

# Submission by the Health Practitioner Registration Boards<sup>1</sup>

## on the Proposed Arrangements for Information Sharing and Privacy

### Introduction

This submission is on behalf of all twelve health practitioner registration Boards except where identified. Where no comment is provided, the proposal as detailed in the consultation paper is endorsed by all Boards. In this regard, the Boards have chosen to submit only on those proposals which they believe require further consideration.

In submitting on the proposed arrangements, the Boards recognise that more detail will be incorporated in the legislation. However, to ensure that such detail is driven by sound policy positions, this submission will address both the broad policy positions proposed and the lower level detail where it is considered necessary to inform the policy position.

### Section 3 Information to be Collected

**Proposal 3.1.1:** *It is proposed that all requests for information will indicate the purposes for which it is being collected.*

#### Submission of the Boards

It is unclear whether this proposal is a general motherhood statement or the expression of a privacy principle which will apply to the information collected by the national boards. To the extent that it is an expression of a privacy principle, the Boards endorse that principle. If it is intended that the motherhood statement be established as a statutory obligation requiring the national boards to provide an explanation of the purposes for which collected data will be used every time data is collected, the proposal is not supported. This is because of the cost of providing such explanations and as it may fetter the discretion of the national boards in using that information consistent with the objects of the legislation.

**Proposal 3.1.2:** *It is proposed that the national scheme legislation provide for the following key categories of information for the registration of individuals.*

#### **b) Date of birth**

*In order to properly identify an applicant, date of birth will need to be collected.*

#### **c) Qualifications**

*In order to be registered, applicants will need to provide a transcript of qualifications obtained which entitle them to registration, the year obtained and the institution that awarded the qualification. Verification of qualifications may be required from the institution issuing the award.*

*In addition, proof of satisfactory completion of a requisite examination or period of supervised practice (including date of completion) will be required, where relevant.*

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<sup>1</sup> Chiropractors Board of Queensland, Dental Board of Queensland, Dental Technicians and Dental Prosthetists Board of Queensland, Medical Radiation Technologists Board of Queensland, Occupational Therapists Board of Queensland, Optometrists Board of Queensland, Osteopaths Board of Queensland, Pharmacists Board of Queensland, Physiotherapists Board of Queensland, Podiatrists Board of Queensland, Psychologists Board of Queensland, and Speech Pathologists Board of Queensland.

#### **d) Overseas registration details**

*If applicants have overseas qualifications and have previously been registered overseas, they will be expected to arrange for the relevant regulatory authority to issue a Certificate of Good Standing directly to the board or relevant assessment body. A decision will be required as to whether this is required from the initial and most recent country of registration, or from all countries in which the applicant was registered, or for a specific time period.*

*Additional requirements may include a work statement, evidence of competence to practice and of English language proficiency.*

#### **Submission of the Boards**

The Boards submit that there are a number of further matters that must be considered as key categories of information. First, in addition to date of birth, the national boards should be empowered to collect country and town of birth for those born overseas and state and town of birth for those born in Australia. The Boards have been advised by the Queensland Police Service that collection of this data is necessary in order to effectively and efficiently identify individuals for the purpose of criminal history screening.

Second, evidence of qualifications should also include such instruments as degrees, diplomas, etc. as it is this category of instrument which can be more readily verified through both internal assessment and with primary source verification. It is further submitted that an additional evidentiary instrument, consistent with proposal 4.2.1 in the consultation paper on the proposed registration arrangements, would be copies of an examination result undertaken by an applicant for registration. The Boards also submit that the legislation should not mandate a requirement for all applicants to submit a transcript of their qualification. This would appear to be a costly exercise both in time and money for those applicants who graduate from a current prescribed course or one accredited in the future by the national board or its delegate. This should be a policy matter determined by each of the national boards.

#### **Section 3.2 Employer Details**

**Proposal 3.2.1:** It is proposed that the national scheme legislation provide the boards with the power to collect employer details and other similar details in order to enable notification by the relevant board to employers when a practitioner's registration status changes or conditions are placed on practice.

There are two options to give effect to this arrangement:

**Option 1:** Require name and address of employer, public health organisations, private hospitals, day procedure centres or nursing homes at which the practitioner is accredited to be recorded on registration and updated on renewal.

**Option 2:** Provide the boards with a power to require the practitioner to provide these details to the board, as necessary.

#### **Submission of the Boards**

The proposal that the national boards be required to collect, record and update on renewal the name and address of employer, public health organisations, private hospitals, day procedure centres or nursing homes at which the practitioner is accredited or employed, is opposed on the basis of its utility and the extensive cost impact for data entry and maintenance of data. In this regard, the Boards request that it be noted:

- A significant number of the professions practice and/or are employed at multiple locations (for example, a VMO with rights to private practice could practice at four or more locations; a dental specialist may do sessional work at up to six different practice locations; a registered nurse may do shifts at multiple locations during each pay period).
- In costing the introduction of criminal history screening, the Office of Health Practitioner Registration Boards identified that the entry of two additional pieces of data for 27,000 registrants required a resource of 1 FTE data processor.
- It is the experience of the Office of Health Practitioner Registration Boards that registrants primarily comply with their notification of change of address obligations when they are renewing their registration and not within the 21 day period of the change occurring. If this proposal is introduced, a further complex data entry process will have to be maintained, either by the registrant directly online or by staff employed by the agency.

Given the above noted factors, Option 2 is supported by the Boards as both cost effective and efficient. However, there is a concern that such notification requirements shift obligations from employers and others to the Boards. It also relies on the honesty of the registrant to notify the Board of all locations at which they are employed or accredited to practise. Additionally, it does not address the situation where: (a) an employer employs a health practitioner or authorises their practice through a credentialing arrangement in circumstances where the individual does not hold current registration; or (b) a registrant changes employers and/or practice locations following the initial notification to the Board. To respond to these matters, the Boards submit that:

- obligations be placed on employers to ensure that a person is registered at the time of employment (or credentialing for practice as the case may be) and that the person continues to be registered during the course of that employment (or credentialed practice);
- the legislation should establish significant penalties for the provision of false information by a practitioner when they are required to provide these details to the national board and such penalties must include options for either a monetary fine or a prison sentence or both; and
- the information technology infrastructure provide a simple mechanism for employers and those responsible for credentialing to monitor any changes in registration status for their employers or those credentialed to practise in their organisation (a model for this mechanism is available from the Office of Health Practitioner Registration Boards which has implemented such technology for employers and credentiallers in Queensland).

### **Section 3.3 The Unique Identifier**

***Proposal 3.3.1:*** *It is proposed that the legislation require that each registered health practitioner be allocated a unique identifier in the new registration system.*

### Submission of the Boards

The Boards support the introduction of a unique identifier for registrants and further propose that each new registration held by a registrant be assigned a unique identifier. For instance the example used in the consultation paper whereby a registrant is registered as a nurse and subsequently qualified for registration as a doctor, the first registration as a nurse will be assigned a unique number (e.g. <Registration number>/01), and the registration as a doctor a new number (e.g. <Registration number>/02). Similarly, if registration lapses, there is a gap in registration and the applicant is required to re-apply for registration, the new registration will be assigned a new number (<Registration number>/03).

Effectively, each registration will be recognized as a separate “case”. This will assist with the separation of responsibility between the national boards, enable the retention of historical information and records in relation to the actions taken against that registration (e.g. conditions imposed), and provide a clear distinction between periods of registration. The same approach can be applied to conduct, performance and health assessment cases.

**Proposal 3.3.2:** *It is proposed that the national scheme legislation authorise NEHTA and Medicare Australia, to adopt, use and disclose the unique identifier allocated to practitioners in order to enable e-health developments and other information sharing in the public interest. It is further proposed that the legislation governing the operation of NEHTA and Medicare Australia provide appropriate protection for the information provided to these agencies by the national scheme.*

### Submission of the Boards

The Boards acknowledge that such sharing of information with adequate protections against misuse may enhance the ability of each agency to effectively discharge their responsibilities. However, there is insufficient detail in the proposal for any further comment. The Boards suggest that the policy needs further explication so that informed comment can be made about a more detailed proposal.

### **Section 3.4 Identity Checking on Initial Registration**

**Proposal 3.4.1:** *It is proposed that the national scheme legislation provide a power for boards to require identity checking, through photo identification and a “100 point check” system. There are three options to give effect to this arrangement:*

**Option 1:** *All boards to require identity checking on initial registration post 1 July 2010, but not for existing registrants.*

**Option 2:** *Boards to decide whether identity checking along the lines of Option 1 will be required in their profession.*

**Option 3:** *Boards to decide whether identity checking along the lines of Option 1 will be required for only some applicants for registration.*

### Submission of the Boards

Consistent with its submission on the proposed registration arrangements, the Boards strongly endorse Option 1 as proposed. It should be noted that Options 2 and 3 are not supported as they appear to be based on a view that the risk of identity fraud can be differentiated on the basis of which category of health practitioner registration the applicant is seeking to attain. It also has the potential to modify the process of assessment for

registration and this does bring some risks as staff should be trained against a standard assessment process.

### **Section 3.6 Information to be Collected on Renewal**

#### Submission of the Boards

The Boards rely on their submission on the proposed registration arrangements in regard to the renewal process which was as follows:

*The Boards support the proposal that an obligation be placed on registrants to notify of compliance with relevant matters as the basis of renewal of registration. Such notification should not require the Board to review documentary evidence at the time of renewal so as to avoid a major and complex bureaucratic burden. Such a burden will limit the viability and usefulness of online renewal processes where the payment of renewal fees is separated from the submission of evidence in support of the application.*

*If all proposals in the consultation paper are included in the legislation, an applicant for renewal will have to:*

- *Report on how the Boards' continuing competence requirements have been met.*
- *Report if charged with or convicted/subject of a finding of guilt for an offence punishable by twelve months imprisonment or more.*
- *Report on any professional negligence claims.*
- *Report if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer.*
- *Provide any data required by the Ministerial Council for workforce planning purposes.*
- *Require registrants to demonstrate PII coverage to the satisfaction of the responsible Board.*
- *Require the registrant to be screened for a criminal history.*

*Renewal of registration to mitigate risk would be more cost effective by requiring the applicant to make certain declarations of compliance, to audit a representative sample of applicants and to include in the legislation breach provisions that provide a significant disincentive to applicants providing false declarations of compliance. Such disincentives should also address the situation where a practitioner drops PII cover after renewal. Consistent with this approach, the Boards propose that an applicant for renewal be required to:*

- *Declare compliance with the continuing competence guidelines issued by the relevant Board and that they will only engage in practice for which they are competent in the new registration period.*
- *Declare that they have reported (as will be required under Proposal 9.4.3) any charges and convictions where a finding of guilt for an offence led to a punishment of twelve months imprisonment or more.*
- *Declare that they have reported (as will be required under proposal 9.4.3) any professional conduct action taken against them by a foreign regulatory authority.*
- *Declare that they have reported (as will be required under proposal 9.4.3) any health condition that impacts on their ability to safely and competently practice.*
- *Declare that they have reported (as will be required under Proposal 9.4.3) any professional negligence claims where a judgement has been made or where the proceedings or part of the proceedings have been settled during the registration period.*

- *Declare that they have reported (as will be required under Proposal 9.4.3) if any clinical privileges or credentials have been withdrawn or restricted by a health service body or third party payer during the registration period.*
- *Declare that they have maintained PII coverage consistent with guidelines issued by the relevant Board and that they will maintain that coverage for the new registration period.*
- *Provide data required by the Ministerial Council for workforce planning purposes.*

### **Section 3.8 Information to be Collected for Workforce Planning Purposes**

**Proposal 3.8.1:** *It is proposed that the national scheme legislation provide for the Ministerial Council to specify from time to time, certain data items that must be collected as part of registration and renewal of registration processes where these data items are needed for workforce planning purposes as long as there is a clear need for the data and it is not too burdensome. Note that provision will also be made for additional data to be collected on a voluntary basis.*

**Proposal 3.8.2:** *It is further proposed that the current voluntary paper-based labour force surveys conducted by current boards on behalf of jurisdictions be discontinued.*

**Proposal 3.8.3:** *It is further proposed that information collected purely for workforce planning purposes will not be made available for board/agency purposes.*

#### Submission of the Boards

Prior to addressing the proposals, the Boards note that they disagree with the view posited in the consultation paper that ... *the voluntary nature of the request has seen a decline in response rates in recent years.* It is more likely that the declining response rate is a result of the introduction of online renewal functionalities where the paper based labour force survey was 'dislocated' from the process of renewal. In this regard, an online survey was not incorporated in the majority of the online renewal modules introduced by Boards within Australia. The view that workforce data must be collected from 100% of registrants in order for it to be useful is also open to challenge. Statistically, data provided by a sufficient sample of the total population of health practitioners will be generalisable to that total population.

The Boards submit that there are a number of matters that should be considered in finalising a policy position on whether workforce data collection should be mandated. First, the reliability of data collected through a mandated process may be questionable as a percentage of society will deliberately enter incorrect data. Additionally, the penalties for non compliance with provision of the mandated data will be problematic. In this regard, it would seem highly inappropriate to refuse renewal of registration merely on the basis that workforce data has not been provided. Similarly, it is likely that it would be considered by the professions as draconian if non compliance with the requirement to provide workforce data formed the basis of disciplinary action under the legislation. The only option then available for non compliance would be a monetary fine. This may not be supported by the wider community and the imposition of a fine would still not ensure provision of the required data. The issue of penalty for non compliance needs further consideration to inform whether the provision of workforce data should be mandated.

Second, the consultation paper appears to assume that there will be no paper based applications for renewal of registration. While access to the internet is high amongst health practitioners, it cannot be assumed that such access is 100% and it must be acknowledged that there are particular problems with accessing the internet from rural and remote locations. As such, paper based applications and workforce data collection will be necessary, in the

interests of fairness and equity, for the foreseeable future. Given this premise, the mandating of data collection may be seen as shifting the costs for data collection and entry from government to the health professions. In this regard, it should be noted that under the current renewal arrangements the Boards generally act as an agent for posting and receiving the labour force survey. They are not responsible for the cost of production, mailing or for the entry of data collected. Such costs are borne by Queensland Health.

The majority of the matters raised in the preceding paragraphs could be addressed through the design of the online renewal infrastructure without placing a mandatory obligation on registrants. However, the issue of cost shifting for printing, posting and entering data from paper based surveys is not addressed by the design of the online renewal functionality. This cost could be minimised by encouraging the use of online applications for renewal by: (a) offering a discount to those renewing online; or (b) imposing a surcharge on those who use a paper based application for renewal.

It should also be noted that if the data items specified in demographics, work characteristics, registration characteristics, qualification characteristics and citizenship characteristics are not currently collected or stored electronically, there will be a significant cost in populating these data fields as a separate exercise or during the initial renewal of registration upon commencement of the national registration scheme.

Further, if the information collected purely for workforce planning purposes is not to be made available to the Board/agency, it could not be recorded in the same database as the information collected as part of the registration process. Therefore, consideration will need to be given to how the two sources of information will be recorded, updated, stored and matched.

**Proposal 3.8.4:** *It is proposed that the national scheme legislation provide for the Ministerial Council to require that specified, de-identified information is provided to the Council and any of its committees for workforce planning analysis.*

### Submission of the Boards

The Boards submit that the costs of providing such data should be met by the users of the data rather than be funded by registration fees paid by health practitioners. This is particularly the case if it is determined by the Ministerial Council that new data items in addition to those already specified in the consultation paper are to be collected for workforce planning purposes.

## **Section 4 Publicly Available Information**

**Proposal 4.1.1:** *It is proposed that the national scheme legislation specify that the following categories of information in relation to each registrant are available on the public register:*

- (e) *Date of first registration*
- (i) *Conditions on practice (where relevant)*

### Submission of the Boards

In relation to publication of the date of first registration, the Boards submit that consideration will need to be given to how information will be presented when a registrant holds more than one registration within one professional group (for example, dental prosthetists, dental hygienists, dental therapists) or across professions (pharmacist and medical practitioner or nurse and psychologist). The approach proposed under 3.3.1 for registrations to be treated as separate 'cases' would allow for the relevant information to be presented.

In relation to publication of conditions on practice, the Boards rely on their submission in response to the proposed registration arrangements in relation to publication of matters. This submission was as follows:

*The Boards submit that the proposals in the paper about placing restrictions on registration are confusing. In this regard, the consultation paper mentions 'agreements', 'other written agreements', 'undertakings', 'enforceable undertakings', 'undertakings which may include conditions', 'conditions', and 'critical conditions'. While the proposal for critical conditions is endorsed, it is submitted by the Boards that a simple set of terms and processes for placing restrictions on registration be progressed. In this regard:*

- *Undertakings should be considered as a voluntary restriction. For the purposes of the legislation, all undertakings should be enforceable and not published on the register unless it is in the public interest to do so.*
- *Conditions should be considered as a national board imposed restriction and published on the register unless it is not in the public interest to do so.*

It is also submitted that: (a) it may be in the public interest to publish the fact of disciplinary action on the register; (b) cancellations of registration should be published on the register subject to the matters to be raised in response to section 4.2; and (c) prohibition orders against non registrants and/or previous registrants should also be publicly available through a register search function.

In order for this to work effectively for a public search, prohibition orders will need to clearly provide for identification of the individual other than by name, e.g. date of birth.

## **Section 4.2 Deregistered practitioners**

***Proposal 4.2.1:*** *It is proposed that the national scheme legislation provide that Option 4 be adopted and that the names of practitioners de-registered for conduct reasons appear on the public register with an indication that they have been de-registered for conduct reasons.*

### Submission of the Boards

The Boards support the proposal that names of practitioners deregistered for conduct reasons appear on the public register. The support of the Boards to the proposal is based on the assumption that matters of health impairment and performance can form the basis of 'conduct reasons' leading to deregistration by a tribunal.

The Boards do not believe there is a degree of unfairness as posited in the consultation paper where those being investigated voluntarily cease registration to avoid publication of a deregistration order. This is because the consultation paper on proposed arrangements for complaints proposed that Boards could continue to take action against a former registrant. As such, powers must be incorporated in the legislation for the tribunal to order publication of a disciplinary outcome in circumstances where the penalty would have been deregistration had the individual not voluntarily ceased their registration prior to the tribunal hearing.

The Boards further submit that the design of the public register will be important to ensure that there is no confusion about whether a registrant is current or deregistered for disciplinary reasons. In this regard, it is suggested that the other publicly available details on the register should not be displayed for deregistered practitioners and a clear message be displayed about their deregistered status. Similar design elements could be included for those subject to a prohibition order.

The Boards also support the back capture and publication of all previous registrants subject to a deregistration order as at 1 July 2010.

### **Section 4.3 Recording of Conditions on Practice**

**Proposal 4.3.1:** *If conditions on practice relate to practitioner health or impairment issues, it is proposed that the national scheme legislation provide that the public register record that a health condition applies, with no further details appearing on the register. However, if specific restrictions on professional practice apply, they would appear on the register.*

*The agency could release information about health conditions in particular circumstances if it was judged to be in the public interest but the test would be a high one.*

#### Submission of the Boards

Consistent with their submission in response to the proposed complaints arrangements, the Boards note that should conditions be placed on a registrant during the course of an investigation, these should be made publicly available according to the test proposed in that submission which was as follows:

*The Boards submit that the proposals in the paper about placing restrictions on registration are confusing. In this regard, the consultation paper mentions ‘agreements’, ‘other written agreements’, ‘undertakings’, ‘enforceable undertakings’, ‘undertakings which may include conditions’, ‘conditions’, and ‘critical conditions’. While the proposal for critical conditions is endorsed, it is submitted by the Boards that a simple set of terms and processes for placing restrictions on registration be progressed. In this regard:*

- *Undertakings should be considered as a voluntary restriction. For the purposes of the legislation, all undertakings should be enforceable and not published on the register unless it is in the public interest to do so.*
- *Conditions should be considered as a national board imposed restriction and published on the register unless it is not in the public interest to do so.*

The Boards also note that the consultation paper is silent on such matters as when conditions are removed from the public register and when the fact of a deregistration order is removed from the public register. It is submitted that the legislation require removal of such matters when the conditions or deregistration order no longer apply.

### **Section 4.4 Online Public Register**

#### Submission of the Boards

While there are no proposals raised under this section for consideration, the Boards submit that there are a number of matters that do need further consideration. First, being able to identify a registrant by their postcode could create safety risks if it is their residential postcode. There appears to be no basis for being able to publicly locate a registrant by

postcode and, as such, a search functionality based on postcode is not supported by the Boards.

Second, the search functionality should enable both single registrant and multiple registrant searches by name or registration identifier. If the policy position is established for employers to have obligations in regard to ensuring employees are registered at the time of employment and annually, a multi registrant search functionality will be essential. It will also assist employers monitor changes in registration status of their employees and for credentialing organisations to monitor changes in the registration status of those credentialed to provide health services in their facilities.

The Office of Health Practitioner Registration Boards makes available to employers and credentialing organisations a multi search functionality which exports all reports to an Excel document. By using an application called 'compare it' (a third party application) two Excel documents produced at different times can be compared to show differences in data. Queensland Health and private hospitals are currently using the application to outline variations in the reports that are produced regularly. This is a significant quality initiative to enable employers and credentialing organisations to ensure those providing health services in their facilities remain registered to do so.

#### **Section 4.6 Public Access to the Findings of Formal Proceedings**

***Proposal 4.6.1:*** *It is proposed that the national scheme legislation provide for the publication of tribunal decisions relating to registrants where it is in the public interest to do so.*

##### Submission of the Boards

The Boards submit that all tribunal decisions, unless otherwise ordered by a tribunal, be published. This is consistent with the proposal that the tribunal hearings are public unless closed for particular circumstances by the tribunal.

***Proposal 4.6.2:*** *There is a public interest in making board or committee decisions in relation to conduct matters public. It is proposed that decisions be published on the register of decisions on the agency's website.*

*There are two options to give effect to this arrangement:*

***Option 1:*** *All conduct decisions of boards or committees are published (with patient details de-identified).*

***Option 2:*** *Boards may order that certain decisions are confidential and order that the decision register contain a confidential information notice.*

##### Submission of the Boards

The Boards submit that this proposal is inconsistent with the proposals made in the complaints consultation paper whereby: (a) panels would be closed to the public; and (b) it would be an offence for the proceedings of a panel to be published in circumstances where the name of the notifier, witness or practitioner could be identified.

The Boards, however, recognise the educative value of such decisions and would support publication of the decisions in a de-identified form.

## Section 5 The Privacy Regime

**Proposal 5.1.1:** It is proposed that the national scheme legislation use the private sector provisions of the *Privacy Act 1988* as the basis for the privacy arrangements in the national scheme.

**Proposal 5.2.1:** It is proposed that the existing Commonwealth private sector privacy regime and National Privacy Principles are incorporated by reference into the national scheme legislation.

### Submission of the Boards

The proposals as documented are supported by the Boards subject to resolution of the following issue:

The proposal to use the private sector national privacy principles does not appear to take into account the proposal that the national agency be subject to the Commonwealth Freedom of Information legislation. In this regard, current Queensland privacy requirements limit access to that existing under the *Freedom of Information Act (Qld) 1992*. Should access be more extensive than that provided through freedom of information avenues, this may have implications for the conduct of investigations and disciplinary actions, particularly if access is enabled to legal advice. In this regard, it is noted that there is no mechanism under the private sector national privacy principles to exempt release of legal advice on the basis of legal professional privilege.

This issue has the potential to be even more problematic given the wide definition of personal information under the *Privacy Act (Cth) 1988* and the potential exclusion of the exemptions available under freedom of information legislation.

## Section 7 Information Sharing

**Proposal 7.1.1:** It is proposed that the national scheme legislation prevents the adoption of the scheme's health practitioner identifier for other purposes by other bodies. The legislation would also need to exempt the adoption and use of the identifier for e-health purposes subject to legislation providing appropriate protections being in place to oversight such e-health activities.

### Submission of the Boards

The Boards endorse the proposal subject to the comments previously raised about Proposal 3.3.2.

**Proposal 7.2.1:** It is proposed that the national scheme legislation provide for de-identified information from the registration system to be available to government agencies and to appropriate classes of other persons for research and statistical purposes.

### Submission of the Boards

The Boards do not oppose the proposal but note that the provision of such data should be on a cost recovery basis. In this regard this should not be a cost shift from other organisations to the national boards for the provision of such data.

***Proposal 7.4.1:*** *It is proposed that the national scheme legislation governing the release of information by the agency and the boards enables the release of information to Medicare Australia and specifies the purposes for which the information is to be released.*

### Submission of the Boards

The Boards do not oppose the proposal as such information sharing is likely to enhance each organisation's achievement of their objectives. However, as previously stressed in response to Proposal 4.4, this should be established as a cost effective and efficient information exchange through the use of the information technology infrastructure.

The Boards strongly endorse enabling Medicare to share appropriate data about registrants not only for the purposes of investigation but also for monitoring those registrants who have conditions or undertakings as a result of professional conduct, performance or health action. Currently Medicare Australia, based on its legislative requirements, will generally only release information with the consent of the registrant. While consent is gained to enable monitoring, it is less likely to be given by a registrant during the course of an investigation about their conduct or performance.

***Proposal 7.5.1:*** *It is proposed that the privacy framework to apply to the agency authorise the disclosure of relevant information to the DIAC for purposes under the Migration Act 1958.*

### Submission of the Boards

The Boards do not oppose the proposal as such information sharing is likely to enhance each organisation's achievement of their objectives. However, as previously stressed in response to Proposal 4.4, this should be established as a cost effective and efficient information exchange through the use of the information technology infrastructure.

The Boards further submit that the information sharing be limited to that information about the registration status of those who do not hold permanent resident status in Australia. This will enable the Department to make decisions about approving visas and the renewal of such visas. It is not envisaged that any other information would be of relevance to the Department's functions.

***Proposal 7.7.1:*** *It is proposed that the national scheme legislation enable the sharing of de-identified information with State and Territory government bodies for specified purposes and the notification of identified practitioners who pose a public health risk.*

### Submission of the Boards

The Boards support the proposal but note that the consultation paper is silent about the provision of information and advice by the agency to individual state and territory health

ministers. In this regard, under current legislation and practice in Queensland, the Office of Health Practitioner Registration Boards prepares Ministerial briefs and correspondence and attends to assist the Minister in meeting with stakeholders. The Boards submit that the national scheme legislation should enable the continued provision of such services to individual Ministers.

**Proposal 7.8.1:** *It is proposed that the national scheme legislation provide that whenever a board identifies that the health of a patient who is not directly involved in a case under investigation may have been adversely affected by a practitioner, the board must notify the relevant State or Territory health department so that remedial action can be taken.*

### Submission of the Boards

The Boards note that there is an inconsistency between the introductory paragraph and the proposal. In this regard, the introductory paragraph refers to ... *potential risk to other patients* ... while the proposal narrows this to the identification of risk to a particular patient.

The Boards submit that it would be in the public interest to enable the Boards to notify Commonwealth, state and territory health departments where the conduct or practice of a registrant may have potentially put at risk the health and safety of a patient or of a class of patient. The definition of risk for the legislation must also ensure that it does not establish an open ended statutory obligation which cannot be met by the national boards. In this regard, the model test proposed in the Boards' response to the proposed complaints arrangements for suspension of a registrant may be useful.

## **Section 7.10 Criminal Record Checking**

### Submission of the Boards

The Boards note that it is unlikely that the jurisdictional police services will provide direct access for the national boards to undertake criminal record checking. In this regard, should criminal history screening be mandated through the legislation, it would be the national boards providing information to the relevant police service. The national legislation will need to make provision for this form of information sharing both to and from the jurisdictional police services.

## **Section 8 Health Records**

**Proposal 8.1:** *It is proposed that the national scheme legislation make the boards the repository of last resort with the power to take possession of patient health records when a practitioner has defaulted on their obligations.*

### Submission of the Boards

The Office of Health Practitioner Registration Boards has had extensive experience in the regulation, maintenance and safeguarding of patient health records, mainly in relation to medical records up to and including September 2007. While the nature and scope of health records management varies amongst the other health professions, the Office's experience with patient medical records may be instructive in developing an appropriate regulatory framework for patient health records.

The current legislation in Queensland gives the Boards a limited role in the safeguarding and disposal of patient records. The focus is on abandoned records and records forming part of a deceased estate. With the former, the Board must first be satisfied that the records are indeed abandoned. The unwillingness of a lawful owner of patient records to deal with records in accordance with board guidelines for safeguarding and disposal of such records is in itself insufficient evidence of abandonment.

There have been a number of instances of retiring practitioners leaving records at their former premises, where they remain for the landlord to deal with. In other cases practitioners or their relatives have contacted a Board and asked that the records be taken into the Board's possession. A position has been adopted by the Boards that wilful abandonment of records by a health practitioner could well raise professional standards issues and be dealt with as a professional standards matter by the Board.

An entrepreneurial owner of patient records, while immune from potential disciplinary action, could nevertheless be exposed to civil liability in the event of disposing of patient records outside of the retention guidelines. Under the current arrangements the handling of patient records in the custody and control of a non-health practitioner does not fall within the scope of the legislation, other than in circumstances of abandonment or death. There is no recourse to the person failing to safeguard the records or take steps for their appropriate disposal. The superseded Medical Act in Queensland allowed the Board to direct a person in relation to the safeguarding or appropriate disposal of records. This was felt to be a useful and workable provision and is consistent with the guiding philosophy in the national scheme that boards should be the repository of last resort.

The guidelines for disposal of medical records which were adopted by the Medical Board of Queensland were consistent with AMA policy in this respect and also reflected nationwide policy. While there is no statutory minimum period for retention of patient medical records, the Board recommended, as an acceptable standard, that patient records should be kept for at least seven years and in the case of minors (under the age of 18 years), at least until they reach the age of 25 years.

In accordance with the Medical Board's guidelines, the owner of the records should first cull those records in line with the above retention standard. All reasonable efforts should then be made by the practitioner or another person in possession of the records to ensure the records remain available for the ongoing care of the former patients to whom they relate. This would include passing the records directly to the patients if practicable. It is common practice for clients and patients to be notified of the availability of their health records either directly (verbally or by written communication) or by way of newspaper advertisement. Those records remaining after established patients have been given the opportunity to nominate a course for dealing with the records should be safeguarded or disposed of in accordance with the guidelines.

The current legislation places an obligation on boards to take into custody all health records forming part of a deceased estate, when delivered into the possession of the board by the personal representative of the deceased person. The responsibility then falls on the board to dispose of the records according to the guidelines. Several extensive collections of patient records have been received in our office in the six years since the current provisions have been in place, with the consequent burden of disposal of the records being met from the relevant board's resources.

Given these factors, the Boards submit that the national legislation governing the safeguarding and disposal of patient health records should expressly provide that primary responsibility for safe and secure management of patient records is the responsibility of practitioners and other persons having lawful custody of such records. Retention standards should be regulated and boards should have the power to direct persons in lawful possession of records on appropriate safeguarding and disposal measures to be followed in any particular case. It is further proposed that consideration be given to including a provision that any cost of safeguarding or disposal of records of deceased practitioners borne by a board will be a charge on the deceased person's estate.