VICTORIA

16 December 2009

E-Health Branch
Primary and Ambulatory Care Division (MDP1)
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Via email **ehealth@health.gov.au**

Dear sir/madam,

EXPOSURE DRAFT HEALTHCARE IDENTIFIERS SERVICE BILL 2010 (FED)

The ADAVB appreciates the opportunity to respond to the Exposure Draft of the Healthcare Identifiers Service Bill 2010 (FED), as it affects dental practice and the provision of dental services.

ABOUT THE ADAVB

The ADAVB represents over 90% of registered dentists in Victoria and has a longstanding commitment to safe and high quality dental care being provided to the entire community. We are pleased therefore to support the general thrust of the draft Bill, both as it applies across all health professions, and as proposed specifically for dentistry.

The ADA operates as a federation and ordinarily the ADA Inc. (the federal body) responds to Commonwealth initiatives and issues. In this case, where regulatory measures are being transferred from a State jurisdiction to a new national scheme, but with some continuing State based variations, we feel it is necessary for separate submissions to be made.

As the peak professional body for dentists, the ADAVB has a long history of acting in the public interest as well as representing our members. The ADAVB mission statement reads: *"The ADAVB is an association of dentists* ***committed to advancing the*** *art, science and* ***ethics of dentistry, the care of the oral health of all Victorians****, and the professional lives of its members."*

We highlight the ethical and community dimensions here because health professions are sometimes characterised (unfairly we believe) as being simply 'vested interests'. Our view of professional obligation continues to place patient welfare first, and that means we hold strong views about the way regulations need to be framed to protect public health and safety.

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Various ADA Branches have long employed senior dentists to assist members and professional indemnity (PI) insurers, with whom they have corporate authorised representative agreements, to deal with patient complaints and administer dento-legal matters. In fact, most of the advice they provide is for complaint resolution rather than for the purpose of a legal proceeding (and our legal advice indicates it is arguable that a disciplinary matter is not a legal proceeding) or for the purpose of being provided to a lawyer for the preparation of legal advice.

CONTEXT

The introduction of e-Health measures occurs as part of a comprehensive reform agenda being advanced by the Federal and State Governments. While the ADAVB has some concerns about the logistics of the change, and certain of the requirements which seem more suited to large hospitals than to small office based practices, we generally support the move to e-Health records and understand the importance of healthcare identifiers.

Mandatory practice accreditation and other safety and quality measures are also being introduced at this time, as well as proposed new Medicare Select and Denticare schemes, each of which will create substantial additional administrative burdens for dental practices.

In our representations in response to the proposed National Registration scheme for health professions, the ADAVB has also accepted that professional indemnity (PI) insurance is a mandatory requirement for those seeking registration. This is essential to ensure that health consumers are adequately protected in the event of a treatment failure – whether due to alleged negligence or to misadventure.

In the light of the Government's recognition of the importance of professional indemnity insurance as a consumer protection mechanism, we suggest that the Healthcare Identifier legislation should also recognise this, and its implications for the way that consumer problems are identified for response.

ISSUES OF CONCERN

The AHMAC Publication Enhancing the Foundation for an e-Health Future (November 2009) states:

> *"These healthcare identifiers will be assigned by the HI Service, and are designed to be used by healthcare providers as unique reference numbers in their own health records systems." (emphasis added) (2009: 12)*

Later the paper describes the purposes for which healthcare identifiers can be used and notes that while a healthcare provider may determine who is permitted to use and disclose identifiers, this can only be for one of the listed purposes.

> *"There will be clearly established limits on the adoption, use and disclosure of healthcare identifiers. Healthcare identifiers can only be used for:*
> *• Health information management and communication in delivery of a health service*
> *• Management, funding, monitoring and evaluation of a health service*

• Health research where approved by a Human Research Ethics Committee in accordance with the requirements set out by the Privacy Act
• For the purpose of establishing an authentication mechanism (such as a digital certificate) for a HPI-I and HPI-O
• Where otherwise authorised or required by law Only 'authorised users' listed above will be permitted to access the HI Service to obtain IHIs and HPI-Is.

Once identifiers have been obtained from the HI Service and are available either via a healthcare providers system or included in a healthcare record, the healthcare organisations will determine who is permitted to use and disclose the identifiers, but only for one of the purposes specified above." (2009: 21)

While the Government's concern to closely guard the use of healthcare identifiers is understandable given that an HI will link to so much information, we suggest that the use of patient health records in the resolution of disputes and complaints has not been adequately considered in the framing of these purposes.

Under Section 15 of the draft legislation, a healthcare provider is authorised to use/disclose a healthcare identifier "*for the purposes of communicating or managing information, as part of:*

(a) the provision of healthcare to a healthcare recipient; or
(b) the management, funding, monitoring or evaluation of healthcare; or
(c) the conduct of health or medical research that has been approved by a Human Research Ethics Committee"

We take this to mean that the disclosure of HI's to an entity such as the practitioner's professional association or professional indemnity insurer (in our case the ADA and Guild Insurance Ltd (GIL), does not fall within Section 15. This view is supported by reference to Section 16, which provides that the legislation does not authorise an entity to use or disclose a patient's HI for the purposes of "*an insurance business*" other than for the purpose of providing healthcare to a person. We note that "*Insurance business*" is defined in Section 16(2) to include a health insurance business, a life insurance business or "*any other business of undertaking liability, by way of insurance (including reinsurance), for any loss or damage, including liability to pay damages or compensation, contingent on the happening of a specified event*".

Section 17 then provides that it is an offence to disclose an HI. This part sets out a specific prohibition on the use or disclosure of healthcare identifiers of recipients of healthcare (i.e. consumers) for health, life or other insurance or employment purposes. It also includes an offence for any use or disclosure of a healthcare identifier by a person that is not authorised under the proposed healthcare identifiers legislation or another law. Two types of offences have been specified, a criminal offence attracting a penalty of 120 penalty units or imprisonment for 2 years or both and a strict liability offence attracting a penalty of 60 penalty units.

Under the terms of standard PI insurance, early reporting provides the insured health practitioner with an opportunity to obtain legal and/or peer advice with a view to resolving the circumstances to the satisfaction of the insured, the patient and the insurer.

When a health practitioner notifies GIL (or the ADAVB as a corporate authorised representative of GIL) of circumstances or a claim, GIL requests that the practitioner provide GIL with a number of documents including the patient record. This information is required to ascertain whether the health practitioner is entitled to indemnity under the policy and if so, to properly manage the patient complaint/claim.

It is therefore necessary for health practitioners to provide their PI insurer with a copy of the patient record in order to comply with contractual obligations to the insurer and to allow agents of the insurer (e.g. peer advisors and lawyers) to provide advice on claims management. For example, if a patient lodges a complaint against a dentist with the Dental Board, the dentist will be asked to provide GIL (and its agents) with a copy of the complaint, any relevant correspondence and the patient record.

We assume that under the Bill, health practitioners will record a patient's healthcare identifier on the patient record. In those circumstances the patient healthcare identifier may be disclosed to the PI insurer, such as GIL (or the ADAVB as a corporate authorised representative of GIL). Neither GIL nor the ADAVB have any use for the patient's healthcare identifier. They will receive it merely because the healthcare recipient identifier forms part of the patient record.

The way the Bill is currently framed, practitioners would be obliged to print out a copy of their records (contrary to the e-Health objectives) and black out the patient's HI number before sending the print out by mail to their insurer. This is inefficient, prone to error, and we suggest it is both unrealistic and unreasonable in small office based practices. If left as is, the effect of the Bill on healthcare complaint management would be to negate several of the key reasons for introducing e-Health measures, namely eliminating the use of paper thereby helping the environment, saving time and money, and better securing records.

RECOMMENDATION

We therefore suggest that sections 15 and 16 of the Bill be amended to accommodate the role of the practitioner's PI insurer. The proposed amendments are in bold and underlined below.

15 Disclosure and use for other purposes

(1) A healthcare provider is authorised to use a healthcare identifier, or to disclose a healthcare identifier to an entity, for the purposes of communicating or managing information, as part of:

(a) the provision of healthcare to a healthcare recipient; or
(b) the management, funding, monitoring or evaluation of healthcare; or
(c) the conduct of health or medical research that has been approved by a Human Research Ethics Committee; or
(d) <u>the reporting of circumstances and/or claims to the healthcare provider's professional indemnity insurer.</u>

(2) The entity is authorised:

(a) to collect the information; and
(b) to use the information for the purpose for which it was disclosed to the person.

16 Use of identifier for insurance and employment prohibited

(1) This Act does not authorise an entity to use or disclose a healthcare recipient's healthcare identifier, which is disclosed to the entity under this Act, for the purposes of an insurance business, other than for the purposes of providing healthcare to a person **or in connection with the authorised use and/or disclosure set out in Section 15(1) (d).**

If Section 16 of the Bill was amended as set out above then PI insurers like GIL could continue to manage claims without breaching Section 17 of the Bill.

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