

13 MAR 2008



Australian Government
Department of Health and Ageing

Professor Chris Baggoley
Chief Executive
Australian Commission on Safety and Quality in Health Care
GPO Box 5480
Sydney 2001 NSW

Dear Professor Baggoley

National Patient Charter of Rights

Thank you for providing the Department of Health and Ageing (the Department) with the opportunity to comment on the draft National Patient Charter of Rights (the Charter) and the associated underpinning Principles.

The Department supports the implementation of the Charter because of its usefulness for patients and providers. It is concise and easy to understand. I have attached comments from the Department on the draft of the Charter.

I note that the Charter raises many fundamental and significant issues directly related to the ethical aspects of the delivery of health care in Australia, in what is a complex and very sensitive environment. As a result the National Health and Medical Research Council would like to be actively involved with the Commission in the development of the Charter and intends undertaking further analysis than what was able to be undertaken during the period for comment. I understand that the NHMRC (Dr Tim Dyke) has already been in contact with the Commission about this work.

If you have any questions about this input please do not hesitate to contact Abha Bedi, Director of the Performance, Safety and Quality Section on (02) 6289 8290.

Yours sincerely

A handwritten signature in cursive script that reads 'Sallyann Ducker'.

Sallyann Ducker
Acting Assistant Secretary
Primary Care Policy and Analysis Branch

17 March 2008



Australian Government

Department of Health and Ageing

Comments on the Consultation Paper for the Draft National Patient Charter of Rights

National Patient Charter of Rights and National Patient Charter Principles

The Department notes that the rights, entitlements and expectations of patients also apply to families, carers and other nominated people where appropriate.

The Department suggests that attention should be given to ensuring all patients are aware of their rights by presenting this information in an appropriate manner. Some patients may have a cognitive impairment which could restrict their understanding of the Charter, so the Charter should be presented in a number of alternative ways, such as through the use of illustrations, oral explanations, large print etc. Where patients have extended lengths of stay in hospital, they should be made aware of their rights on entry, should be able to revisit them during their stay and should also be reminded of them after a certain period.

Rights included in the Charter

The Department supports the draft rights included in the Charter. However, it is important that the Draft be crafted (linguistically and theoretically) to take account of the universal nature of the patient rights it asserts. For example:

- The language of rights, around which the project is centred, is arguably diminished by the interchangeable use of the terms ‘patient entitlements’, ‘charter of rights’ and ‘fundamental human rights’ when they are not necessarily the same concept in either definition or intent;
- Right 7 (page 5) appears to assume that privacy and confidentiality are the same concept. Privacy and confidentiality are two different concepts. The Department suggests that ‘confidentiality’ be changed to ‘privacy’ to avoid the risk that there may be an inappropriate overemphasis on confidentiality in situations in which health information needs to be shared between health providers to provide quality health care;
- The current Charter also fails to mention the general right that patients have to access their own health information;
- The patient right to privacy may be better described in terms such as:
‘PRIVACY: I am entitled to be informed and make decisions about how my personal health information will be handled and to have access to my own health information.’

The Charter's focus on Patient Rights in health care settings is consistent with the *Mental Health Statement of Rights and Responsibilities* (the Statement). The Statement outlines the rights and responsibilities of consumers, families, carers, advocates, governments and service providers (health and non-health focused, including those in community based settings) across policy and program development, implementation and health care provision in the mental health sector.

Points included in the Principles

Line 2 of “Access” (page 6), which states “be admitted to a public hospital as a public or a private patient”, could be clarified with an additional sentence which states: “Where patients are public patients, services must be provided free of charge.”

In the Charter there is an expectation that patients are to provide medical histories. The inclusion of a point encouraging the involvement of a patient's GP with the patient and their treatment while in hospital would be of particular assistance to patients, many of whom are older people, who are undergoing extended medical treatment and may be involved in a number of different health and care systems.

The Principles' inclusion of "effective continuity of care and appropriate referrals" (page 6) and "discharge and continuing healthcare arrangements when in hospital" (page 7) are noted as being of particular importance for mental health consumers to support sustainable recovery in the community and prevent relapse. A patient's entitlement to access "care that is appropriate, timely and based on need, not the ability to pay" is also highly relevant to mental health consumers in order to minimise the need for a mental health consumer to be admitted into mental health care involuntarily (page 16: the *Mental Health Statement of Rights and Responsibilities*).

The Department suggests that there be more explicit reference to Indigenous Australians and people from culturally and linguistically diverse backgrounds in Principle 2 - Respect. This might be possible in both the Charter and the Principles document.

The Department suggests that some adaptation may be required in Indigenous health care settings both within mainstream service providers and, more particularly, in Aboriginal and Torres Strait Islander community controlled health organisations. The Department suggests that the Commission consult key stakeholders from within the Aboriginal and Torres Strait Islander community controlled health sector regarding this issue.

Rights and responsibilities

The Department would prefer the charter and its principles (pages 4-8) to incorporate more patient responsibilities such as those outlined in Queensland Health's public patient charter. These responsibilities relate to actions patients can take, such as being on time for appointments.

Existing Charters

The Department recognises the important role that the Commission has in reviewing the States and Territories Patient Charters. The development of a National Patient Charter of Rights and National Patient Charter Principles will provide a recognised minimum standard for the Commission in reviewing any future changes to these Hospital Charters. The inclusion of the accompanying Principles is important as it provides further guidance, above the Charter of Rights, for health providers in developing their own Charters and supporting policy development.

Possible uses of the Charter

The Department recognises the continuing importance of the Public Patients' Hospital Charters, sees a continuing role for the Commission in the review of public patients' hospital charters and supports the draft National Charter of Patient Rights as being a sound basis for this work. The charter may be useful in accreditation processes, provided that objective measures of adherence can be developed.

How the charter applies in different sectors and settings

The Department supports the brevity of the proposed charter's rights and principles to assist patients' engagement. However, further detail needs to be available to patients should they wish to avail themselves of the rights and principles in practice. For example, if they feel their privacy has been breached, patients need appropriate information to be able to make a complaint. Patients also need to understand how to elect to be a public or private patient and what this election means in practice. Supporting documents, therefore, need to be made available. The

Department suggests that the charter lists a link to a Commission-based website (which might link to other sites) that provides access to key current documents.

In addition, attention should be given to ensure that the Charter complements the Clinical Handover project of the Commission to ensure patients, particularly older patients, and those transferring between systems (such as transition care or residential aged care), are aware of their rights to care and that there is communication between the different systems regarding patient health histories to ensure correct care is given.

There will need to be some consideration about implementation of the Patient Charter. For example, while it is laudable to say that everybody has a right to equitable access, what does that mean in practical terms for rural and remote health care? How will communication be facilitated for people from culturally and linguistically diverse backgrounds?

Other Comments

There are a number of definitional and/or typographical inconsistencies in the Draft. For instance, reference to the 2003-2008 Australian Health Care Agreement Schedule D – Public Patients Hospital Charter and Complaints Body, 1998. Elsewhere there is reference to a Private Patients Hospital Charter (page 1). Since there are no citation details for this document, it is not clear if it is the same as, or different to, the Public Patients Hospital Charter.

There is consistent reference to global and overarching frameworks for rights, for instance, the United Nations Declaration of Human Rights. This is welcome although there are assumptions in the Draft about how such documents would inform other matters raised in the Draft. For example, it is not clear how this Draft is to be adapted and applied as a ‘standard setting, accreditation, education and training’ device for universal human rights as they apply in health care. To have any practical and beneficial effect such assumptions need to be much more clearly articulated.