



**AUSTRALIAN DENTAL  
ASSOCIATION INC.**

**Australian Dental Association Inc. response to  
National Registration And Accreditation Scheme  
For The Health Professions**

**CONSULTATION PAPER**

**Proposed arrangements for information sharing and privacy**

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**Authorised by  
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AUSTRALIAN DENTAL  
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## **SUBMISSION IN RESPONSE TO CONSULTATION PAPER**

### **Proposed arrangements for information sharing and privacy**

The Australian Dental Association Inc. (ADA) is the peak national professional body representing about 10,000 registered dentists engaged in clinical practice. ADA members work in both the public and private sectors. The ADA represents the vast majority of dental care providers. The primary objectives of the ADA are to promote the practice of evidence-based dentistry and encourage access for all Australians to affordable preventive oral care. There are Branches in all States and Territories other than in the ACT, with individual dentists belonging to both their home Branch and the national body. Further information on the activities of the ADA and its Branches can be found at [www.ada.org.au](http://www.ada.org.au).

The ADA thanks the Practitioner Regulation Subcommittee of the Health Workforce Principal Committee for the opportunity to respond to this Consultation Paper. It is also grateful for the opportunity afforded it to attend the national forum organised by AHMAC.

This submission will deal with the Paper in the order in which it was presented. It will only respond specifically to issues of interest to the ADA by dealing with each of those Proposals. Should a Proposal from the Paper not be responded to, then the ADA has no comment or input to make in respect of that proposal.

#### **Consultation Paper:**

##### 1. Background

##### Scope of paper.

The ADA agrees that the key factors in the development of a national scheme relating to information sharing and privacy have been identified in the "Background" to the Paper. What is needed to be created is a scheme that will correctly balance the benefits of information sharing whilst at the same time maintaining existing principles of privacy for both the practitioner and patient. There cannot be any undue focus or provision of primacy to either the practitioner or consumer. Rather, as the Principles state in the paper there has to be the creation of a balance of rights and interests of consumers with those of health practitioners.

Pertinent to the topic addressed in this Consultation paper, the ADA in its Policy on *Dental Acts and Boards* states:

**"3.1.6 Communication with the Public**

- *It is essential that Boards inform the public on relevant matters pertaining to the regulation of dental practice within the Board's jurisdiction.*
- *Communication with the public should include:*
  - *availability of that part of the Dental Register which is open to the public,*
  - *Annual Reports,*
  - *current statutory requirements*
- but, should not include:*
  - *any claims lodged or settlements determined,*
  - *any conditions on registration that are not current,*
  - *the naming of impaired providers who are not currently practising,*
  - *any previous penalties levied against a dental care provider."*

The ADA suggests that these recommendations be followed in the Scheme to be created.

[2. Overview of information required to operate the scheme.](#)

The ADA accepts the stated information function of the Board and Agency but emphasises that the exercise of that function has to be carried out recognising that the primary purpose of the new registration process is to register health practitioners in the interest of the protection of the public.

As stated earlier, any release of private information concerning a health practitioner can only be done when the interest of the protection of the public justifies such action. There needs to be a direct correlation between the protection required and the disclosure. Only in the most serious of cases should the protection of the privacy of the health practitioner be lowered by disclosure of information.

Disciplinary action under the new registration scheme can involve a number of different stages being passed through from initial receipt of a notification, preliminary investigation, hearing and then a decision being made by either a tribunal or Board. So as to ensure that processes of natural justice are followed and privacy principles complied with, the ADA requires that there be absolutely no annotation of the details on a practitioner's records in respect of a notification until there has been a final determination.

Protections against misuse of any power must be incorporated in the scheme designed.

[3. Information to be collected.](#)

The ADA supports the proposals under 3.1. It suggests that there is no need for home address details to be provided as place of residence serves no public benefit and would request that this requirement be removed. If however a registrant uses their home address as a mailing address then it should not be on the public register.

### **Proposal 3.2.1**

Practitioner registration is personal. The provision of “employer and other similar details” by practitioners places an onus on the practitioner to keep the Board or Agency informed of workplaces. As the focus is personal safety, the ADA sees no reason why this information needs to be provided to the Board. If a registrant’s status changes or conditions are placed on practice, it must be the personal responsibility of the practitioner to comply. There is no necessity for a collection of workplaces to be informed of these matters-which in the case of some restrictions may not be relevant to that institution or place of practice.

However, the ADA has no opposition to the creation of a requirement that the practitioner be then obligated to supply information to Boards as to places of practice and to then be required to discuss with the Board what action, at those places of practice, should be taken in respect of the status change or condition being imposed. It is anticipated that not all status changes will be required to be communicated to all institutions and this suggested methodology provides the correct balance between patient protection and practitioner privacy.

For these reasons the ADA would support option 2.

### **Proposal 3.3.2.**

There should be some framework outlined that will identify what the public interest is that will be served by provision of data that will serve e-health developments. NEHTA’s and Medicare’s ability to “adopt” and “disclose” information should only be confined to issues relating to patient safety. Data distribution to other organisations designed to enhance that organisation’s efficiency or practices should not be permitted. Removing restrictions on privacy of practitioner information would not be justified in these circumstances. It would not serve patient safety.

If data is to be shared in such circumstances then no blanket authority should be provided under national registration but rather individual permission of the health practitioner must be obtained.

### **Proposal 3.4.1.**

Option 1 would seem the most convenient and effective.

### **Proposal 3.8.1, 3.8.2, 3.8.3 and 3.8.4.**

Workforce planning is essential and the ADA would seek to adopt measures to support this. However the creation of a national registration scheme is primarily designed to improve patient safety and the delivery of health services and any workforce planning objectives should be secondary to the process. To therefore superimpose an obligation on practitioners that serves workforce data collection is onerous and not consistent with the focus of national registration.

To meet the Government’s needs to review workforce data, the ADA would be prepared to agree with the sentiments expressed in the proposals. Certainly the efficiency of collection of “national” data is encouraged. The ADA would support encouragement of practitioners utilising electronic renewal processes. Specific

workforce data should be collected separately without identification as occurs in dentistry currently. De-identification must be assured in all instances-particularly in remote or isolated regions where provision of basic data may create identification.

What is not understood in the Consultation paper is why workforce data collected will not be made available to the Boards and Agency for their purposes as specified in Proposal 3.8.3. In fact the ADA would suggest that rather than empower the Ministerial Council to request workforce data from the Agency, this power ought to be provided to the Boards which then have a duty imposed to, as soon as possible publish the relevant workforce data that is collected. The creation of an intervening organisation such as the AIHW to receive analyse and report on workforce would not necessarily serve the public interest as it would only create a potential delay in provision of the material. Publication by the Boards of workforce data should be mandatory (by say inclusion in the annual reports of the Boards). Organisations such as AIHW and others would then have access to the data as would the public.

Regarding the list commencing on page 10 of 37 the ADA suggests under "Demographics" replace "Sex" with "gender" and "Residential postcode" with "Practice postcode".

#### [4. Publically available information](#)

##### ***Proposal 4.1.1.***

The ADA questions the reason for provision of a "contact address and name of postcode area." The dilemma being faced here is appreciated in that in some cases it may be necessary to include such information to enable the public to distinguish between professionals with the same/similar names. Providing a contact address – which for practitioners working from multiple sites may mean provision of residential details - is requiring the disclosure of private information for no appreciable benefit to the public. Perhaps the provision of one work/practice postcode would be more effective. So for (c) change to "Postcode of practice address etc." Also change (b) to "gender" and for (j) a limit of how long this should remain after the suspension is served, should be set, say five years.

##### **Proposal 4.2.**

This is opposed for the reasons set out here.

Of the 4 options provided under this heading, the ADA would prefer Option 2 on balance. The ADA can see little if any added benefit from all the other options and feels the adoption of option 2 provides the correct balance between the interests of patient safety and privacy of practitioners.

A register of practitioners should be just that and the ADA sees no need for the inclusion of de-registered practitioners regardless of the reason for their de-registration. A register should be the repository of details of currently registered practitioners only. Identification of de-registered practitioners serves no purpose. If it did then there would be no logical reason why details of deceased practitioners should not be included.

A compromise may be that Option 2 is adopted but that the Board keep a separate confidential register of those practitioners that have been de-registered. By this

means a register of de-registered practitioners would be kept for reference by appropriate authorities, including the board, but not be accessed by the public.

***Proposal 4.3.1***

Care needs to be taken to ensure that the conditions do not indicate the practitioners' illness.

***Proposal 4.4 Online Public Register and 4.5.1.***

Data available on this public register will be a valuable resource. If information there is to be made available for a fee, as is proposed then fees received should be utilised to counter registration costs. The ADA would be reluctant to permit the Agency to provide this information to commercial entities as this may only generate receipt of unwanted advertising/promotional material. There are already many complaints from professionals relating to State and Territory boards selling such data to commercial interests and those professionals being inconvenienced by contact from marketers. The register should remain just that a register and not converted to a marketing tool for innovated marketers. Release of the data to research or similar organisations should however be permitted if it can be seen as in the interests of the community.

***Proposal 4.6.1 and 4.6.1.***

The ADA feels the public interest would only be served by the publication of tribunal, board or committee decisions if the decision made was an unfavourable one to the practitioner resulting in some finding that impacts upon the practitioner's ability to practise. The public interest would not be served by publishing decisions that made no adverse finding by any authority or findings that recorded only minor matters which did not impose any restrictions on practice.

Of the 2 options the ADA would support Option 2 but would add the caveat suggested above. Publication of findings that have had no impact on the practitioner's ability to practise serve no useful purpose. They could only create some unjustified suspicion in the minds of some members of the public.

[5. The Privacy regime.](#)

***Proposal 5.1.1 and 5.1.2***

Proposal 5.1.1 and 5.1.2 are supported for the reasons stated in paragraph (a) of the paper.

[6. Confidentiality](#)

The only comment the ADA would make here is that perhaps where uncertainty exists on privacy issues the services of the Agency's legal advisors or those of the Privacy Commission be sought.

## 7. Information Sharing.

### ***Proposal 7.3.1.***

Qualified support for this is provided by the ADA. The ADA contends that if this power is to be given then the following should apply:

- The power be confined to the Board and not made available to the Agency. It is the Board not the Agency that will be best able to evaluate when release of information is in the public interest. The Agency's function should remain administrative and be at the request of the Boards.
- Parameters have to be put in place to set out the "circumstances" when material is to be provided to the PSR.

### ***Proposal 7.5.1.***

For reasons similar to those expressed in 7.3.1 the ADA feels that the Agency should firstly consult with the relevant Board prior to disclosure of this information to determine if such action is suitable.

## 8. Health Records

### ***Proposal 8.1***

For no reason other than the ADA would see the retention of records as an administrative task, the ADA suggests this task is one best left with the Agency rather than a Board. Much more detail and work is required before this could proceed.

The ADA again wishes to thank the Subcommittee for the opportunity to reply to the Consultation Paper.



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8 December 2008