

Australian Government's Concept of Operations Relating to the Introduction of a Personally Controlled Electronic Health Record

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Services for Australian Rural and Remote Allied Health commends the Department of Health and Ageing (DoHA) and the National E-Health Transition Authority (NEHTA) in its efforts to implement the Personally Controlled Electronic Health Record (PCEHR) as part of the Australian Government's broader e-Health agenda.

SARRAH broadly supports in principle the concepts outlined in the consultation paper and acknowledges the work done by NEHTA in modifying the concept paper in response to feedback provided in consumer and professional forums. The comments below are made in the understanding that the PCEHR is not designed as a substitute for professional liaison and there is a real risk that the system will be used as a reason for not properly linking and coordinating service around the consumer.

There remain a few core concepts that do not appear to be adequately acknowledged or emphasised within the Concept Paper.

A core principle supported by SARRAH is that the health record must link the private, public and non-government health sectors across the continuum of care. There are three main areas still requiring further attention.

Opt In or Out?

The operation of an electronic health record must be useful for rural and remote people, improve access to and coordination of services, and not present further barriers to people who already find it difficult to access health services.

SARRAH fully supports the initial opt in approach for Australians but is concerned about the uptake of the PCEHR in rural and remote areas which may require special consideration. In small communities where there are few health care professionals, care may already be adequately coordinated by a community nurse or a general practitioner. If this is the case then there is little incentive for consumers to become involved and the process may need to

be one of opting out. Consumers who do not have the capacity to seek medical or health services in metropolitan centres and who only access health services in extreme circumstances would also not find any initial benefit to being involved. Conversely, where it is not possible to recruit permanent medical staff to the rural community, consumers may have to rely on locums constantly changing so that service continuity is difficult with different tests being ordered and changing diagnoses.

Care Coordination

SARRAH acknowledges the primary role of General Practitioners in assisting consumers to access the range of health services but feels strongly that the PCHER must not entrench a system of care coordination that relies on general practices. Access to general practice is difficult in regional, rural and remote settings because of the increased tasks built into the general practice role and consequently this contributes to further complexities in record keeping. SARRAH members emphatically stress that the current gate keeping role played by General Practice is not sustainable and are concerned that the PCHER will continue to entrench a system where consumers are not encouraged or supported to manage their own health and illness. It is acknowledged that nationally, General Practices have computerised systems in place and that this change has been brought about by many years and millions of dollars in incentive payments by the Commonwealth government. Allied Health Professionals in private practice have not had the same computerised services however they have only recently been given access to the MBS and PBS systems. Community Pharmacies do have computerised services and could play an immediate role in service coordination. It is vital therefore that the PCHER allow for Australia's health system to develop so that health consumers can choose whom they wish as their advocate and service coordinator even if the processes are not yet in place to support this.

- Allied Health Professionals (even in the public sectors) need to have better access to computerised information systems in order to be able to better contribute to the more integrated health record system.
- There are not many of the Allied Health Professions involved in the lead sites currently. Optometry is a critical area which is already electronically linked and should be considered.
- Provider access for the Allied Health Professions must include both the registered and self-regulating professions.

Governance

SARRAH is concerned about the governance process associated with the PCHER. Without a clear decision of how the system will be managed within the complex current administrative structure many risks can be inflated or overlooked. SARRAH urges NEHTA to frame a concise governance system which includes clinical governance for consultation. There is

some urgency about the development of the governance system and all the good work in stakeholder engagement driven so far by NEHTA could be undone from a poorly thought through process.

For these benefits to be realised on a scale that will contribute to meaningful health improvements, the Australian Government must afford equal footing to a wide range of health care disciplines in its change, adoption and support strategies. Furthermore, the construction, maintenance of and access to the National Broadband Network, plus technical support is crucial for rural and remote Allied Health Professionals.

Unless the current imbalance of e-Health support and infrastructure between members of the health care team is strategically addressed, it will have adverse implications for the achievement of truly integrated, seamless and coordinated care.

I would welcome the opportunity to provide you with further information about any of the positions taken in this response.

Rod Wellington
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General Comments:

SARRAH welcomes the opportunity to provide comment on the Concept of Operations Relating to the Introduction of a PCEHR.

SARRAH is nationally recognised as a peak body representing rural and remote Allied Health Professionals working in both the public and private sector.

SARRAH's representation comes from a range of allied health disciplines including but not limited to: Audiology, Dietetics, Exercise Physiology, Occupational Therapy, Optometry, Oral Health, Pharmacy, Physiotherapy, Podiatry, Psychology, Social Work and Speech Pathology.

These Allied Health Professionals provide a range of clinical and health education services to individuals who live in rural and remote communities. Allied Health Professionals are critical in the management of their clients' health needs, particularly with chronic disease and complex care needs.

It is noteworthy that in many smaller and more remote communities those people in need of primary health care are reliant on nursing and allied health services. If these health professionals are well supported then the need to access specialist and hospital services will be reduced.

SARRAH maintains that every Australian should have access to equitable health services wherever they live and that Allied Health Professional services are basic and core to Australians' primary health care and wellbeing.