptively enforced according to past rule. It should be more widely understood why the application of the legal word leads to 'junk science'. Court practice often reflects a view of the world before the common dictionary.

From the regional planning perspective the term '**health care worker'** is preferred to **'health practitioner'** as it is clearer and more correct. The latter term neglects the fact that work produces service which may appear, and/or be, of variable quality for many good and bad reasons, which may often have to be continuously pondered comparatively and historically for best effect scientifically and personally. **Health practitioner,** suggests the service provider can do no wrong. We all do wrong.

For related reasons the term **'health consumer'** is crazy when applied in a relationship between two people, one of whom is expected to be a key service provider to the other**. 'Health consumer**' implies those who provide a service have an infallible product. This is the 'noblesse oblige' approach picked up from past law, which is outmoded. This view is particularly to be avoided in the field of mental health as it leads to the idea that one can be an expert on another whose current and historical circumstances, drivers and thoughts are often completely sealed books. When we all know more or less than we are capable of saying or willing to say, what can they do? (Strike up the band; look up at the camera and sing?)

Under **3. Appropriate conduct in relation to treatment advice,** the Code states:

(2) A health care worker must not attempt to dissuade a client from seeking or continuing medical treatment

It should state: **(2) A health care worker must not UNREASONABLY attempt to dissuade a client from seeking or continuing medical treatment**

The current statement under the Code is an invitation to abrogation of the personal responsibility which appears central to the honest practice of any person, let alone of one who appears to be comparatively knowledgeable, skilled and experienced in the treatment of a particular health problem apparently being felt by another individual. (Stop sulking. The realization that the client has a right to make their own decisions about their own life, does not mean that the facts of life should not be clearly put to them by anybody with reason to think they may have a better handle on them. Surely any parent of teenagers would be able to tell you this. Get a life.)

The empirical question is not whether the cat (health care worker, product or provider) is black or white, but whether it catches mice. The key issue is thus how best to provide service to an individual in an apparent situation which may be

comparatively common or rare, known or unknown. This is ideally the dawn of personalised care before personalised medicine, as the latter is driven by the top professional interests, whatever they are. Professionally driven service cannot often support good planning, which is ideally based on historical analysis of the arena. The excellent directions suggested by the WHO often appear undermined by many professional associations with much narrower specialist interests and outlooks.

In current global, regional and individual planning and management contexts, in which post-war Australia has accepted and effectively integrated higher rates of immigration from around the world than almost any other country, one naturally also accepts the definition of community put forward by the International Labour Organization (ILO), the United Nations Education, Scientific and Cultural Organization (UNESCO) and the WHO. In the context of community based rehabilitation (1994), these organizations saw 'community' as:

a. a group of people with common interests who interact with each other on a regular basis, and/or
b. a geographical, social or government administrative unit

This is a great definition because it is clear and allows services or goods to be managed transparently (openly, clearly) on related international and regional bases for the purposes of improving wellbeing and understanding in Australia and beyond.

The democratic point made earlier, about people ideally being treated in their regional contexts, rather than being extracted and compared against some ideal rule of law or theoretical profession, cannot be too strongly put for quality management of human health and environments. One usually needs to know the ideal objects and related practices in order to question and justify their denial in the particular context of service provision. Ideally all have a right to question and get an honest response.

Environment, work, health and insurances are ideally addressed in related place and service categories, according to the Australian and New Zealand Standard Industrial Classification (ANZSIC). Ideally this system enables better planning and data gathering for work and related land, community development and risk management purposes globally and locally. This direction was designed in workers' compensation insurance and in related injury, rehabilitation, maintenance and re-employment costs*.* It is also logically addressed in Medicare and industry superannuation plans. In the current NSW environment it is now being addressed in Crown Lands and housing.

16. Health care workers to be covered by appropriate insurances

Q. Should the National Code include a minimum enforceable standard in relation to the professional indemnity insurance obligations of health care workers?

A. This depends partly on what is meant by the term 'minimum enforceable standard' and on how any breach of service that is claimed, or any related unintended consequence of treatment, may be expected to be handled

The requirements of the Code in 16 seem fine whether the service provider or related health worker is required to have professional indemnity or other insurance or not. The passage of state OHS Acts widened coverage for the responsibility for safety at work across all Australian workplaces. Ideally, the Code should be broad.

However, the ways insurance may be ideally designed in the public, individual and related organizational interest are complex and deserve more substantial inquiry into injury risk so as to learn more. The question of whether insurance is ideally required by law or left to the individual to decide, is also related to the issue of who is most likely to experience the costs of any failure at work. Also complex are questions of whether any particular insurance is or should be in no-fault or fault based schemes. Other issues relate to the ideal treatment of risk and related premium categories.

Historically, insurance schemes developed before the taxation based extension of the welfare state which guaranteed services such as Medicare to all Australian residents. It is in this context that one also wonders about the ideal meaning and application of the term '**minimum enforceable standard',** when considering any claims for disability, supposedly as a result of wrongdoing by another, or not. It is best to avoid applying the concept of 'minimum enforceable standard' in the slow, adversarial, narrowly inflexible, costly, court. Court practice, however, often drives all others because of legal professional privilege which may hide key information relevant for settlement of a question from the eyes of those most relevant, until a case in court.

Historically, insurance schemes were developed to protect people whose ventures may end in catastrophe on some grounds (e.g. storm and tempest, rising water and flood, fire, theft, malpractice, etc. etc.). The fact that court is expensively adversarial and slow with unintended consequences for rehabilitation and re- injury is largely unrecognized. In a court case, catastrophe is often approached long after the event, in order to affirm or deny fault. This entails denial of early help for rehabilitation, related data gathering for injury prevention or for containing the runaway costs driven by adversarial lawyers and their selected duelling experts. The point of codes is not to treat them like law, but more like the product of expert opinion which may also be denied for good reason, during the process of data gathering and development of a related body of knowledge.

The operations of insurance underwriting in the private sector and the use of the court greatly increase financial instability, repeated catastrophes and related cost-shifting in general. This makes rehabilitation more difficult and penalises good management. In 1994 the UN defined community-based rehabilitation, which offers a better way forward to the extent that its practitioners are willing to be openly questioned and also willing to question and respond on performance questions. The UN direction appeared to offer a means of providing more immediate and cheaper support after catastrophes or for real or apparent threats more broadly, when it defined community based rehabilitation as:

> A strategy within community development for the rehabilitation (CBR), equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families and communities, and the appropriate health, education, vocational and social services (UN Social Development Division 2001: 1).

In 2000, Australia began a coordinated health and disability management process with the development of regional health plans based on population profiles, including socio-economic indicators and a focus on the needs of the aged (NSW Health 2000). This is a health service context in which all related service provision, (e.g. for crime prevention) may be addressed. Australian governments recognize that reducing the supply of motivated offenders requires reduction in the general level of community stress. In NSW, coordinated place management, community housing and crime prevention strategies are ideally implemented to achieve this (Standing Committee on Law and Justice 1998 2002). Dispute management and insurance are related to this.

The aging of the population is highly related to increasing disability. It is vital to clarify the ideal aims and design of insurances applied to the home, its surroundings and to any related services provided to persons and places. The ideal is for clearly related and equitable service designs to meet individual and community need as effectively as possible. The first NSW Government Strata and Community Title Law Reform Position Paper entitled '**Strata Title Law Reform**' appears to be good direction.

The NSW Fair Trading pamphlet dated November 2013 entitled: Responsibilities of the owners' corporation in a strata scheme', also appears related to this. It states that the insurances that this housing and related place based scheme should now have are: **Building insurance; Public liability insurance; workers' compensation insurance and Voluntary workers insurance.** These four replace 8 kinds of insurance formerly required of owners of property under strata title. (These were building; common contents; loss of rent; legal liability; personal accident; fidelity guarantee; office bearers and catastrophe insurance). It is impossible to justify this former mandate as insurances were managed secretly and supposed ideally to benefit insurance company stockholders. Neither is it clear how professional liability insurance is ideally related.

New state views of insurances necessary for owners or managers of places where people live and work are ideally part of transition to funding regional plans and schemes driven by people and related evidence, rather than mainly designed to put profit first. The profit motive driving public or private funds alone, has been linked with increasingly ignorant, costly and high risk practices for all related businesses, in comparison with more open and stable fund design. From any perspective, the type of professional indemnity insurance required and who pays the premium usually depends on whether the health worker is a subcontractor, employee or engaged in another type of practice. Competition should be designed, as Hilmer (1993) intended, to drive better quality of life. This may often be a question of what the individual seeks most, so as to gain it.

The questions of whether or how anybody should be covered by an insurance or levy are complex and should not normally be used to bring closure of service and the denial of broad consumer choice. The related concepts of protection of the consumer and the public from the unintended consequences of practice on no-fault and fault based insurance grounds are difficult to decide. However, broad coverage is usually best to the extent that it increases the range of key data or evidence capture which can also reduce cost as well as provide more reliable information on any question.

Should the National Code include a minimum enforceable standard that addresses the provision of treatment advice?

One wonders what those who wrote the National Code and those who will be responsible for its implementation mean when they use the term 'minimum enforceable standard' beyond the existence of the National Code itself and anybody who questions or challenges its application openly or in secret on the grounds of the health care provider being wrong, or engaged in even worse practice, to some degree or another.

Such administrative matters are addressed on www.Carolodonnell.com.au, including in an article entitled 'A healthier approach to justice and environment development in Australian communities and beyond', in Public Administration Today, (Issue 9, 2006). The website www.Carolodonnell.com.au also shows how the NSW Office of Fair Trading Home Building Contract', may be applicable more broadly as a model practical guide to quality management of many other projects and related community services.

Also see the attached submission to the Productivity Commission (PC) inquiry into public infrastructure with particular reference to the PC draft recommendation (14.1) on 'recognition and' provisional accreditation' and many services best delivered more openly in public/private/voluntary community partnerships. One often makes recommendations similar to those below to support any service provision:

1. Understand the pioneering objectives, design and power of Australian workers compensation, health care, and non-profit superannuation models to deliver better services and data in regional planning contexts

2. Take planned regional development and place based routes to treat land, housing, health insurance, superannuation, and related service provision for fund stability, more effective competition and reduced stress and cost.

3. Develop jointly owned state and community funds which call for competitive services to the particular person and place in the interests of key stakeholders and the broader public, so many service providers and advanced manufacturers may flourish on common grounds.

Australians should adopt related international and regional directions for many place-based service delivery and competition models which may also drive manufacturing. 'Sustainable Sydney 2030, for example, is a plan produced from consultation since 2004 and which involves '*the full range of economic, social and environmental issues confronting us'*. Implementation requires all actors work more openly together, while also using competition to achieve their common and individual goals more broadly.

Thank you for the opportunity to make this submission. Yours truly, Carol O'Donnell, St James Court, 10/11 Rosebank St., Glebe, Sydney. www.Caroldonnell.com.au