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Committee Secretary
Senate Legal and Constitutional Affairs Committee
Department of the Senate
PO Box 6100
Parliament House
Canberra ACT 2600

5 March 2010

Concerning the -
Inquiry into the Healthcare Identifiers Bill 2010

Dear Secretary

Thank you for the invitation to make a submission to the Committee's inquiry into the Healthcare Identifiers Bill 2010.

We welcome this Bill as a significant step toward introduction of health information technology, which in turn would not only enhance productivity and efficiency within the health system, but also lead to improvements in chronic disease management. As such, we consider this Bill to be a cornerstone of the e-health movement in Australia.

It is worthwhile to briefly state the arguments in favour of creating a dynamic mechanism for building, maintaining and updating an integrated electronic information system, comprising the relevant records of the healthcare providers as well as healthcare recipients, duly indexed, and classified by unique identifying numbers, i.e. the healthcare identifiers:

- **Developing a robust electronic information system is one of the foremost pre-requisites for improving operational efficiency and productivity in healthcare**

We note that in the *Background Paper, prepared for the National Health and Hospitals Reform Commission* ('NHHRC Paper') (June 2009)[1], it is aptly recognized that "The National Health and Hospitals Reform Commission ('NHHRC') terms of reference require it to develop a long-term health reform plan to improve the performance of the health system, and a key component of performance is *efficiency*."

NHHRC Paper points out that, "*operational inefficiency* or waste refers to the inefficient and unnecessary use of resources in the production and delivery of services," and examines operational inefficiency in terms of "duplication of services; inefficient processes; overly expensive inputs; and errors."

The authors of NHHRC Paper have cautioned that one of the reasons for "inefficient processes" may be the "lack of or inappropriate electronic information systems," and, while focusing on the "drivers and enablers of efficiency improvements that are of particular interest to the NHHRC", they have laid emphasis on the need for "development and implementation of a patient controlled *electronic health record;* performance measurement, surveillance and action."

NHHRC Paper also recalls that the *Productivity Commission* (2006)[2], after analyzing the literature on health system efficiency, had determined that the difference between its current level of efficiency and what it theoretically achieved could be between 10 and 20 per cent across the *total Australian health sector*, and estimated that the *improvement in productivity and efficiency* would result in huge *net resource savings* for states and territories as well as the Commonwealth. Likewise, NHHRC Paper draws upon the findings of *Productivity Commission* (2008)[3], which reported that "anecdotal evidence from some aged care providers suggests there may also be potential for further productivity improvements by *adopting advances in information technologies*."

NHHRC Paper identifies, inter alia, "e-health and patient electronic health records" and "greater use of data through measurement and surveillance of health system performance" as the potential "*solutions for improving operational efficiency*," and suggests that the "introduction of health information technology,

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[1] *The Australian Health Care System: The Potential for Efficiency Gains* – A Background Paper, prepared for the National Health and Hospitals Reform Commission, at the request of Commission, by Emily Hurley *et al*. (June 2009), staff of the secretariat to the Commission.

[2] Productivity Commission (2006) *Potential Benefits of the National Reform Agenda*, Report to the Council of Australian Governments, Canberra.

[3] Productivity Commission (2008) *Trends in Aged Care Services: Some Implications*, Commission Research Paper, Canberra.

in particular individual patient electronic health records (IEHR), would enhance labour productivity and technical efficiency within the health system."

NHHRC Paper also suggests that "efficiencies are expected to be delivered across in-patient and out-patient services by *minimizing the need to transcribe medical records*, wait for paper records to be delivered, and re-order tests and diagnostic imaging because the *results and x-rays/scans could be attached to the IEHR*. *Adverse events are expected to be reduced* as it will be easier to manage medicines (and their interactions) and medical histories (including, for example, allergies)."

- **Drawing support from the studies conducted in U.S.A. vis-à-vis Australia**

  Girosi (2005)[4] estimates that *full adoption of health information technology* in the U.S. could save approximately four per cent (US$81 billion) of total yearly health spending (approximately US$1.7 trillion). Although the initial investment in information technology is high, estimated to be US$7.6 billion, the annual benefits far exceed the costs. It is anticipated that IT-enabled improvements in prevention and disease management in the U.S. could more than double these savings while also lowering age-adjusted mortality by 18 per cent and reducing annual employee sick days by forty million.

  In Australia, one study (ACG, 2008)[5], commissioned by the National E-Health Transitional Authority (NEHTA), found that the *economic benefit* to Australia from the *implementation of an IEHR network* would be between $6.7 billion and $7.9 billion over 10 years (in 2008-09 dollars). The ACG model assumes efficiency gains because of reductions in the number of adverse events (including medical errors) and duplication of services - for example, the number of repeated tests and images. There may also be further efficiency and effectiveness gains down the track if IEHR leads to the development of better decision-making tools, and more accurate and rapid diagnosis. The ACG model assumes that there will be an increase in throughput (for example, a reduction in hospital queues), rather than savings (that could, for example, be handed back to government) due to excess demand for health care. *Real output in the hospital and medical services sector is expected to increase by between 4.8 and six per cent by 2019 following the implementation of an IEHR network from 2010* (ACG, 2008).

- **The Bill is in line with Government's recent impetus to Health Reforms**

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[4] Girosi, F., Meili, R., and Scoville, R. (2005) *Extrapolating Evidence of Health Information Technology Savings and Costs*, RAND Corporation, http://www.rand.org/pubs/monographs/2005/RAND_MG410.pdf

[5] ACG (Allen Consulting Group) (2008) *Economic impacts of a national Individual Electronic Health Records system*, July.

While releasing the National Health and Hospitals Network Report ('NHHN Report) (March 2010)[6], the Australian Government has announced major structural reforms to Australia's health and hospital system on 3 March 2010. One of the key recommendations of NHHN Report is setting up of "*personal electronic health record and national e-Health System*"; and the NHHN Report also stipulates that over the coming weeks and months, the Government will, inter alia, announce additional reforms in several area, including ***e-Health***, and shall take further steps towards the introduction of a personally controlled electronic health record for all Australians.

- **Specific suggestions on the Health Identifiers Bill 2010**

1. It is suggested that in the **Definitions** given in **Section 5** of the Bill, among others, ***corporation*** and/or ***incorporated body*** should also be included in the definition of ***entity***, just as in the 'Example' given underneath the definition of ***healthcare provider***, a *corporation* that runs a medical centre has been considered a healthcare provider.

2. In **Section 5** of the Bill, ***healthcare provider*** is defined as (a) an individual who *has provided* ... healthcare; or (b) an entity ... that *has conducted*, ... an enterprise that provides healthcare ... but it is not specified therein as to '**within what length of time**' prior to the enactment of Bill an individual should have provided healthcare or an entity should have conducted an enterprise, so as to qualify for the definition of ***healthcare provider***. This may cause confusion as to 'who' is actually going to be covered under this definition. It is, therefore, suggested that the Bill should specify either the **time period** (say, one year, or two years, or six years prior to the enactment of Bill), within which; or may fix a cut-off date, after which, an individual has provided healthcare or an entity has conducted an enterprise to be considered a ***healthcare provider***. Likewise, such time-limit or cut-off date needs to be specified in respect of the provisions set forth in **sub-clause (a) (i)** and **sub-clause (b)** of **sub-section (3)** in **Section 9** of the Bill.

3. There is an inherent confusion and overlapping in the provisions of Bill regarding the authorisation of the service operator and a national registration authority insofar as assigning of healthcare identifier to a healthcare provider is concerned because, in **Section 9** of the Bill, under **sub-section (1)**, the service operator is authorised to assign ***healthcare***

[6] *A National Health and Hospitals Network* for Australia's Future – A Report (March 2010) http://www.health.gov.au/internet/main/publishing.nsf/Content/nhhn-report/$FILE/NHHN%20-%20Full%20report.pdf

identifier to uniquely identify: (a) a healthcare provider included in a class prescribed by the regulations for the purpose of this paragraph; whereas, under **sub-section (2**), a national registration authority is authorised to assign a ***healthcare identifier*** to uniquely identify a healthcare provider, if: (a) the healthcare provider is an individual who is a member of a particular health profession; and (b) the national registration authority is responsible under a law for registering members of that health profession. This confusion needs to be resolved, and appropriate modifications be incorporated in Section 9 of the Bill.

We, at OrthoSearch - a leader in e-Health communication and healthcare collaboration – strongly support the enactment of Health Identifiers Bill 2010. Our vision is to bring together patients, surgeons, general medical practitioners, physiotherapists, other allied medical professionals and suppliers on a common, integrated information system for the benefit of all, with the objective of facilitating communication and partnerships between healthcare providers and patients, aimed at reducing costs of providing healthcare and improving patient outcomes.

We trust that the Committee will duly consider the matters raised in this submission, and we thank the Committee for its attention. We would welcome the opportunity to elaborate on this submission or to furnish the Committee with further information.

Yours sincerely,

Brent Hall
Chief Operating Officer