AUSTRALIAN DENTAL ASSOCIATION INC
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All Correspondence to:
PO Box 520 St Leonards NSW 1590

5 March 2010

Ms Naomi Blesser
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

Dear Ms Blesser,

Re: Healthcare Identifiers Bill 2010 and Healthcare Identifiers (Consequential Amendments) Bill 2010

The ADA writes to you today in response to the Senate Community Affairs Committee Inquiry into the Healthcare Identifiers Bill 2010 and Healthcare Identifiers (Consequential Amendments) Bill 2010.

As you may be aware, the Australian Dental Association (ADA) delivered a submission to the Department of Health and Ageing on the Exposure Draft of The Health Care Identifiers Bill 2010 on 7 January 2010. A copy of this submission is attached for your information and can be accessed by visiting www.ada.org.au.

The submission highlights the key concerns of the ADA which can be summarised as follows:

- There is a current lack of detail that exists in relation to the precise mechanisms in how the scheme will operate from a 'hands on perspective' and the impact the Bill will have on dentistry;
- Many dental practices are not computerised and are therefore non E Health compatible at this stage;
- The ADA remains concerned that the administrative impact and expense of adopting an E Health framework; and
- Systems must be provided to dentists to assist in the establishment of the initiative and financial assistance must be offered to practitioners who cannot implement E Health strategies in accordance with the Government's overall ambition.

The ADA thanks the Committee for the opportunity to raise these concerns and looks forward to working with Government to ensure a smooth transition into E Health for dentistry and the healthcare industry as a whole.

Yours sincerely

Dr Neil Hewson
Federal President

Australian Dental Association Inc.

Submission to
E Health Branch
Primary and Ambulatory Care Division (MDP1)
Department of Health and Ageing
ehealth@health.gov.au

EXPOSURE DRAFT OF THE HEALTH CARE IDENTIFIERS BILL 2010 (THE BILL)

7th January, 2010

Authorised by
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Federal President

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EXPOSURE DRAFT OF THE HEALTH CARE IDENTIFIERS BILL 2010 (THE BILL)

The Australian Dental Association Inc thanks you for the opportunity to comment upon the Exposure Draft Health Care Identifiers Bill 2010.

This submission is in addition to the ADA submission to the Department of Health and Ageing on healthcare identifiers and privacy: discussion paper on proposals for legislative support, dated14 August 2009.

Background:

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 encourage the improvement of the oral and general health of the public and to advance and promote the ethics, art and science of dentistry, and

- to support members of the Association in enhancing their ability to provide safe, high quality professional oral health 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.

The ADA and its members consistently emphasise the importance of focusing on the welfare of the patient in provision of any treatment. A consistent theme in policies developed by the ADA is that the primary responsibility of its members is to the health, welfare and safety of their patients (see Appendix 1 ADA Policy Statement 5.4 Principles of Ethical Dental Practice).

The ADA promotes to members the absolute necessity for accurate record keeping, noting that the keeping of such records will improve diagnosis, treatment planning and case management for patients and will aid in the efficient and complete delivery of care in the event of another clinician assuming the patients treatment (see Appendix 2 ADA Guidelines for Good Practice - Patient Information and Records).

E Health:

The ADA notes the crucial part that the creation of an E Health technology will play in the implementation of the Government's National Primary Health Care Strategy. The Strategy states:

"E Health will allow information to be available when and where a patient needs care, can drive communication and partnership between providers and with patients, will reduce the risks of adverse events for consumers and, with it, reduce costs and improve patient outcomes".

"Electronic Information Exchange, particularly individual electronic health records (IEHs) are a strong support for multi disciplinary primary Health Care collaboration enable efficient exchange of information between the primary Health Care, community and specialist Health Care settings".

The objectives as outlined in this strategy have the support of the ADA and its members as they are consistent with the objectives of the ADA itself as outlined above.

The creation of a process for health identifier information is an important initial building block for the implementation of the Strategy.

Perusal of the legislative proposals for legislative Health Care identifier as outlined in the "Building the Foundation for an E Health Future..." states that:

"The key objective of the Health Identifier Service will be to provide a national capability to accurately and completely identify individuals and health care providers to enable reliable health care related communication between individuals, providers and provider organisations".

It is said that:

"The service will underpin the development of the national electronic health system by removing technological and organisational impediments to the effective sharing of health information better resulted from poor patient and provider identification".

Again the ADA is in agreement with these objectives. The objectives are consistent with the importance the ADA places on optimum dental care and service delivery to patients.

A concern for the ADA and its members is the current lack of detail that exists in relation to the precise mechanisms through which there will be this transfer of health information between individuals, providers and provider organisations. The ADA recognises that the publication of the Exposure Draft Bill on Health Identifiers is a first step in the process for the implementation of E Health Objectives. However, the absence of specifics as to the precise way in which the scheme will operate, from a "hands on perspective", makes it difficult for a full and comprehensive evaluation of the Health Identifiers Bill and the impact the Bill will have on dentistry, delivery of dental care and communication between patient and providers. It is with this caveat in mind that ADA will respond to the exposure draft.

Whilst the ADA notes the recognised benefits of E Health, it repeats the comments it made in its earlier submission in response to the discussion paper on Proposals for Legislative Support of 14 August, 2009. There, the ADA raised the fact that many dental practices are not computerised, either through use of specific dental software or at all and are therefore non E Health compatible at this stage. Many dentists continue to use hard copy patient treatment records as distinct from full electronic systems. As such, there will be considerable difficulty experienced by Practitioners in adopting any E Health initiatives.

The ADA remains concerned that the administrative impact and expense of adopting an E Health Framework may be sufficiently distressful and distracting to practitioners that it may well cause some compromise in the delivery of good quality treatment due to their need to adopt an alien record system for compliance with E Health in addition to the one that they already use.

Systems must be provided to dentists to assist in the establishment of the initiative. Similarly, financial assistance must be offered to practitioners who cannot immediately implement E Health strategies in accordance with the Government's overall ambition.

If a practitioner is currently practicing dentistry in a fashion that is delivering premium quality dental services with no risk to the patient then there ought to be no compulsion to change without assistance either financial or educative.

Health Care Identifiers Bill:

In general terms, the ADA is supportive of the proposed legislation.

Set out below will be a number of comments/issues which the ADA would ask be considered in the progression of this Bill to Legislation.

The order of the comments/issues made below is in general terms consistent with the order in which they are raised in the legislation.

Matters for consideration.

1. In the definition section of the Bill, a "health care provider" is described as "an entity". An "entity" is then defined to include a "person or unincorporated body". If we have interpreted the definitions correctly there would appear to be no place in the Bill for an incorporated health care provider. The ADA would like to point out that in most jurisdictions incorporated entities are able to own and operate dental practices and as such there should be inclusion of this category in the definition of "Health Care Provider".

   Review of Section 6 (2) (c) though refers to a "health care provider who conducts an enterprise". It then goes on to identify that health care provider as being either "A self employed individual or an enterprise that employees individuals."Further it then deals with "a corporation that runs a medical centre".

   In our view, even with the extension to the definition of health care provider set out in Section 6, it does not expand the definition of a health care provider to include an incorporated body in a dental setting. The ADA would recommend that this issue be clarified.

2. In Section 6, it is noted that the assignment of Health Care Identifier is provided by "the service operator". "Service operator" is then defined as meaning either the Medicare Australia CEO or another entity prescribed by the regulations.

   The ADA agrees that at this early state of the implementation of the E Health initiatives, the public's confidence in the system would certainly be enhanced if the service operator appointed was the Medicare Australia CEO. Medicare Australia has developed a solid reputation for security and with the numerous privacy issues that have been raised in E Health debate, the ADA would recommend that for peace of mind of individuals and providers, the service operator should continue to be the Medicare Australia CEO.

   To provide this "service operator" role to an entity other than Medicare Australia would, in the Association's view, undermine public and professional confidence in the process. Security systems adopted by that unknown service operator would not have the guaranteed sophistication of security and privacy already achieved by Medicare Australia.

3. Sections 8 and 9 of the Bill refer to the allocation of identifying information. Section 8 refers to a "data source." This is defined in Section 5 as including "a registration authority." Such authority is authorised to disclose identifying information regarding a Health Care Provider to the Service Operator for the purposes of the Service Operator assigning a health care Identifier to the health care provider. Section 9 however appears to slightly contradict this as it suggests that "if" a health care provider wants to be assigned a Health Care Identifier then the health care provider must give to the Service Operator appropriate identifying information to enable that assignment to occur. This in turn further contrasts with the comments made in *"Building the foundation for an e health future...update on legislative proposals for healthcare identifiers."* At page 12 of that text it states, "Identifiers will be automatically assigned by the HI Service Operator to all individuals enrolled in Medicare Australia's Medicare program and Department of Veterans Affairs when the HI Service commences." There is an inconsistency here that should be addressed.

   The ADA would imagine that the data source, being a registration authority, would hold appropriate identifying data, and thus provision of a Health Care Identifier to a Health Care Provider under Section 8 would be automatic. There may be some opportunity for clarification to be provided of this in a revised bill.

4. Section 11 refers to the disclosure of a Health Care Identifier to an identified Health Care Provider or to someone authorised by the identified Health Care Provider. The ADA can see the practical reasons for this and agrees with this mechanism. It does however, seek some clarification as to what might be the responsibility or liability of the health care provider, should the person authorised by that health care provider otherwise breach the provisions of the legislation.

   The ADA would suggest that the service operator be directed to prepare an appropriate standard authority pursuant to which written notice is provided in Section 11 (1) (b) and that the authority limit the health care providers responsibility for compliance with the legislation in respect of any unauthorised or unlawful behaviour by the individual to which the authority has been granted. The ADA can see no reason why the health care provider should be made responsible for any such illegality or inappropriate behaviour by the individual that has been so authorised.

5. Sections 16 and 17 of the draft Bill have been the subject of specific comment by Guild Insurance Limited (GIL) and the Australian Dental Association Victoria Branch (ADAVB). ADA would ask that favourable consideration be given to the issues raised by these entities in relation to these two sections.

   In addition though, ADA would like to suggest that the recommended amendments to section 15 and 16 not only extend an ability on the part of the Health Care Provider to report on circumstances and/or claims to the Health Care Providers Professional Indemnity Insurer, but also to any "data source" as defined in Section 5.

   Specifically, should a complaint be lodged against a Health Care Provider to a Registration Authority, or other similar body, the health care provider must be permitted to provide records of treatment in response to any such complaints. As raised in the GIL and ADAVB submissions, the current legislation would not permit this as inherent in those records would be the provision of Health Identifier data.

Natural justice would dictate that there must be an ability on the part of the health care provider to respond to such a complaint utilising copies of the records. An exclusion must be provided in the legislation to permit this.

Conclusion:

As indicated the ADA is generally supportive of the E Health initiatives being embarked upon by Government and recognises that the publication of this Bill is the first building block towards the development of the E Health Strategy.

It hopes that the observations/comments made in the correspondence are of assistance.

Yours faithfully,

Dr Neil D Hewson
Federal President

Appendix 1

AUSTRALIAN DENTAL ASSOCIATION INC.

POLICY STATEMENT 5.4

PRINCIPLES OF ETHICAL DENTAL PRACTICE

1 Introduction

The ADA Inc. has established these Principles of Ethical Dental Practice as a guide to the obligations and conduct of Members of the Association. In addition, each State Branch of ADA Inc. has established its Code of Ethics, the observance of which is a mandatory condition of membership. These Codes of Ethics are complementary to State and Territory statutory requirements.

2 Obligations Towards Patients

2.1 The primary responsibility of dentists is the health, welfare and safety of their patients.

2.2 Dentists should perform treatment only within areas of their competence.

If appropriate, referral for advice or treatment to other professional colleagues should be arranged.

2.3 Dentists must accept full responsibility for all treatment undertaken by themselves and, as permitted by law, by allied dental personnel acting under their supervision and direction.

2.4 No service or treatment shall be delegated to a person who is not qualified or is not permitted by the Laws of the Commonwealth, State or Territory to undertake that service or treatment.

2.5 Records that are comprehensive, accurate and respectful must be created and safeguarded for all patients.

2.6 Confidentiality and privacy with respect to both clinical and non-clinical information must be maintained except where the Laws of the Commonwealth, State or Territory dictate otherwise. It should be recognised that patients have the right to access their personal records and/or receive copies of them. Care should also be exercised to make certain that the issuing or transferring of personal records can only occur with the proper authority of the patient concerned. It is the obligation of dentists to ensure that allied dental personnel under their supervision observe that same confidentiality.

2.7 Dentists should ensure that they provide patients with clear information about their dental condition and proposed treatment options so that patients are then able to make decisions that lead to informed consent for a particular option, without which it should not proceed.

3 Attitudes Towards Colleagues

3.1 Dentists should build their professional reputation on merit.

3.2 Dentists should be willing to assist their colleagues professionally.

3.3 Dentists should make the results of personal research freely available and should be prepared to share any scientific, clinical or technical knowledge.

4 The Practice of the Profession

4.1 Dentists should act at all times in a manner that will uphold and enhance the integrity and dignity of the profession.

4.2 Dentists should express opinions, make statements or give evidence in an objective and truthful manner.

4.3 Dentists should maintain professional competence throughout their careers by active advancement of their knowledge of scientific, clinical and technical developments.

Policy Statement 5.4:

- ✓ *Adopted by ADA Federal Council, November 21/22, 2002.*
- ✓ *Adopted by ADA Federal Council as the Code of Ethics of ADA Inc., April 10/11, 2003.*
- ✓ *Amended by ADA Federal Council, April 7/8, 2005.*

Appendix 2

AUSTRALIAN DENTAL ASSOCIATION INC.

GUIDELINES FOR GOOD PRACTICE

F1 – PATIENT INFORMATION AND RECORDS*

WHY MAKE RECORDS?

- A record of each encounter with a patient is an essential part of the practice of dentistry, which improves diagnosis, treatment planning, case management and fees control.

- Accurate records assist efficient and complete delivery of care in the event of another clinician assuming that patient's treatment.

- Patient records may be used in a forensic role for patient identification.

- Patient records form the basis for retrieval of treatment details in the case of a dispute or the requirement to provide evidence. It is desirable that such details provide an adequate contemporaneous record that obviates the need for any later, and possibly questionable, assumptions that a dentist's 'usual practices' were followed in a specific case.

- Personal details (besides health information) are needed for satisfactory business management of a patient. This record should include the name of the person or entity responsible for payment for the treatment.

  Features which make health information special include:

  - Confidentiality of collection. Health information is collected in a situation of confidence and trust in the context of a dentist/patient relationship and may be of a sensitive nature.

  - Sensitivity of information. Some health information is highly sensitive and can include details about an individual's body, lifestyle and practices which are particularly intimate or which may, if improperly disclosed, be misused.

  - Duration of retention (see part 5). Health information may be required long after it has ceased to be needed for the original episode of care and treatment.

WHAT CONSTITUTES RECORDS?

- Notes made by clinicians and staff
- Completed written medical history
- Consent documents
- Copies of correspondence about the patient
- Radiographs, tracings, measurement
- Diagnostic casts
- Special test findings
- Photographs
- Records of financial transactions

STANDARDS FOR RECORD KEEPING:

Records must comply with statutory requirements and should include the following information about the individual:

- Name, birth date, address and telephone (facsimile) contacts of the patient
- Gender of the patient
- If the patient is under 18 years of age, the name and address of a parent or guardian
- An adequate medical history which is updated regularly
- The date of every visit and appointment made which the patient failed to attend

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*Legislation on this topic will differ between States and Territories. Reference should be made to such legislation. What is set out here is general information on the topic.

Records should also include where appropriate:

- A description of the presenting complaint, relevant history, clinical findings, diagnosis, treatment options and treatment plan agreed to advice given to the patient* on:

  - Treatment options
  - Pre- and post-operative instructions
  - Likely outcomes

- Any treatment undertaken. Notes should include detail about the material used, variation from your usual technique and comments on the procedure. The detail should reflect the complexity of seriousness of potential sequelae.

- Any treatment advice that the patient was unwilling to accept
- Drugs prescribed (quantity, dose, instructions)
- Drugs administered (dose)
- Consents obtained for treatment (see part 7)
- Unusual sequelae to treatment reported by the patient
- Estimates or quotations for fees
- Relevant comments by patients on concerns over offered treatments
- Any comments or complaints by patients about treatment provided
- Annotations made by staff following telephone conversations etc

All comments should be couched in objective, unemotional language. It is desirable that the treating dentist does not delegate responsibility for the accuracy of medical and dental information to another person.

Records should be legible and abbreviations standard ones. They should be readily understood by any third party (particularly another dentist) accessing the file.

Where corrections are necessary, liquid paper products or erasable pens should not be used. Corrections should be undertaken by the person striking out the incorrect words and rewriting the correct words. If the document is being rewritten the original document should be kept as a reference.

Computer records:

The principles applying to handwritten records also apply to computer records.
Computer records should be time logged and, if codes are used, they should be readily convertible to conventional language.

Other desirable features pertaining to computer records are:

- a dental practitioner's records must show who made each entry and when it was made;
- it must not be possible for entries to be changed without trace, that is, there must be an audit trail;
- there should be security procedures such as access being available only by password;
- there must be a standard procedure for entering treatment record data that is recorded in an office manual or memorandum to the practitioner's staff; and
- there must be adequate computer back up systems in place.

STORAGE AND SECURITY OF RECORDS:

It is the responsibility of the dentist and staff to keep in confidence information derived from a patient. Information should only be divulged from a patient in accordance with relevant legislation and Australian Standard 44100.

Appropriate arrangements should be made for the adequate physical security of patient records.
*References hereafter to 'patients' should be read as 'patients and where applicable, their custodial parent(s) or guardian(s) or duly authorised person.'

RETENTION OF RECORDS

The retention of records must comply with statutory requirements but, as a general rule, with the possible exemption of diagnostic casts, all records should be kept for at least seven years after the date of the final entry.

Records relating to the treatment of minors should be retained for at least seven years after the minor has attained majority.

If records are released for whatever reason, dental practitioners should obtain an acknowledgment receipt and also retain copies for their own records. In the case of radiographs, if it is a contentious issue a copy should be kept.

It is a reasonable alternative that diagnostic casts be given to the patient and regarded as a patient held record.

ACCESS TO RECORDS:

Patients need access to the information in dental records for a variety of reasons. Some move to a new town or suburb and need to consult a new dentist. Others may have compensation cases lodged with the courts, where their medical/dental condition and treatment are central issues. Some patients simply want to understand what is wrong with them and to fully understand the treatment they have had or intend to have.
It is preferable that the information should be provided in a report, and not simply by sending a copy (never an original) of the records. A report written for the express purpose of the request may be far more helpful than the records themselves.
Records remain the property of the practitioner. In some jurisdictions, regulations entitle patients to view or obtain copies of their records.
In some jurisdictions, regulations entitle patients to obtain copies of any radiographs and records, or a report of their
treatment, at their own expense.

CONSENT RECORDS:

The issue of consent is currently under scrutiny by law reform commissions, the National Health and Medical Research Council, various other government, statutory and community bodies and the media. In order to practise in a legally defensible and professionally responsible manner, a practitioner must assist patients to make well informed decisions about treatment procedures.

- By action of consulting a dentist, consent for examination is implied.
- Implied consent would usually pertain for minor and familiar procedures.
- For more complex procedures a more formal consent (which may be verbal or written) is required.
- Mere agreement by a patient does not fully satisfy the requirement of consent.

For this to be valid, some information about the proposed procedure must be provided and the patient must understand what it is he or she is consenting to.

In all situations it is necessary to keep careful, clear records. Disclosure of information and subsequent oral consent (which suffices for the vast majority of dental procedures) should be listed in the clinical notes.

For major treatment, either in terms of invasiveness or expense, written consent forms acknowledging that the nature, implications and risks of the proposed procedure have been explained, may provide substantial evidence that the information was given and consent granted.

- ✓ *Adopted as a Code of Practice by Federal Council, 17-18 April 1997.*
- ✓ *Adopted as Guideline for Good Practice by Federal Council, 11-12 November 1999*