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AUSTRALIAN DENTAL ASSOCIATION

30 June 2016

Data Availability and Use
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

Sent online: www.pc.gov.au/inquiries/current/data-access

Re: Data Availability and Use

Dear Productivity Commission,

The Australian Dental Association (ADA) welcomes the opportunity to provide feedback on the Productivity Commission ('the Commission')'s Issues Paper on Data Availability and Use (Issues Paper).

Considering the wide range of areas in which questions of data availability and use can apply, the ADA will confine its remarks to how these may affect dentistry in Australia.

While developments in technology and the internet have much potential and promise to enable greater data availability, sharing, and analysis for the benefit of consumers, patients, practitioners, government and commercial interests, the manner and framework in which greater access to data is facilitated must be thoughtfully developed. Healthcare services are a specific area that places particular importance on principles of patient privacy, security, consent and appropriate use of sensitive information, which must continue to be recognised and respected.

Access to private sector data

Considering the sensitive nature of healthcare, making data about practitioners, patients or practices available should always be consistent with the principles outlined by the *Privacy Act 1988*. That is, where access to data about specific individuals is being canvassed and used beyond the purposes for which this data was originally provided, a genuine opportunity to 'opt out' must be provided. Dentists have additional responsibilities based on their professional relationship with patients as well as under the Dental Board of Australia's Guidelines to ensure that data relating to their patients is safely stored and used for appropriate purposes and that patients' privacy is protected at all times.

Health records differ significantly from general information. There is a certain sanctity that attaches to health records and this must be maintained.

Plans that envisage accessing or accumulating high level, de-identified, aggregated data on a large scale basis must have appropriate processes and mechanisms in place to ensure that such data is provided in a secure manner and is used solely for the purposes that they are intended. Where possible, consultation about the provision of data and ideally consensus should be developed not only on an individual basis but sector, profession and industry wide. Particularly for data mining that is conducted for commercial purposes, the subjects from whom the data is being gathered, mined or shared need to have adequate 'buy in' so that they can see the tangible benefits they also receive as part of their participation with such initiatives.

Ultimately, any data availability, access or sharing initiatives must, on an administrative level, be as simple and as easy to manage as possible for staff and practitioners.

With respect to attempts by the Australian Government to procure data from the private sector, the Commission is advised to refer to the former's attempts to increase participation in the national electronic health record system, *My Health Record*. This is a strong case study of the ongoing challenges that any future data availability, sharing and access initiatives must address to best ensure the success of such plans.

Problematic data sharing initiatives

Private health insurers' use of HICAPS

In the private sector, in particular relating to private health insurance, one example of problematic access and use of data is that facilitated by the use of HICAPS claiming system. The vast majority of private health insurance claims in dentistry are processed through the HICAPS system which is the processing and payment system of choice by private health insurers (PHI). One of the main reasons for this is because PHI can access data about the charging practises of individual practitioners and practices who use the HICAPS system. PHIs, especially those that are vertically integrated and operate practices owned by them have the advantage of access to granular sensitive information of the pricing, clinical practices of their competitors (the practice where the PHI's member attended for treatment), the specific procedures performed and the identity of the patient who received these procedures. This places the PHI in an unique position of being privy to the actual prices of its competitors; knowing which services are being provided and the busyness of those practices. This enables them to have access to sensitive information and be able to act on this information to increase their competiveness. It also enables the PHI to identify suitable members it can then 'steer' to the PHI owned dental clinics and/or to their contracted 'preferred' provider network - either by way of pricing signals, such as level of rebate/level and out-of-pocket expenses or contractually in the terms and conditions of policies. They are also privy to the busyness and volume of trade in competing practices and having this market data may enable them to identify suitable areas in which to open their own practices. Over time, PHI can build their database of fees rendered and service volumes from their competitors.

This conduct has a materially detrimental effect on competition, as the PHIs, particularly large ones that occupy significant proportions of the private health insurance market, are privy to the commercially sensitive data of their competitor dentists. The PHI then has the ability and incentive to utilise this information to their advantage and to thereby skew the competitive process.

As it currently stands, the clauses relating to the use of confidential information in the HICAPS contract are too generous to the PHI.[1] Dentists should be made aware of the precise nature of the information collected through the HICAPS agreement and the precise manner and purpose for which it is used, especially secondary use of such information. Also the parties to whom the information can be disclosed is far too wide. Specifics of whom is receiving information and the use to which it is put should be disclosed in the agreement such as secondary purposes and how they are related to the primary purpose.

It is highly likely that through technologies relating to electronic payment systems such as HICAPS, PHIs use market and consumer sensitive data in a manner which distorts the market and is not ultimately in consumers' interests. For instance, PHIs can use this data to "derecognise" (i.e. identify as no longer able to provide services to the PHI's members that would be eligible for a PHI rebate) otherwise productive dentists, or reduce rebates on profit draining expensive services which otherwise are in high demand due to the health needs of consumers.

This example of the use of HICAPS shows how data accessibility can be used in a way to serve commercial interests that are not in the long term health interests of patients and consumers. Similar risks apply in situations where commercial entities procure the 'consent' of healthcare consumers who use the former's products to onsell their data (via the small print of terms and conditions). Health practitioners are restricted by their ethical and professional obligations from engaging in such activity yet other commercial entities are not. Policy makers in response should consider strengthening the privacy law and develop data sharing governance frameworks in Australia that require greater meaningful disclosure of these information sharing

[1] HICAPS, *HICAPS Provider Agreement Terms and Conditions*, Clause 6.2.

and use arrangements as well as setting boundaries around the uses that information can be used in a health service provision context.

Review websites

There are a number of examples where platforms, such as review websites based on particular data repositories claim to provide valuable information to consumers to assist them in choosing healthcare providers. While examples of review websites for activities such as booking hotels, purchasing goods and services can provide benefits to consumers, applied in the healthcare sector, unintended consequences arise. Healthcare is a particular service for which a typical 'consumer review' approach to scrutinise the service is not appropriate. The patient is not in a positon to accurately comment on the clinical competencies of health practitioners. The clear asymmetry of knowledge in the technical aspects of the service provided means the patient has limited knowledge upon which to formulate their review of the service provided. Peer review by fellow professionals can fairly ascertain the quality of a particular service provided. Australian Government bodies already exist to perform this role such as the Professional Services Review Scheme and AHPRA .

One such review website that offers limited value to consumers is Whitecoat. This review site purports to offer the ability for consumers to post rating reviews of practitioners that are sourced from directories that collate publicly available information such as Sensis. Previously Whitecoat itself issued ratings based on aspects such as 'cost' and, in the ADA's view, did not provide its methodology of how it rated 'cost' of service transparently. While this feature no longer appears on this review website, this serves as an example of the care and scrutiny that must be applied to such websites that purport to provide assistance to consumers both in methodology and of the underlying purposes that such websites can serve.

Adopting such commercial review models to data relating to healthcare service provision diminishes the public's understanding of the standards and qualifications that all practitioners must obtain before they are granted registration status with the Australian Health Practitioner Regulation Agency.

High value private sector data

One example of high value private sector data in the healthcare sector that can be further built upon and expanded are reporting obligations that PHI have to the Australian Prudential Regulation Authority (APRA). PHIs are statutorily required to provide prudential and financial information to APRA so that reporting and monitoring of the private health insurance industry can occur.

Much like the public health sector, where information is collated and reported on to generate a better understanding of the health care needs of Australians, the Australian Government should consider mandating that PHI not only provide their corporate information, but also information related to the specific subtypes of healthcare services that have been rebated by private health insurance policies. While currently there is reporting by APRA on how many instances of 'dental' services were rebated by private health insurance, there is no further granularity of information on the types of services or the frequency of provision of those services. This data could potentially be mapped by region, location and socio economic status of policy holders nationally. This would not only provide further data in which policy makers can better target government resources, but also encourage PHI to be more efficient in funding healthcare services. The data would also allow for provision of new practices being established by the private sector in perceived areas of high need for dental services and thus improve competition. One other source that government could consider accessing and make publicly available (in a deidentified manner) could be from HICAPS. There would be considerable public interest in having this level of data available.

Access and use of public sector data

In a similar vein, within the government context what should be kept in mind is that increased data availability per se does not replace the importance of having adequate consultation with all relevant stakeholders impacted by prospective policy changes. Similarly, government must provide an adequate review of a wide range of evidence so that policy decisions are best informed as possible.

One example is that government policy until recently funded the expansion of a number of dental schools

and had set migration pathways to allow overseas trained dentists to work in Australia based on incomplete data about the true state of the dental workforce. This situation only started to be addressed when the previous Health Workforce Australia was commissioned with performing a supply and demand study, which included a comprehensive input from a range of practitioner bodies and data collection agencies. The result of that process was the finding that in fact Australia has been and will experience an oversupply of the dental workforce until at least 2025. Policy makers have been able to start adjusting their policy settings accordingly to address the dental workforce oversupply. This alone could not have occurred by increasing data availability alone. In other words, policy processes must continue to be rigorous and discerning of the data it seeks and assesses in forming policy decisions.

Data literacy

While evolving technologies provide more opportunity and potential for consumers, industry, the health sector and government to access more data, any decisions and frameworks that are adopted to determine the form this access should take must consider how all stakeholders' data literacy can be constantly improved.

The ADA is not suggesting that measures must be developed to ensure that all patients and consumers become experts in developing their own data analytic platforms. However, in order to rectify the knowledge asymmetries that exist when it comes to the data and information offered by these platforms and those who consume what is provided by these platforms, consumers in turn should be supported and provided with the skills, knowledge and understanding to be able to interrogate this material. Platform developers and data hosts should be required to perform an educative function, which in turn requires a level of transparency that can best inform and equip those who use the data while appropriately protecting commercial sensitivities should they apply.

Should you require further comment regarding the ADA's feedback, please contact Robert Boyd-Boland

Yours sincerely,

Dr Rick Olive AM RFD
President