STATE DEVELOPMENT AND REGIONAL INDUSTRIES COMMITTEE

Members present:
Mr CG Whiting MP—Chair
Mr MJ Hart MP (virtual)
Mr JE Madden MP
Mr JJ McDonald MP
Mr TJ Smith MP (virtual)

Staff present:
Ms S Galbraith—Committee Secretary
Mr Z Dadic—Assistant Committee Secretary

PUBLIC BRIEFING—INQUIRY INTO THE HEALTH AND OTHER LEGISLATION AMENDMENT BILL 2021

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 27 JANUARY 2022

Brisbane

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The committee met at 11.30 am.

CHAIR: Welcome to the public briefing for the committee's inquiry into the Health and Other Legislation Amendment Bill 2021. I now welcome representatives from Queensland Health.

ALLAN, Professor John, Executive Director, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

CLUGSTON, Ms Bobbie, Director, Legislation Unit, Mental Health, Alcohol and Other Drugs Branch, Queensland Health

LIDDY, Mr James, Director, Legislative Policy Unit, Social Policy and Legislation Branch, Queensland Health

McBRIDE, Ms Liza-Jane, Chief Allied Health Officer, Allied Health Professions' Office of Queensland, Queensland Health

CHAIR: Good morning and thank you for coming back to appear before the committee today. The committee has invited you here to talk more about the issues related to the Mental Health Court and all those other issues raised in submissions to the inquiry. Would someone like to make an opening statement?

Prof. Allan: I acknowledge the traditional owners of the land upon which we meet today and pay my respects to elders past, present and emerging. We meet today on the land of the Jagera and Turrbal people.

Thank you for the opportunity to come back. We have had an opportunity to have a look at the submissions. In relation to the mental health submissions, we were quite pleased that the submissions supported the amendments that we are looking to make. We note that in the submissions a number of things were raised which were outside the scope of the particular amendments, and we would be happy to have a further discussion around some of those matters at your disposal. I will hand over to James.

Mr Liddy: I want to add that we have brought the Chief Allied Health Officer with us this morning. She is able to explain to you how, in a practical sense, allied health practitioners might be able to use the information in the Viewer. If you had any questions about that, Liza-Jane is happy to help.

CHAIR: We have a number of different questions, but I will start by asking about the privacy protection provisions that are relating to the Viewer. The OIC outlined what is happening in the federal sphere through the My Health Records Act in 2018, and this relates to what we talked about. Should we be, across Australia, moving to a uniform privacy protection system that may or may not be similar to what is contained in the federal act?

Mr Liddy: When the department puts forward these reforms and these new systems, we have to balance a range of considerations. Privacy is certainly one of them, but one of the other things that is important, from the department's perspective, is to look at the benefits to patients and health consumers. Going to hospital is a very stressful time for people. I recently had to unexpectedly go to hospital as a result of a bike accident. All of a sudden you are in quite a vulnerable state where you are perhaps not in your best mind. You may not remember everything that has happened while you are in hospital. There are a lot of things going on: people are asking you to sign things, there are medications given and you see lots of different people.

I think it is really helpful for consumers to have that dedicated record of what has happened to them in hospital so that when they go to see another health practitioner they are able to—they may not know the technicalities of the medications they were given, the procedures they had and that sort of thing, so from Queensland Health's perspective, one of our key aims is to really improve that continuity of care. It has been noted as a gap, when people are moving from the public health system back into community care, to make sure there is that continuity. For example, at the moment it might

mean that someone goes to their allied health practitioner for an appointment that they may have had to wait for or taken a day off work for. They might get there and they may not have all the information at hand to give to the allied health practitioner in order for that person to immediately give them the care they need. The Viewer will enable them to do that. At the moment that is a manual process that takes time. It means a person has to come back for another appointment. I might ask Liza-Jane in a moment to speak more generally about the benefits for allied health practitioners.

We have also built a large number of safeguards into the Viewer, some of which we spoke about at the last hearing. It is not the sort of thing that people can just look up random people based on being their friends or neighbours. They need to be a patient. There are specific patient identifiers that need to be entered into the system, like a Medicare number et cetera, to ensure the person can access. There are professional obligations on these people. There are privacy protections. There are legal and ethical protections. There are penalties for misuse. There is auditing.

I heard the discussions this morning about choice. Importantly, patients do have the choice and option to opt out if they wish to do so. If they are seeing a particular health practitioner—for example, a physiotherapist—and they do not want their mental health history to be disclosed, they can say, 'I do not want access to the Viewer given to physiotherapists. However, I am happy for my mental health records to be given to my social worker,' for example. Liza-Jane probably has some better examples. We have tried to strike a balance and, from the department's perspective, we think we have the balance right.

CHAIR: To clarify, you can say, 'I do not want the physiotherapists to see this information,' or those other allied ones? You can say, 'No, I do not want this particular allied health to see this'?

Ms McBride: Sorry, to clarify, you cannot segment parts of the Viewer record. I think that was the point the Privacy Commissioner was making this morning with regard to it being an opt-in or opt-out, but it is an opt-in to the whole record. I am happy to provide some examples that address some of the issues that were raised that are clinically specific if that would be helpful.

I note that one of the issues the commissioner has raised is around the relevance of information. Before I address that specifically, it might be helpful to explain what we mean when we are talking about self-regulated allied health professions because the purpose of the amendment is to expand it to this additional group of practitioners who are not Ahpra registered, so they are not regulated through the National Registration and Accreditation Scheme that we call NRAS. However, like their Ahpra registered colleagues, as James indicated, they are university trained, highly skilled health practitioners who are subject to the same professional practice, privacy and ethical standards as their Ahpra registered counterparts. In fact, in many cases people do not realise that professions like speech pathology, dietetics or social work are not Ahpra registered.

In talking about that, it is important to really understand that NRAS is really only one form of professional regulation. There are a number of other quite effective forms of regulation, including self-regulation, which these professions are, as well as the statutory codes of conduct administered by governments such as the National Code of Conduct for Health Care Workers. In fact, in 2018 the COAG Health Council issued a communique to clarify that the purpose of the NRAS was to protect the public from harm and not intended as a means to confer a higher professional standing or credibility on those individual professions that are included.

As it is for our medical and nursing colleagues, it is really important that allied health professionals have access to a patient's complete medical and health history, and that is to enable them to provide comprehensive assessment and treatment planning with their patients and their carers. It is generally not possible to determine in advance which records an allied health professional might need access to because it depends on the individual patient and the circumstances at the given time. As I mentioned, these professionals are guided by the same professional, legal and ethical obligations as their Ahpra registered counterparts when they are accessing these records.

An example that talks to the point the OIC raised about why an audiologist would perhaps need access to mental health records is the hypothetical case scenario where an elderly patient presents to a private audiologist with his daughter for assessment following the recent history of falls that has been associated with an episode of vertigo. On an initial history-taking, the audiologist notices some inconsistencies and gaps in the patient's recall about events, including the details of a recent medical admission to hospital. The daughter advises that the father was admitted due to falls but mentions that her father is getting forgetful, they looked into this at the hospital but she does not have any further information. With the patient's and daughter's agreement, the audiologist can quickly check the Viewer and identify that the patient has in fact been diagnosed with mild dementia at his most recent admission, in addition to the suspected vertigo. This information then allows the audiologist to

amend their explanations to the patient, to make sure they take the additional time to clarify understanding, and also to modify the test for vestibular function to reduce the impact the patient's dementia might have on the reliability of the results of the test.

CHAIR: That is a good example that you have drawn there. To clarify, what we have talked about is that patients have to opt in and opt out of the system as a whole. They cannot say, 'I do not want my records on this part to be viewed by these professionals,' at this point under the bill?

Mr Liddy: That is correct. I will clarify as well. The system that we have at the moment—the opt-out system—has been operating since these changes were made back in 2016 or 2017. Initially the Viewer was rolled out to GPs, then to other types of medical practitioners, then to nurses, paramedics and midwives and subsequently to some of the registered allied health practitioners. That has all been done through regulation. Initially the amendments were made through an act that went to parliament which was considered and the opt-out model was considered at that time. It was approved. We have come back to parliament this time because there is a minor definitional issue that we had to fix up in order to allow access by these professions that are not registered professions that Liza-Jane spoke about. The opt-out system is already operational and it has been found to be suitable.

CHAIR: I understand that. We talked a bit about that particular model. Certainly it is a point of difference with the OIC saying, 'We want to open up the Viewer to these professions,' but at the moment the patients do not have the option to say, 'No, I want to block that particular part off.' We have established that.

The OIC made five points, and I think you agreed with a number of them—for example, community awareness campaign, better training and the PIA. I think those have all been welcomed by everyone including the OIC. Obviously there is a difference in opinion about the opt-in or opt-out model which may be a larger question which is not covered by this bill, and obviously the patient restrictions for that particular one. I will go to the issue of community campaign. That is something that you have talked about in your response—having a good community or public awareness campaign. What would you have planned once these changes do happen? What would you have planned or envisaged for an awareness campaign about patients' rights?

Ms McBride: I can talk to that specifically around the additional allied health professions. One of the things we have committed to is working with Health Consumers Queensland to develop some materials around the access for these additional professions. We will be quite guided by them in terms of the best method and means for that distribution, notwithstanding that the Hospital and Health Services themselves will update all of their fact sheets and information related to the consent process so that it is very clear that consumers are able to opt out for any of these additional professions individually.

Mr McDONALD: I appreciate you watching this morning so I do not have to update you on what is happening there. I am a little confused by what you said, Mr Liddy, and what you just said, Liza-Jane, about the opt-in situation. I think you said, Mr Liddy—correct me if I am wrong—that if you did not want to provide a physiotherapist with mental health information you could opt out for that particular practitioner. Is that right, or is it the whole system?

Mr Liddy: The way the opt-out functionality works is that you can opt out of a particular profession accessing your information. It is profession based. You can decide, 'No speech pathologist will be able to access my records'—or no physiotherapist or whatever the case may be.

Mr McDONALD: The individual can make that choice?

Mr Liddy: Yes.

Mr McDONALD: Through consultation with Health?

Mr Liddy: The methodology is to call 13HEALTH on the phone and they can opt out that way.

Mr McDONALD: One of the questions this morning was: are there any jurisdictions where you know an opt-in process has happened? It was pretty clear at that stage that there was not, so I am very comfortable with the opt-in option of capturing people. The examples you have given are great. In terms of education and consultation, we heard that there was an extension of time for the federal process. Are there some learnings from the opt-in process through the federal health information that you might implement which you could share with the committee?

Mr Liddy: The Viewer is a standalone system that is separate to My Health Record. We have checked with other jurisdictions with regard to what they are doing in this space. I would have to say that I think Queensland is leading the nation in terms of this initiative. Our colleagues in Victoria are

very interested in what we are doing. They are looking at going out to tender to do a similar type of system. Each jurisdiction has its own arrangements because public hospitals are effectively a state-by-state responsibility. Some of them share blood test results and things with GPs. A lot of it is moving towards email and more electronic forms of sending information, but it is very piecemeal, state by state. No other state or territory has a system like Queensland has.

Mr McDONALD: The other question I had was with regard to the concept of best interest of the patient subject to mental health issues and the comments that the Law Society had about the Guardianship and Administration Act appointments in that space. Could you enlighten the committee with any experience or evidence that you have around any concerns or issues in that area in terms of safeguards of vulnerable people? I note in your response that you refer back to the Mental Health Act and section 125 or what have you, but I thought, given the conversation of this morning, if you had further to add I would give you the opportunity.

Prof. Allan: I think the issue is that people who are unfit for trial, for example, are going to have a whole lot of issues around understanding, capacity and so on. We believe that having somebody to assist them to help them make those decisions is actually important for protecting their rights and protecting their outcomes. We rarely have issues with people acting in an irresponsible or malicious way. Usually when it does happen, it does become obvious. There have been times where, aside to this issue, for example in family break-ups, people have tried to use some of those things against a person in a Family Court matter and try to obtain information that way. There have been complaints about that and that has been dealt with. Generally we find that people take their responsibilities seriously and act in a reasonable matter. Also, clinicians are aware and would have the capacity to filter out those people.

Mr MADDEN: You may have heard me asking questions of the Privacy Commissioner this morning about the opt-in, opt-out situation and I was quoting from their submission where they propose that it should be opt in rather than opt out—I think I have that around the right way. The basis for that was that an opt-in is more likely to meet contemporary community expectations. Then I asked whether there were any case studies where this situation had failed and he said no. We have had recent incidents where police have illegally accessed information for nefarious reasons and were prosecuted. With regard to the health provider portal, if somebody illegally accessed it, for whatever reason, what is the mechanism for them to be prosecuted?

Mr Liddy: All registered health practitioners in Queensland are overseen by the Australian Health Protection Regulation Agency, Ahpra, and also the Queensland Health Ombudsman. A complaint can be made to the Health Ombudsman or Ahpra about that practitioner and they will do an investigation and take the necessary disciplinary action against the practitioner. The non-registered health practitioners, the ones we are adding in this process—audiologists, speech pathologists et cetera—are also subject to oversight by the Queensland Health Ombudsman. They can take disciplinary action or investigate any health practitioner.

CHAIR: What about the criminal prosecutions, as has happened in the police cases?

Mr Liddy: There is an offence in the Hospitals and Health Boards Act, I think off the top of my head. The penalty is very high. It is a 600-unit penalty. Certainly proceedings can be brought for an offence if someone used the information maliciously.

CHAIR: They would be referred to the police once those initial investigations were done?

Mr Liddy: I believe that is the way the offence would proceed, yes.

Mr MADDEN: I am glad you clarified that because it fits in with the questions I was asking of the Privacy Commissioner about why the Privacy Commissioner was concerned about the current arrangements. Thanks very much. Those are my questions.

Mr HART: Can the department tell us whether they had a look to see whether it is possible to run an opt-in system or a system that allows people to opt out of certain categories? Is it technically possible? Is it too hard to do? Where is the department with that?

Mr Liddy: I would probably have to defer to the IT experts for a detailed answer on that one. In general terms, I think it would be more costly to set up an opt-in system. It certainly would be more difficult to reach consumers to try to convince them to opt in. It would be practically very difficult. Anything is potentially possible in terms of an IT system if you have enough time and enough money, but it is a question of those exact things—the resources being devoted to it.

Mr HART: You have not done any work on that at all?

Mr Liddy: I am not aware of any work being done, no.

Mr HART: Did you have a chance to listen to the Law Society this morning? With respect to the Mental Health Review Tribunal, they were saying that they thought it was a legal requirement to have recordings of those tribunal processes. Have you taken any Crown Law advice or any other advice to see what the legalities of that might be?

Prof. Allan: Yes, we have received Crown Law advice about the legality of the way they record information, and we understand that they meet the Recording of Evidence Act, so we believe that is the case. What the recording is about is improving that and making it more accurate and providing more opportunity for people to look at the record. I note that the Mental Health Review Tribunal have conducted a trial of recording. That has now finished and they feel that it would be satisfactory to do it. There are now some issues around the technical process with regard to cost and setting it up. I am sure you are aware that the pandemic has meant they have moved from having hearings in rooms to very much hybrid hearings, and there are issues around the quality of using a Zoom recording versus what would be considered to be the appropriate legal quality. That is one issue which is a monetary issue. The second issue is whether or not there needs to be an amendment of the Recording of Evidence Act or the Mental Health Act, or whether there needs to be no amendment at all. That is currently being explored.

Mr HART: Finally, there were some issues raised about the delays that are happening in QCAT for appropriate representatives and matters like that in the mental health area. Is the government doing anything to speed up the process of results of QCAT because of this sort of thing?

CHAIR: I am not sure that Queensland Health can answer questions relating to issues of speeding up their processes through QCAT. That might be government policy. I do not know if anyone has anything to add to that.

Prof. Allan: I do not have any information about that.

Mr HART: You are aware of the issue, though?

CHAIR: I think everyone is aware of the delays and burdens on poor old QCAT. Do you have any further questions, member for Burleigh?

Mr HART: No, that is it for now.

Mr SMITH: My line of questioning is around opt in and opt out. Please forgive me if it is repetitive and monotonous. When the bill passes, all allied health professionals will have an ability to log in and have access to Viewer. My question is regarding the details required to log into that patient's profile—name, Medicare number. What are the other identifiers to be able to log in?

Mr Liddy: Not all allied health practitioners will automatically be given access to the Viewer. There is a registration process that the allied health practitioner goes through to get access. It is not an automatic thing. It would only be those allied health practitioners who regularly receive patients from a public hospital that have follow-up care and see it as something that would be valuable to them. In order to get access, there is a registration process. The person has to register with Queensland Health. They have to provide all of their details. I do not know if Liza-Jane can provide more detail about that, but the registration process involves the person being notified of their privacy obligations and the purposes for which they can use the information. Do you want to add anything to that, Liza-Jane?

Ms McBride: One of the implementation issues that will be worked through is around what additional identifiers we will be able to use for registration with the health practitioner portal to replace the Ahpra registration as one of the points of identity. We will be working with the self-regulated professional associations around confirmation that the individuals are in fact accredited with those self-regulating entities. That will create some technical challenges in terms of the time frames for implementation, but the requirements around the information that they will need about the patients will be the same in order for them to be able to access those records. I do not have the details of that, but I imagine their full name, date of birth and Medicare number would be the likely sort of patient identifiers.

Mr SMITH: In that sense then, really unless a patient has actually gone to an allied health professional and unless there is someone out there who wants to start stealing Medicare cards, the allied health professional is not going to access the Viewer unless there is a patient who has actually come to them for a reason. In that sense, is there an avenue where the allied health professional needs to have a discussion and obtain consent before being able to register to access that profile? Is that part of the process or is that something that could be a part of a process and then when you register there is a box that says, 'Patient so-and-so has given consent'? Then we can allow a notification to the patient that someone has claimed consent on their behalf?

Mr Liddy: I think it definitely would be best practice for the health practitioner to have that discussion with their patient, just in terms of the patient-clinician relationship. It is not technically required by the legislation but certainly in terms of the practitioner's professional obligations it would be expected that they would discuss that with the patient. The health practitioner may not even know that the patient had an episode of care in a hospital unless the patient disclosed it in the first place or that was the very reason they were seeing the health practitioner. They might disclose it and say, 'I was just recently in hospital and I now need some rehabilitation,' or 'I have had throat surgery for cancer and I am here to see you as a speech pathologist to help with my speech pathology issue' et cetera.

Mr SMITH: I want to try to settle this opt-in, opt-out and people's privacy and accessing it. Would it not be a good option for Queensland Health to put a little bit of the responsibility back on the practitioner so that when they do register they have to tick a box and fill out details such as, 'I obtained consent from the patient on this day at this referral'? That way, basically the responsibility is on the health practitioner that, 'Yes, I did engage with this conversation. I did have a meeting. I did obtain consent and this is my proof of record.' Therefore, if there is an opt-out, the patient just says in the consultation, 'No, I don't want you to access my Viewer.' When the allied health professional does tick that box it sends out through 13HEALTH a text message to detail it—like we do with COVID and so forth—to say, 'Your physio has accessed your records based on the consent obtained on this date.' Is that not a possibility? It might be some more work, but it might also cancel out the conversations around opt-in, opt-out.

Mr Liddy: These are the types of things that get looked at during the implementation phase for legislation. It certainly is something that we can work on with the professional bodies, the peak bodies, to educate their members about and talk to them about during implementation to see what we can do in that space.

Mr HART: Tom has raised some really good points there. What sort of education or information process may the department run after these changes are made? What information or education programs did the department run after they changed who could access this information by regulation, as Mr Liddy said before?

Mr Liddy: Throughout this process the department has engaged with Health Consumers Queensland, which is the peak body for health consumers. The committee may be interested to know that, although they did not make a submission to this inquiry, they have been supportive of these changes. We are going to work really closely with them during the implementation phase, as Liza-Jane mentioned, in terms of rolling this out to the new allied health practitioners. There will be updated guidance materials and training materials for practitioners and for consumers as a result of these changes.

Mr HART: How do consumers find those?

Mr Liddy: I am aware that there are pamphlets in hospital waiting rooms and things like that. I have seen them. We can send one to the committee if that would be helpful. They are provided now about the Viewer and how people can opt out. It explains to consumers how their information is used. We can certainly provide an example of that.

Mr HART: Are they available in public hospitals?

Mr Liddy: They are, yes.

CHAIR: My question relates to the audits that are conducted on the use of the Viewer. In response to one question, Queensland Health said that potentially inappropriate access is automatically flagged in the monthly lists of access. Can you provide more details on that? How is that flagged and what is flagged?

Mr Liddy: I would have to take that on notice. We could certainly follow up with the auditing team that does the auditing and provide more details about how that works in practice.

CHAIR: For example, when it is accessed and what happens with people who have the same name, as we heard about before. Could you give us some more details about how that flagging process works?

Mr Liddy: Sure.

CHAIR: On the issue of the benefits of the electronic recording of MHRT hearings, Queensland Health said that it is actively considering what happens next. What are the next steps? We have talked briefly about this, but I thought it would be good to actually specify it.

Prof. Allan: The tribunal has done that work. They are looking to make a submission. There are two issues, as I have said. One is really around what it is going to cost and how to actually get the tech to do it. For example, there needs to be some more work done about, as I have mentioned, how to deal with the hardware issues and what is the standard that is required. I am sure that you are aware of the standard you require when you do the electronic recordings of these things. You have people here monitoring and looking after that. Throughout COVID, when you do a recording or do something such as an overseas presentation, there are technicians always there monitoring and making sure the feed works. That would be a big change of practice for the tribunal in terms of cost. The tribunal is not set up as an adversarial hearing. It has tried to be friendly and intimate. However, there is a need, of course, to get that record and have the evidence very clear. All that technical work would need to be done. We would need to look at what the cost of that would be. There have been a number of opinions given about whether or not there needs to be amendment to an act. That would then come together as a package and we would work with the tribunal to put something to government about that. That is happening. I am not sure if we have any time frames on that.

Ms Clugston: The proposal at this stage is to go through our legislative working group as a first step, which is a Queensland Health requirement. They are set down for their first meeting around March, I think—the middle of March. I guess one of the key issues that we need to look at in terms of the legislation is that it sits across two government agencies at this stage in terms of responsibility. Any change we make that might impact the tribunal in either legislation would have long consequences for the Mental Health Court if we did the Mental Health Act or other tribunals set up under the Recording of Evidence Act so we need to look at it all comprehensively before we make a change.

Mr McDONALD: That raises an issue with me, and this is a follow-up to the QCAT issue. Obviously in regulation or legislation—you would know but I do not, off the top of my head—it will inform a person or the court of the process it has to go to before it is referred to QCAT. We have heard that there are delays with the QCAT process. Is that something that Health could take on board, to review that regulation or legislation and to have another step in the process before it is referred to QCAT? As an outsider, it appears that QCAT, which was established to take on a lot of different tribunals, has ended up as a catch-all. Is that something that the department has considered or could consider?

CHAIR: Just to clarify, that is about the appointment of a legal representative to call an adjournment or the appointment of legal people to the MHRT?

Mr McDONALD: It actually raises the issue of the legislation and regulation that Health look after and when matters are referred to QCAT in general.

CHAIR: It is a bit broad and probably outside what we are looking at in the bill.

Mr McDONALD: It is a great question.

CHAIR: I am not denying that. They are always good questions, thank you, member for Lockyer. Certainly there might be a general response.

Mr McDONALD: Can I ask more specifically: has the department considered reviewing regulation or legislation in terms of the matters that affect this bill, in terms of referring to QCAT?

Ms Clugston: Not to date. We have a regular meeting with the Office of the Public Guardian where we could discuss the interface issues and have a look at it more generally.

CHAIR: There are no further questions. A question was taken on notice about information and brochures for consumers. There was another regarding audits of access to the Viewer and how issues are flagged. We will send a copy of those questions on notice to you. Could we have the answers to those questions provided by Friday, 4 February? That concludes the proceedings today. Thank you to Hansard and the secretariat for their work. Thank you to everyone for coming along and being a part of the hearing. A transcript of the proceedings will be available on the committee's parliamentary webpage in due course. I declare the hearing closed.

The committee adjourned at 12.12 pm.