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AMA submission on Data Matching Bill 2019

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The AMA appreciates the Department providing a draft of the *Health Legislation Amendment (Data Matching Bill) 2019* for comment.

The AMA strongly supports accountability within the health system, including the appropriate use of the Medicare Benefits Schedule (MBS) in providing patients with equitable access to medical services. This includes the responsibility that all medical practitioners have as stewards of the health system – a stewardship that aims to maximise quality of care, protect patients from harm, while also working to ensure affordable care in the future.

The AMA values the existing relationship with the Government to develop and promote compliance initiatives in partnership with the medical profession. The AMA also maintains its commitment to the goal of minimising the risk of incorrect MBS billing and increasing the efficiency of medical practice.

However, while improvements have been made since 2018, the AMA still has major concerns.

Changes to the role of Information Commissioner and reduced reporting requirements

The Department previously assured the AMA that the proposed data matching regime would not seek to override the Privacy Act or change privacy setting.

As noted in the Consultation Guide:

> Currently, section 135AA of the *National Health Act* 1953 and associated *National Health (Privacy) Rules 2018* (the **Privacy Rules**) only permit matching of Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) data in narrow circumstances. The proposed legislation will exclude data matching from this restriction when the matching is undertaken for specified Medicare compliance purposes.

In other words, the Department will no longer have to comply with the Privacy Rules – including the specific protocols for data matching – established by the Information Commissioner under section 135AA of the *National Health Act*.

The AMA appreciates that:

- the use and disclosure of personal information must be consistent with new section 132B of the *National Health Act* for it to be authorised by law;
- the CEO Medicare will be required by section 132F of the *National Health Act* to consult with the Information Commissioner in relation to its systems and processes; and
- the Information Commissioner may undertake an assessment under section 33C of the *Privacy Act* as to whether there has been compliance with these systems and processes.

However, there is:

- no minimum time period for consultation;
- no requirement to consult broadly;
- no requirement for regular review of the effectiveness and appropriateness of the systems and processes;
- no requirement for the Information Commissioner to endorse the systems and processes; and
- no requirement for the Information Commissioner to report on behaviour which may be consistent with the systems and processes made by the CEO Medicare but would not otherwise be consistent with the Australian Privacy Principles or the expectations of ordinary Australians.

The AMA notes also that there is no requirement to publish the systems and processes, although they could potentially be subject to FOI. Given the publication and wide consultation undertaken to develop current guidelines governing MBS and PBS data matching, it is appropriate for the new data matching system developed by the CEO Medicare to also be published.

By contrast, under the existing legal framework, Guidelines concerning data matching have been made by the Information Commissioner only after broad and considered consultation and contain a considerable number of protections.

Given the privacy issues experienced with large Medicare datasets, the removal of this control is very concerning.

Equally concerning is the very real conflict of interest between the Department's compliance objectives and its role as a data custodian. Currently there is no conflict as the rule making power rests with the independent Information Commissioner rather than the Department.

Delegation

New amendments have been included in the Bill which allow the CEO Medicare to delegate their powers to "any person". Unlike other recent legislation (such as the *Medical Indemnity* changes) there is no requirement that the person be a member of the Senior Executive Service.

There is also no requirement that the person be a public servant. Theoretically the CEO Medicare could delegate their data matching powers – including their powers to determine the systems

and processes – to private health insurers or a foreign government. The sensitivity of MBS and PBS information makes it appropriate the legislation requires the CEO Medicare to maintain a public register of all organisations authorized to data match under delegated powers.

Data-sharing with other government agencies

The 2018 Bill proposed that the CEO Medicare could authorise another Commonwealth entity to undertake matching on the CEO Medicare's behalf but only where the "Commonwealth entity is an authority to whom that kind of information may be divulged" under the secrecy provisions of the National Health Act and the Health Insurance Act.

New section 132B(2) allows the CEO Medicare to authorise any Commonwealth entity – and currently there are 172 such entities – to match information on behalf of the CEO Medicare for a permitted purpose.

Section 132B(3)(b) provides that the Commonwealth entity may only disclose the results to the CEO Medicare or "a person authorised, in writing, by CEO Medicare". The AMA notes that:

- this provision does not regulate use of the data by the Commonwealth entity; and
- the CEO Medicare could authorise any person. Again, this could theoretically be a private company.

This is not consistent with the repeated statement in the Consultation Guide that data will not be permitted to be provided to private health insurers. At a minimum there should be an obligation on the CEO Medicare to publish a complete, up to date list of all persons authorized to access the results of matched data that includes MBS and PBS.

Data-sharing with private health insurers

As noted above, the legislation continues to include the ability for Australians' private health information to be provided to persons outside government.

The AMA is also concerned that new section 132D gives private health insurers a blanket authorisation to disclose patient data to the CEO Medicare – without patient consent – either at the Department's request or "of their own initiative".

The Consultation Guide (p6) suggests that:

> Private health insurers may voluntarily provide information to Health about anomalous claims with data that goes beyond what is routinely held as a result of Medicare claims … including details such as the start and end times of a surgical procedure.

However, section 132D is not limited to situations where the private health insurer reasonably believes there has been some non-compliance; private health insurers could legally send their entire data base to the Department in the hope that the Department will identify and query outliers.

The current Australian Competition and Consumer Commission actions against Medibank Private illustrate the tension between health insurance business imperatives and the best interest of the insured patient.

Using compliance activities to drive clinical judgement

The AMA is a strong supporter of an appropriate compliance framework to ensure the integrity of MBS and PBS arrangements. However, the operation of any MBS/PBS compliance scheme must be certain, so that there is no ambiguity for medical practitioners about the bounds of appropriate medical practice as defined by the Act for MBS/PBS purposes.

The AMA is concerned that the proposed changes outlined on page 5 of the Consultation Guide will seek to override clinical judgment. It states:

> *Matching PBS dispensing to MBS data would assist to identify if corresponding medical consultation and pathology services were provided to indicate if PBS prescribing requirements have been met.*
>
> *Information from private health insurers will be matching with MBS data to assist with identifying when services may be claimed incorrectly or inappropriately within private health hospitals.*

While most medical practitioners seek to only undertake necessary tests, retrospective data driven compliance reviews could be used in the future to override years of clinical judgement and experience. Gross tools such as retrospective data driven compliance reviews do not take into account complexity of case mix and geographical issues. This may result in unnecessary investigation and loss of productivity for both the doctor and government agency.

AMA members will vehemently oppose a system where clinicians need health insurer approval before providing private patient treatment.

The AMA supports targeted provider education as preventative intervention for compliance and, where necessary, behaviour change. The AMA encourages the Department to work closely with the relevant medical colleges, associations and societies in the development and dissemination of provider education, to ensure it is appropriate and effective for the different clinical groups. Behavioural interventions should not be aimed purely at recovering payments.

Expansion of *Health Insurance Act* to the Department of Veterans Affairs (DVA) and other Defence funded services

Page 5 of the Consultation Paper notes that amendments are being made to the way DVA services will be counted towards the 80/20 rule. This is a reference to “prescribed pattern of service” in sections 82, 82A and 86 of the Health Insurance Act. This amendment is supported by the AMA.

However, as noted previously, the AMA was unable to identify any amendments that are limited to the 80/20 rule. The amendments as drafted appear to extend Part VAA to all DVA, and a wide

range of Defence, funded medical services. Any such expansion is obviously substantial and would need to be considered in conjunction with existing compliance and recovery regimes that relate to that legislation.

The AMA appreciates that a new amendment has been included in the 2019 bill that clarifies that the definition of "inappropriate practice" in section 82(1) does not extend to services funded by DVA.

However, AMA is concerned that amending the definition of services (to include services funded by DVA) will have unintended consequences given the wide use of the term services. For example, section 88 (initial investigation by Director PSR) and section 129AAD (Notice to produce documents) will now apply to DVA funded services.

Piece meal approach to legislation

As previously highlighted by the AMA, there is some lack of consistency with the amendment being made to Part VAA of the *Health Insurance Act*.

Separate to the amendments made in this Bill, PSR has proposed amendments to many of the same sections – 81, 92 and 106U – some of which delete provisions which are being duplicated in this legislation.

Conclusion

The AMA believes the new Bill substantially changes the regulatory arrangements currently in place.

Improved compliance is important from both a clinical and health financing perspective. However, it should be patient-focused, ensuring the health system delivers on the high-quality and necessary care for Australians when they need it. It is vital the Department ensures the data matching arrangements are transparent to withstand public scrutiny and well communicated to reassure patients their privacy will be protected.

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