Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

College Submission
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Feedback on Ahpra's Draft Data Strategy

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is ***the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care***. It provides a quality Fellowship program including training, professional development, and clinical practice standards; and support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM has more than 5000 rural doctor members with1000 doctors in training, who live and work in rural, remote, and indigenous communities across Australia. Our members provide expert front line medical care in a diverse range of settings including general practices, hospitals, emergency departments, Aboriginal Medical Services, and other remote settings such as RFDS and Australian Antarctic Division.

Initial Comments

The core objective of Ahpra's draft Data Strategy (the Strategy) is stated as follows:

"To identify additional ways that the data we hold could provide greater benefit to the public, practitioners, and our regulatory effectiveness, while also ensuring that we protect the privacy of those whose data we hold".

There is certainly a global trend toward greater transparency in regulation, and recognition of the public value in using and sharing data between government agencies and other entities. Increasing

data flows between regulators, governments and other organisations can assist in efficient interaction with the public and in responding to evolving public policy questions.[1]

The objectives of the National Scheme are:

- to protect the physical, psychological, and cultural safety of the public
- enable service delivery and a sustainable health workforce
- facilitate public choice and access to health care provided by registered health practitioners, and
- support our work with practitioners, notifiers and others who engage with the National Scheme.

As much of the data collected and held by Ahpra is personal information, it is imperative that the Strategy balances disclosure risk and data utility and has a framework which takes a multi-dimensional approach to risk management. The Five Safes framework is an example designed to facilitate safe data release and prevent over-regulation, through assessing and describing each risk aspect in a qualitative, allowing data custodians to place appropriate controls on both the data and the way the data is accessed.[2] The public interest must be balances with the interest of individual practitioners.

Response to Survey Questions

Draft Data Strategy

1. Does the draft Data Strategy cover the right issues?

We note the Strategy is intended as a 'high-level' guiding framework to inform how Ahpra uses and shares the data it collects and holds.

The four strategic objectives – 'Regulatory efficiency and effectiveness', 'Trust and confidence', 'Insight generation' and 'Shared data value' – are generally supported with some concerns as detailed below. The aspiration to maximise value to practitioners, the public and regulatory effectiveness while ensuring data is always appropriately governed and managed is supported.

Notably absent is any recognition of the commitment to applying natural justice within the framework.

- ***ACRRM Recommendation:***

  We would like to see explicit reference in the overarching framework that the principles of natural justice will be applied to the publication of data about practitioners and their patients

We are also concerned by the "*Insight Generation*" sections reference to *"expanded risk factors data to help determine risk of harm."* We consider this approach to be highly problematic.

Where data is collected about an individual doctor's conduct as a predictor of their future conduct this is fair and reasonable. Where aggregated data is collected based on context factors such as age, geography, gender, etc. and used to predict any individual doctor's future conduct this is not a true representation of that person's capacity and patently against natural justice.

This misrepresentation is especially important because patient risk as assessed by poor health outcomes is likely to reflect contexts with intrinsically poor health status and poor access to care and

[1] https://ausdatastrategy.pmc.gov.au/australian-data-strategy-snapshot
[2] https://www.abs.gov.au/about/data-services/data-confidentiality-guide/five-safes-framework

resources. Such areas typically experience significant challenges in practitioner recruitment. Publicising projections of potential patient risk in these contexts (that reflects upon but is not based on the conduct of individual practitioners in that context) will disincentivise practitioners to work in these areas and thus serve to worsen, rather than improve patient healthcare.

- ***ACRRM Recommendation:***

  The framework needs to explicitly recognise the potential to harmfully misrepresent skilled practitioners through this approach and its onus of responsibility to take a highly nuanced approach to this information. At least, we would like specific indication included in the high-level framework that the Ahpra will in all circumstances clarify to the public the distinction between risk associated with a generic context and risk associated with an individual doctor. Noting that even where such distinctions are made it is likely that doctors will be viewed as guilty by association.

2. Do you think that anything should be added to or removed from the draft Data Strategy?

It is imperative that the Strategy balances disclosure risk and data utility and has a framework which takes a multi-dimensional approach to risk management, such as the *Five Safes* framework mentioned previously.

The public interest must be balanced with the interest of individual practitioners and ACRRM would suggest the Strategy requires a stronger focus on safety across all four strategic objectives.

Focus Area 1: The Public Register

ACRRM agrees that the public register must continue to be a trusted source of information about health practitioners to assist the public in making informed choices about their healthcare.

We note the intention to potentially including additional information about health practitioners and their practice on the public register, including:

- additional qualifications, including post-graduate qualifications and professional qualifications and training (e.g., administration of vaccinations).
- approval to provide specified MBS-funded services
- provision of telehealth services
- authority to prescribe
- cultural safety training
- areas of special interest
- end dates of suspensions, conditions, or undertakings
- registration history
- regulatory action history
- preferred or professional name
- relevant licences e.g., radiation
- membership of professional associations
- practice names and locations, and/or
- further practitioner and/or consumer generated information about a registered health practitioner for example, consumer feedback
- disciplinary history

3. Do you agree with adding more information to the public register?

The College has some concerns around this general approach and would emphasise that information provided by the Ahpra must be authoritative and thus maintain the utmost levels of accuracy and reliability. We see considerable risk that broadening the scope of information provided may lead to inclusion and tacit endorsement by Ahpra of information, which is not objective or verifiable, unreliable, or out-of-date.

ACRRM agrees however that adding certain additional information to the public register could be of benefit to practitioners, the public and others. For example, adding information regarding:

1. additional qualifications, including post-graduate qualifications and professional qualifications and training (e.g., administration of vaccinations).
2. approval to provide specified MBS-funded services
3. authority to prescribe
4. cultural safety training
5. preferred or professional name
6. relevant licences
7. membership of professional associations
8. practice names and locations

could be regarded as beneficial to everyone using and accessing the register. It would allow practitioners to list their full range of formerly approved qualifications and licences all of which could be considered of interest to both the public and to future employers.

ACRRM agrees, for example, that the inclusion of data around qualifications to administer vaccinations on the public register could have been useful during the COVID-19 pandemic, with practitioner consent, and could have informed the public and employers as well as assisting governments in vaccination planning.

4. Do you agree with adding health practitioners' disciplinary history to the public register?

Currently, conditions or limitations on a practitioner's ability to practice are not published once they are no longer in place. Restrictions which have been met and no longer apply should not appear on the register as historical records. This could have ongoing consequences beyond the intended protective effect of the regulatory action.

5. How long should a health practitioner's disciplinary history be published on the public register?

The issue with publishing spent disciplinary or regulatory history on the public register is that it will allow the public and employers to access information beyond the expiry date of the original measures put in place. This action would prioritise the public interest over the basic human rights of health practitioners and could be regarded as punitive rather than protective in nature, extending the reach of the protective measures beyond their intended reach.

When regulatory action has been taken, in the form of conditions for education, supervised practice and mentoring, these conditions have an end date i.e., once the conditions have been fulfilled, the conditions are removed from the public register. Continuing to publish details of disciplinary history which has expired is detrimental to practitioners and could impact employability and future career prospects.

Recent amendments to the National Law, which have been very broad in scope and conferred wide ranging powers on the National Boards, have already created a situation where priority is given to public confidence and trust over the rights of health practitioners. The suggestion that Ahpra would publish expired disciplinary history on the public register is contrary to natural justice and creates a

perverse situation where the public could perceive a risk from a practitioner who has had restrictions imposed in the past which are no longer applicable or enforceable.

6. Who should be able to add additional information to the public register?

Whilst ACRRM would be prepared to support information numbered 1-8 in our response to Question 3 being included in the public register, if the decision is taken to include such information, we believe that practitioners should retain the right to choose whether to provide this level of additional information.

The information should only be listed on the public register if it has been voluntarily provided by the practitioner e.g., Ahpra could request this additional information as part of the registration process, but practitioners should not be under any obligation to provide it.

For all other types of information being considered by Ahpra for inclusion on the public register the College does not support this being included on the register. Should it be included however, this information should only be added by Ahpra, and other than in relation to current disciplinary or regulatory action, should not be included without a practitioner's prior approval in writing.

7. Are there other ways to enhance the effectiveness and value of the public register for the public and/or practitioner?

The public register is currently easy to access, information is presented clearly, and is easy to understand. The process of searching for a health practitioner is straightforward to navigate, with conditions, undertakings, and reprimands all clearly signposted and well defined. ACRRM would caution against numerous changes to the way information is presented from the search function on the Ahpra website, as this could make the system unwieldy and more difficult to navigate.

Focus Area 2: Data sharing

We note that Ahpra is interested in sharing data with, and receiving data from, other organisations (where this is legally allowed) to benefit practitioners and the public, and that future data-sharing might include:

- real-time verification of practitioner identity, including two-factor authentication (that is, verifying that a practitioner who is logging into a service for instance is who they say they are by sending a code to their email address or mobile). This could provide additional security for practitioner data
- data uses related to significant public health issues, such as COVID-19, including for immunisation registers and training
- use of additional practitioner identifiers when exchanging data including government health departments and others wanting to exchange information using the unique Healthcare Provider Identifier that Ahpra issues to each practitioner, and higher education providers wanting to use medical intern placement numbers or student numbers to assist with the transition from study to employment
- exchanging data with health sector employers and Government agencies to help with workforce planning, including to identify and address areas of need or workforce shortages, and
- a small number of government organisations having access to specifically customised versions of the PIE service. For example, customisations to PIE have been developed to enable the objectives of, and data exchange with, the Commonwealth Department of Health for National Real Time Prescription Monitoring.

8. Our National Law enables us to share data with some other organisations in certain situations. Do you have suggestions about how Ahpra could share data with and/or receive data from other organisations to benefit the public, practitioners and/or our regulatory work?

We note that data is currently shared for the purposed of meeting legislative obligations, such as with co-regulators, Departments of Health and Services Australia, police, courts, and accreditation authorities, and focuses on Ahpra's regulatory work and specific responsibilities.

ACRRM sees a clear overlap and interaction between the data held by Ahpra and the responsibilities of other health agencies, where sharing information could aid in the effective and efficient targeting of funding and resources. Health workforce planning is a clear example where this information could be utilised, through sharing data around practitioner lifecycle, education patterns and gaps in specific areas of practice.

The College would not however support any data sharing which did not respect the privacy of patients and practitioners and was not in accordance with the principles of natural justice.

Focus Area 3: Advanced Analytics

We note that Ahpra considers that advanced analytics and machine learning technologies could make regulatory work more efficient and effective, benefitting practitioners and the public. ACRRM is pleased to note that advanced analytics will only be utilised within a robust legal and ethical framework with transparent information available about the approach, and complex regulatory decisions which impact practitioners will continue to be made by humans.

- The use of technologies to expedite notifications, triage high risk matters and manage caseloads, thereby reducing timeframes for assessment and resolution could mititage the pressure on practitioners who are subject to notifications.
- We would firstly reiterate the issues raised at point 2 regarding the need to dinstinguish between an individual practitioner and their risk factors as evidenced by their personal history and risk factors related to their context and profile, which may or may not apply to the individual at all. This notwithstanding, identifying and sharing potential risk factors with practitioners (which are clearly identified as related either to to the individual practitioner or their profile and context), could be utilised to assist in self management of risk and to support professional practice. To be effective, this would have to be accompanied by resources.
- Good use of the new analytic technologies could be achieved by using existing data to identify the interventions, restrictions and compliance approaches that have proved most effective and achieved the best patient and health service outcomes.

9. Do you have any suggestions about how Ahpra should approach using advanced analytics and machine learning technologies?

As technology rapidly evolves, the importance of checks and balances to ensure safety of those potentially impacted becomes even more paramount. Artificial intelligence holds great promise for the delivery of healthcare and medicine, but only if ethics and human rights are put firmly at the heart of its design, deployment, and use.

The World Health Organisation states human autonomy as the first principle of AI in healthcare [3], and this applies across the entire sector, including its regulation.

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6110188/

As outlined above we would emphasise the need for the Ahpra processes to clearly distinguish between patterns of behaviour related to context and practitioner character traits and each individual's professional history.

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live and pay respect to their Elders past present and future.