

**Australian Medical Association Joint Submission on the  
proposed arrangements for information sharing and privacy for the  
National Registration and Accreditation Scheme for the Health Professions  
(the scheme)**

**Executive summary**

This joint submission is made by the Australian Medical Association (the AMA), the Australian Society of Otolaryngology Head & Neck Surgery, the Australian Association of Surgeons, the Australian Orthopaedic Association, the Australian Association of Pathology Practices, the Royal Australian College of General Practitioners, the Australian Society of Plastic Surgeons, the Urological Society of Australia and New Zealand, the Australian Society of Ophthalmologists, the Council of Procedural Specialists, the Australian Society of Orthopaedic Surgeons and the Australian Society of Anaesthetists (the co-signatories).

The AMA continues to engage in the government's consultation process on the proposed National Registration and Accreditation scheme. We continue to oppose this model which is costly, lacks transparency and provides Health Ministers with powers over registration and accreditation of the medical profession and other health providers which puts at risk the standards of health care delivery in Australia.

The AMA and the co-signatories support a system of national registration arrangements and consistent standards for the medical profession across Australia to facilitate workforce mobility. This can be effectively achieved without compromising the independence of accreditation and does not require the COAG model.

The consultation paper on the proposed arrangements for information sharing and privacy purports to take the best of the various approaches in each of the jurisdictions. We note the effect of this is that there will be changes in most jurisdictions to the way information is handled that will need to be explained to registrants and complainants.

As a general principle, the legislation must contain clear and solid controls on the use of data and strong penalties for misuse of information collected under the scheme. The personal information of registrants, and the patients of practitioners who are the subject of investigations, must be protected.

Further, the AMA and the co-signatories are concerned that government is being opportunistic in implementing the scheme by:

1. imposing additional requirements on registrants to provide information, including workforce data, to the relevant board as a condition of registration; and
2. extending the existing arrangements for sharing information about registered medical practitioners between various government bodies beyond what is currently allowed, without setting out specific circumstances and reasons for doing so.

The medical profession is very concerned that government intends to use the national registration and accreditation scheme implementation to unilaterally introduce new requirements, processes or arrangements. This concern applies in respect of registration, and for handling complaints and dealing with performance, health and conduct matters for medical practitioners. Proposals in the consultation paper on information sharing and privacy (and earlier consultation papers) demonstrate that this is in fact what government is doing.

In implementing the scheme, government should confine itself to reflecting and harmonizing existing jurisdictional arrangements.

Any additional requirements on registrants or new arrangements in relation to information sharing and the use of that information, beyond that which already exists in Commonwealth and State and Territory law, requires extensive consultation with health providers and the community on what, when, where and why. This information has not been provided to date.

### **Specific concerns about particular proposals**

The AMA and the co-signatories have a number of concerns about specific proposals in the consultation paper.

#### **Information to be collected**

##### *Information to be collected at registration and on renewal*

The proposal for registrants to provide the name and address of their employer to the board is additional to existing requirements<sup>1</sup>. The rationale provided in the consultation paper is so that boards can inform employers when a registrant's registration status changes or conditions are placed on his or her practice. We note this proposal was not included in the consultation paper on the *proposed registration arrangements* in the relevant sections on information required for initial applications and renewals.

The requirement to provide and update employer details is too onerous, particularly for medical students and junior doctors who rotate through training positions.

The number of changes to registrants' employer details would far exceed the number of changes to registration status. Therefore, it would be administratively efficient to instead require registrants to notify their employers when there is a change in registration status where that change is directly relevant to their employment arrangements. Further, the boards could just be empowered to seek the information and notify employers only in those cases where communication with the employer is actually required. Of course these requirements will have little effect for those registrants who are self employed.

##### *Information to be collected for workforce planning purposes*

The AMA and the co-signatories recognise there is a paucity of workforce data. This has made it difficult, particularly in respect of the rural workforce, to undertake proper

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<sup>1</sup> Except in NSW for practitioners who are being investigated.

workforce planning. It is important to ensure the collection of workforce data is appropriate. But it is also important to remember that the public interest arguments in respect of a national registration scheme are not the same as the public interest rationale for workforce data collection.

The provision of workforce data by registrants **must not** be a mandatory requirement for gaining registration. A mandatory process does not guarantee more reliable and comprehensive data, and so we do not support proposal 3.8.1. As stated in our submission on the proposed registration arrangements, it would be inappropriate for the board to not register an individual simply on the basis that he or she had not provided information beyond that which is material to the board's decision to register an individual or renew an individual's registration.

Better workforce data would be collected from the medical profession on a voluntary basis, albeit it could still occur at the time of re-registration, as is currently the case. Registrants will provide more reliable data when they are not compelled to 'fill in forms' in order to renew their registration, and when the purpose of the data collection is properly explained. Registrants will have greater confidence, and be willing participants, in the processes if they are assured that registration data will not be linked to workforce data.

The final data set should be informed by the work of the National Minimum Data Set Project. It appears that this project may not have been completed and so there should be further discussion on transitional arrangements pending the finalisation of that project. In the meantime, the collection of workforce data is managed by the Australian Institute of Health and Welfare and should continue as per the current arrangements. However, timeliness of publicly available information based on this data should be improved.

Finally, we note that as the scheme is to be self-funded, the health professions will inevitably be required to meet the additional cost for boards to collect workforce data through increased registration fees.

#### *Ownership of data collected by the boards*

The AMA and the co-signatories are very concerned that the consultation paper is unclear about whether the boards or the national agency own the data collected by the boards, and indeed the medical register itself. The consultation paper variously states that the agency will decide what information is on the register (4.1) and who has access to information (4.5.1 and 7.5). We are strongly of the view that the legislation will need to be clear that it is the medical board that is responsible for protecting the information provided by registrants and complainants. Further, it is the medical board that should make decisions about who can access the information, not the agency. The primary legislation must establish the board as a legal entity in its own right and confer this and other important responsibilities on it.

Further, it is important that registrants fully understand which entity they are effectively providing information to and what that information will be used for.

It is not appropriate to take a cross profession approach to who can access information held by the boards. There may be profession-specific circumstances which need to be taken into account. The AMA and the co-signatories want the medical board to have authority over the information it holds and to make decisions about who can access that information.

### **Identity checking on initial registration**

The “opportunity” to introduce identity checking via a “100 point check” system has not been sufficiently justified in the consultation paper. No specific problem has been identified, nor has any evidence been provided to demonstrate that such a measure will protect the public. The AMA and the co-signatories oppose the introduction of a “100 point check” system on the basis that it is a new requirement and will impose additional administrative burden on both registrants and the board, and possibly result in increased registration fees.

### **Information on the public register**

Any publicly available information must protect the safety and security of individual medical practitioners: their home locations must not be available from the register. It follows that the greater the amount of information on the register about registrants, the higher the concerns will be about personal privacy and security.

Further, the more information that is on the public register, the more effort will be required by registrants and the board to maintain its currency. This is particularly so for medical students and trainees who regularly rotate through positions.

### **De-registered practitioners**

The AMA and the co-signatories do not support the register including the names of people who have been de-registered for conduct reasons. The register is a list of people who can practice. Therefore, if a person’s name does not appear on the register, they cannot practice – it is immaterial why a person who was previously registered to practice is no longer registered.

### **Recording of conditions on practice**

It is not clear to us what members of the public would do with (i.e. how they would interpret) information that a practitioner has some sort of health condition on their registration (proposal 4.3.1). Such broad undefined information might be misinterpreted as a restriction on practice, and could even unreasonably taint the public’s perception, and therefore the professional reputation, of the registrant. Further, providing more detailed information about health conditions would be a breach of the registrant’s privacy. The AMA and co-signatories oppose a register that contains information about registrants’ health conditions.

We do support a register that provides clear information about restrictions on practice, and does not contain information that is open to interpretation.

### **Public access to the findings of formal proceedings**

It is proposed that the serious disciplinary matters and appeals will be heard by state and territory tribunals and consequently governed by state and territory law. Therefore, there should be no need to include further provisions about the publication of tribunal decisions in the legislation for the scheme as this matter should be covered by the state/territory law governing the operation of the tribunal.

Further, it is proposed that board or committee decisions on conduct matters will be published on a website by the national agency. Currently, the point at which decisions are made public varies from state to state. It would be appropriate therefore to give further consideration to when in the process a decision should be published, for example once a registrant has accepted the decision or exercised his or her rights of appeal. Publishing details too early in the process risks public concern being raised about a registrant before full investigation and resolution of an issue. We oppose publication of these decisions before natural justice has been afforded.

### **The privacy regime**

The government will need to make separate arguments in each jurisdiction as to why the existing privacy arrangements need to be replaced by the Commonwealth privacy regime. Further, the implications of the interface between Commonwealth privacy laws on state and territory agencies involved in the scheme will need to be explored in more detail.

### **Information sharing**

#### *The unique identifier*

The AMA and the co-signatories are concerned that the proposal to have a consistent unique identifier for each registrant for the register and e-health databases will create a platform for greater data linkages. Given the privacy risks associated with this, this particular proposal will need to be explained in greater detail before we can support it.

We also note other health professionals not covered by the scheme will also require a unique health identifier for e-health purposes, thereby requiring a second system to allocate identifiers.

#### *Information sharing with other government agencies/entities*

In implementing the scheme, government should refrain from taking the opportunity to “establish greater linkages” within existing processes. We recognize the need to get the balance right between the public interest and the privacy of registrants. However, the proposals in section 7 represent a substantial shift in current arrangements. We cannot support them without detailed proposals and clear reasons about what information will be shared, under what circumstances, for what purpose and when. We cannot support broad powers to allow information to be exchanged between agencies without considering these issues in depth.

In respect of the Professional Services Review (PSR), the Director of the PSR is already able to provide information to boards, and this can be adequately reflected in the Health Insurance Regulations once the national medical board is established.

However, it is our understanding that there are no current provisions that require existing medical boards to provide information about registrants to the Director of the PSR as proposed in Proposal 7.3.1. Greater linkages such as that proposed should only occur after extensive consultation with the medical profession about the purpose and the relevant circumstances.

Similarly, the AMA and the co-signatories cannot support a broad power for information to be shared between the medical board and Medicare Australia, the Department of Immigration and Citizenship, health complaints bodies and tribunals and Commonwealth, State and territory agencies, beyond that which already exist, without extensive consultation on what, when, where and why.

If any of the above-mentioned agencies has a greater need for information in order to carry out its functions, then it should put forward the proposal with a clear rationale for changing existing arrangements, and undertake consultation with the relevant stakeholders.

### **Health records**

The proposal to make the board the repository of last resort for patient records will further add to the cost of the scheme. It will require dedicated staff (because the skill set will be different to the staff of the board and the national agency) and storage arrangements. We oppose this proposal because it does not fall within the terms of the Intergovernmental Agreement and is not a core function of the board.

### **Conclusion**

There are a range of additional requirements on registrants proposed in this paper, beyond those that currently exist, that will create an unnecessary burden on registrants, and require additional administrative resources that will be imposed on registrants through higher registration fees.

The AMA and the co-signatories are concerned that there is too much flexibility in the information sharing arrangements proposed in the consultation paper. Further, there is insufficient specificity about the particular circumstances and reasons why broader arrangements are being proposed beyond those that already exist. We cannot support these proposals without much more detailed consideration and advice, and we do not consider this should be undertaken as part of the implementation of the scheme.

In implementing the scheme, government should only include arrangements that reflect and harmonize current state and territory arrangements.

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