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This year has already been a busy one with the AHHA establishing new arms of the organisation in consulting and research.
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HAVE BEEN doing ‘clinical informatics’ for more than 10 years, but was forced to re-evaluate just what it is that I do, and the context in which I do so, following the request from AHHA for this article. I used to give lectures to Masters students five years ago on ‘Introductory Health Informatics’, so I went back to those slides to see how little, or how much, the landscape has changed.

The principles are the same – health informatics is about providing better care to patients using technology. It sits at the intersection of computer science, information science, health care and healthcare management.

The definitions all congregate around the notion of the art and science of providing better health care using IT. But what are the driving forces behind health informatics?

Firstly, there has to be a ‘desire to take better care of patients’, deep and right at the core. Others include the increasing power of technology and the internet, an increasingly stronger need to demonstrate public accountability in the context of errors becoming more public (eg the Bristol Royal Infirmary), the information explosion, and also the need to provide more care in the context of the greying of the population, higher costs, increasing expectations and increasing cost of technology, but a reducing workforce.

Essentially, this means the need to provide demonstrably better care to more patients with constrained resources and proportionally fewer staff.

How does health informatics expect to achieve these aims?

Let’s follow the patient journey to analyse where health informatics can assist.

The patient presents and is registered. Have we uniquely identified the person to ensure we have the right person and the right information held against them? If we have a robust unique person identification system and process then we have made a good start.
In depth

The focus of clinical informatics has narrowed onto the use of information in IT systems in health care by clinicians

Do we have relevant history available from past encounters with our practice and others? Immunisation status? Medications? Important lab and imaging results? Alerts and allergies? Again, an encounter summary with unique person identification will help the process of care.

Can we compare the images from the past to those captured today? A Research Information System (RIS) or Picture Archiving and Communication System (PACS) program will do this, assuming it is fed by the unique identity system already in place. Perhaps the symptoms and signs are not diagnostic – decision support listing differential diagnoses will assist.

The condition found is unusual – what is the best care? Access to the internet will quickly determine what is evidence-based medicine. The prescription process, one of the four main sources of errors in health, should be monitored by clinical decision support software that applies expert rules devised by senior clinicians along with graded drug/drug interaction alerts. The process of clinical care on the ward should be monitored for unusual observations, again by expert IT systems.

When the care pathway is over, the transfer of care should be electronic and seamless. The monitoring of the processes of care in the facility should be able to be supervised by the clinicians, by both analysis of the triggering of the rules engine noted above, but more importantly as to outcomes of care, by disease, by patient group, by ward, by operation and by clinician.

Lastly, the monitoring of the processes and outcomes of care should be able to be applied to the population as a whole by the aggregation of de-identified patient data. An interesting example of the latter was the analysis by Kaiser Permanente of its large data store that identified that Vioxx contributed to an excess rate of myocardial ischaemia.

The various academic definitions have not changed in a real sense over the last decades. So what has changed?

The focus of clinical informatics has narrowed during the last years onto the use of information in IT systems in health care by clinicians.

What has also changed has been the increasing pervasiveness of technology. Google, similarly, has made significant changes to the way we work and study. Some of this article was sourced from Google, the depth and reach of which was unthinkable when I started this job.

So, what do Clinical Informaticians do and what do they use?

Who are Clinical Informaticians?

Clinical Informaticians are doctors, or nurses, or health information managers who know enough about health and health care, and its work processes, and have learnt enough about information and computer sciences that they can assist both their clinical colleagues and the IT groups to achieve common aims.

Bill Gates said it fairly succinctly in 1999 in his book *Business at the Speed of Thought*:

“It’s impossible to properly re-engineer a process using technology in an area without oversight of someone who can bridge [the different] teams.”

The technologists just don’t understand healthcare processes; and clinicians, without further training or experience, don’t understand the technology. It has become the solid perceived wisdom that it is easier to train a doctor or a nurse to have enough understanding of the broad brush strokes and some of the detail of technology so they can effectively bridge the teams.

In fact, in the USA, there arose, in 2009, the clinical sub-specialty of clinical informatics.

These professionals use their knowledge of healthcare processes, of informatics...
principles and processes, and health informatics tools. Clinical processes need no introduction — but what are the latter two? Informatics principles are about IT technology, privacy and health law, database concepts, project management, change management, statistics, health and IT standards, messaging, person identification and so on. Health informatics tools are things like clinical guidelines, pathways, order sets and staff education processes, to name a few.

So, what does the clinical informatician seek to do? (s)he seeks to:

• Assess and inform the information needs of clinicians, managers and patients
• Characterise, evaluate and improve clinical processes.

How does the clinical informatician seek to do this?

In essence, they achieve these goals by bridging the different teams. Specifically, this means to develop, implement and refine clinical decision support systems, understanding both the clinical processes in depth and the technology in a broad way. As well, it means to lead or participate in the procurement, customisation, development, implementation, management, evaluation and continuous improvement of clinical information systems, again understanding both the clinical world and the IT world.

It would be understood that clinical informaticians, then, would do this work from before the inception of a clinical project or system, to well after the (nominal) project had finished — it is a truism that health information systems projects are never finished until the data and information have been passed onto the next system and the original system has been turned off.

The last of the queries is where and the answer is fairly intuitive — wherever clinical care is delivered and close to the point of care.

The state of play for clinical informatics in Australia is not optimum — there are a handful of doctors who do it full-time and a much larger number who do so part-time. There are no training positions and some tertiary courses.

What I find the most gratifying, as a doctor in this field, is the capacity to improve the care that large numbers of patients receive, and interestingly, from a ‘life satisfaction’ perspective, problem-solve with my colleagues how we will practice medicine tomorrow.

References

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Cautious first steps in health reform

In March the AHHA expressed serious concern about the lack of consultation by the Federal Government on legislation to establish the National Health Performance Authority and warned of the risk to future health reform if similar approaches continued to be used.

“The Bill establishes the infrastructure and legislative mechanisms for the NHPA. However, the legislation fails to recognise the role of state and territory governments as the majority funders and system managers of our public health services as agreed at COAG,” said AHHA’s Executive Director, Prue Power. “This is despite the fact that Health Ministers are accountable to their local populations, along with their senior officials, to meet the demands of a dynamic and complex system and for making sure services are available at all times.”

The approach threatened to undermine the National Health Reform Agreement formulated at the COAG meeting in February as well as the Commonwealth’s stated commitment to a cooperative approach to health reform with the states and territories. “As a result of the lack of consultation, the legislative framework for the NHPA has a number of critical flaws which will reduce the body’s capacity to fulfil its role. Hospital and health service performance is a complex area in which the states and territories have considerable knowledge and expertise,” said Ms Power.

The AHHA therefore called on the Commonwealth to make critical amendments to the Bill in consultation with state and territory governments. We have also sought an ongoing commitment to involving the states and territories, as system managers of public healthcare, in the following processes:

- NHPA strategic planning;
- Developing performance indicators to assess quality; and
- Dealing with underperforming hospitals when necessary.

As originally drafted, the legislation prevents the jurisdictions from participating in all these activities. We will keep you posted on the establishment of the NHPA and other new organisations over coming issues.

The Health Advocate June 2011 13

Dental probe welcome, but not the solution

THE AHHA WELCOMED the Federal Government’s intention to further investigate widespread misuse of the Medicare Chronic Disease Dental Program, but expressed disappointment that our earlier warnings went unheeded, which has resulted in massive over-spending on a program with limited scope in the community.

We have for years been highlighting the problems with the Medicare dental program while lauding its focus on improving the oral and general health of people with genuine chronic conditions. Two years ago the AHHA proposed a solution to the problems inherent in the program that would have dramatically reduced spending under this scheme and delivered much better value for money. It is frustrating that this poorly designed and targeted program has been allowed to run for so long when it is clearly wasting valuable health resources which could be used to help those in genuine need – particularly low income earners, Indigenous communities, others in rural and remote areas and older Australians.

The AHHA urges the government to consider a new proposal we developed in consultation with our Oral and Dental Health Network, in conjunction with dental health experts and peak groups, to address the growing oral health crisis in the Australian community.

The proposal focuses on the provision of medically necessary oral health care for those with genuine chronic conditions and targeted assistance to the 30 percent of Australians who currently have difficulties affording private dental care. It involves integrating the Medicare Chronic Disease Dental Program into a revised version of the Commonwealth Dental Health Program, which was proposed by the government before the 2007 election.

The proposal focuses on ensuring funding is directed to delivering cost-effective, essential and preventive oral health care for those who need it most. It would also include universal dental care for children aged 0-18.

You can read more about the outcomes from our Oral and Dental Health Network meeting in Adelaide on page 16.

Have your say...
We’d like to hear your opinion on these or any other healthcare issues. Write to us at admin@aushealthcare.com.au or PO Box 78, Deakin West, ACT, 2600

In the news
A study from February’s Australian Health Review has found that the increased demand for ambulance services over the past two decades is putting pressure on health care resources potentially resulting in reduced access, safety and quality of care for patients.

“In Australia, as in other developed countries, there is an expectation that the health system will fulfil our care needs, especially those that are urgent and life-threatening. The role of ambulance services has evolved over the past 20 years into a vital community resource embedded in the health system,” said study author, Judy Lowthian, an NHMRC post-graduate research scholar.

Initially designed as an emergency transport service, ambulance services now provide a range of healthcare needs, including pre-hospital emergency and urgent primary care, emergency and non-emergency patient transport and referrals to alternative healthcare professionals.

In recent years escalating growth in demand for emergency patient services has placed increasing strain on both ambulance and hospital resources. Rising utilisation of ambulances is occurring in common with increased emergency department attendances. Pressures on hospital systems are well recognised, with congestion and overcrowding reported regularly in the media and peer-reviewed literature.

This study involved a review of the literature concerning trends in utilisation of emergency ambulances throughout the developed world and discusses the major underlying drivers perceived to be contributing to this increase. A better understanding of causes of increased demand is essential to enable the development of strategies to manage demand in the future.

The review found evidence that patient transportation by emergency ambulances has been increasing over the last 20 years. Many contributing factors have been postulated, related to changes in the needs of the community arising from ageing, declining health, social structural change, and changes in organisation of primary healthcare. Limited price signals and improved accessibility of ambulances, alongside improved community health awareness and expectations possibly contribute to a degree of avoidable use. The relative contribution of these factors to the continuing rise in transportations has not been well studied.

The authors recommend further investigation of the major causes of rising demand. For this to be undertaken, there must be collection and recording of standardised data with common definitions of demographic, socioeconomic and health-related factors. Effective management of future demand will depend on a comprehensive analysis that goes beyond simple demographics of age and population growth. Until we have a better understanding of the drivers of demand for ambulance services we cannot ensure the future sustainability of this essential healthcare service.

You can access the Australian Health Review by becoming a member of the AHHA. Find out more about the AHIR and our other publications on our website at www.ahha.asn.au.
Private health insurance needs change

The structure and regulation of private health insurance needs to change radically in order to meet consumers’ need within our current health system. The new research was reported in the February issue of the AHHA’s peer-reviewed journal, Australian Health Review.

“Most Australians are familiar with high profile private health insurance (PHI) companies, like Medibank Private and HCF, but few people understand how this unique sector of the economy operates and the influence it exerts on the delivery of health care in Australia,” said study author Dr Ardel Shamsullah of La Trobe University.

The company structure of the PHI sector has always been markedly different from typical commercial industries, in part due to the comprehensive framework of Commonwealth regulation within which they operate. This regulatory regime was designed to ensure that PHI, heavily subsidised from the public purse, was accessible to all (irrespective of their health status), that contributors were treated fairly and that the organisations were prudently managed.

Competition between funds on price and product innovation and differentiation has been deliberately stifled in order to realise these objectives. This may have made good policy sense when the private health funds were the financial lynchpins of the Commonwealth’s national health scheme, prior to the introduction of a universal health insurance scheme. However, its rationale is questionable in the current environment given bipartisan support for Medicare as a universal public insurer.

The result of this system is that private health funds are now wedded to a highly regulated and subsidised system that assures their existence while they deliver expensive insurance packages to a segment of the Australian population covering a select set of healthcare services. The Commonwealth guarantee of a certain level of income (from subsidies and incentives for people to take out PHI) has insulated the health funds from the conventional business imperatives to satisfy customers and contain costs in the industry, and inflated their significance in the funding of healthcare in Australia.

If the Commonwealth wishes to preserve a system of private hospital treatment employing user charges as an alternative to its own hospital Medicare, it should consider redirecting its subsidies to the hospitals themselves. PHI could then be reconfigured as an option for accessing private hospitals rather than the privileged mechanism for doing so. A deregulated industry using insurance principles of risk-rating and allowing competition between firms would emerge, and it may attract a more diverse contributor demographic, which would consist of more demanding and price-sensitive customers.

“This would result in a PHI industry that supports, rather than hinders, innovation within the health sector and which is genuinely centred around consumers’ needs,” Dr Shamsullah said.

Safety and quality a focus for health

Australians can look forward to safer health care in the future with a permanent organisation dedicated to promoting safety and quality throughout the health system – the Australian Commission on Safety and Quality in Health Care.

While we were concerned with parts of the legislation to establish the National Health Performance Authority, the other component of the Bill to make the Commission a permanent body was most welcome.

Over several years the Commission, and before it the Council, has undertaken excellent work in raising the profile and evidence base for improved safety and quality in a range of health care settings. This has included major campaigns to increase hand washing and hygiene, reduce hospital-acquired infections and improve medication management.

Australia’s health system is very safe by world standards but too many Australians are still harmed unnecessarily in the process of receiving health care. The AHHA believes that every person has a right to receive safe and high quality care and that each avoidable adverse event is one too many.

Most harm caused in health care is not the result of individual errors but due to underlying problems such as a lack of consistent information systems across jurisdictions, health services and sometimes within individual hospitals. This is why it is crucial that we have a body dedicated to identifying and addressing the policies, structures, practices and cultures that can make our health system safer.

The permanent establishment of the Commission enshrines the critical imperative for safe and high quality healthcare in all public, private and non-profit health services.
Events & meetings

Oral health experts agree on a way forward

THE AHHA CONVENED its Oral and Dental Health Network in Adelaide on 11 March 2011. The meeting brought together Directors of state and territory public dental services (most of which are members of the AHHA) as well as representatives from the National Rural Health Alliance, the Public Health Association of Australia and the Australian Dental and Oral Health Therapists’ Association.

The discussion centred on building a campaign for the ‘poor cousin’ of hospital and primary health care reform, oral health. Along with mental health, oral health has been put on the back burner to simmer away while hundreds of thousands of needy Australians continue to struggle with accessing affordable and timely oral and dental care.

The group worked from the basis of the REPAIR proposal agreed during the 2010 election campaign by the National Oral Health Alliance (of which the AHHA is a member). This proposal is available on the NOHA website at: www.oralhealth.asn.au.

The revised proposal reworks some of the touchstones for oral health reform – including stronger links to the evolving National Health Reform agenda, such as through the National Preventive Health Agency and possible inclusion in the National Health Agreement – and emphasises that the starting point must be a program to address the oral health problems of those most in need.

We are seeking integration of the existing Medicare Chronic Disease Dental Program into a revised Commonwealth Dental Health Program (with a new name) that will mean all care provided is on the basis of highest need while ensuring best value for the taxpayer dollar. As originally intended for the CDHP, the new combined program would ensure care for the 500,000 people on public dental waiting lists as well as specific early intervention and treatment targets for those with chronic conditions, Indigenous and rural/remote communities, the aged and children/young people (aged 0-18).

The group also agreed to put forward more specific recommendations in relation to the workforce plan of an intern year for oral health professionals. We would prefer to see an oral health foundation year that in the first instance will be an application-based (and therefore voluntary) program. For instance, 20 foundation year placements may be offered in the first year, expanding over time. Using this model, a focus can be placed squarely on rural and remote placements in the initial roll-out.

At the ensuing National Conference of the National Rural Health Alliance held in Perth over 13-16 March, one of the priority recommendations agreed by delegates was this combined proposal formulated at the AHHA’s Oral and Dental Health Network meeting. You can find the NRHA’s priorities on their website at: 11nrhc.ruralhealth.org.au.

We look forward to working with our partners, members and the government to ensure that another year does not pass without action on oral health. If you would like more information on the AHHA’s oral and dental campaign, contact us on 02 6162 0780.
Moving towards health governance in regional areas

ON 18 APRIL, a beautiful autumn day in Canberra, the AHHA convened its first Policy Think Tank for the year in partnership with the Australasian College of Health Service Management (ACHSM). Our focus for the day was on the distinct governance issues facing rural and remote health services, particularly under the national health reforms.

The day was facilitated with great skill by Associate Professor Paul Dugdale from the Australian National University. We had a fantastic range of speakers who impressed the delegates with their perspectives:

- Prue Power and Daryl Sadgrove, Directors of the host organisations, gave good overviews of the reform context on which discussions focussed throughout the day;
- Jodi Hallas and Jenni Pilcher from Queensland Health detailed state-wide work on health service planning, particularly to support rural and remote health service districts;
- Terry Findlay from the Transition Team in the Australian General Practice Network shared some substantial insights to the imminent roll-out of the first tranche of Medicare Locals on 1 July;
- Carole Bain travelled all the way from Silver Chain in Western Australia to discuss the issues facing a community care and nursing service that needs to work across all parts of the reforming health system in metropolitan, rural and remote towns; and
- Mark Ashcroft from Alpine health, a multi-purpose service in the Victorian high country, shared some very interesting strategies for community engagement in health service governance and planning.

Delegates commented on why they liked the Policy Think Tank:

"The discussion and different perspectives in the presentations and linking back to on-the-ground issues. [It was] well facilitated with a great variance of people with real commitment to rural and remote health."

"The practical and advocacy-directed focus of the whole day."

As a follow-up from the event, the AHHA wrote to the Federal Minister for Health, Nicola Roxon, to outline some of the key issues and possible strategies for making health reform work in the bush. We will be advancing the outcomes from the day in a formal policy development program that will contribute to our inputs to the National Rural Health Alliance. For more information or a report from the day, please contact us.

Our next Policy Think Tank will be focussing on community health in the reforms. We would love to welcome you to Canberra in winter (it’s not as bad as you think!) on Friday 22 July. For more information or to register your interest in attending, please email the AHHA at admin@ahha.asn.au.
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The development of e-health

Michael Legg provides the first instalment of a personal history of health informatics in Australia

ALTHOUGH CHATHAM HOUSE rules were invoked at the recent meeting of the CEOs of the Medical Software Industry Association, I hope Minister Roxon won’t mind me picking up on a comment she made recognising that many in the room had been working in the field for a long time and that a debt was owed. Her comment and a recent article by Robert Flanagan on ‘why IT is all so hard’ prompted me to record something of what I knew of the history of health informatics in Australia. Because the space is small and since I have had the privilege of spanning most of it, this will be somewhat personal and focused around pathology.

The early years

It began for me in 1977 when, in my third year at Sydney University, I was in a physiology course taught by Michael Taylor - what turned out to be his last. Michael Taylor was a mathematician¬-physician-physiologist interested in optimisation. Fascinated by his account of this field, I undertook to do an honours year with him.

Taylor had a distinguished research career looking at the physical properties of arteries and how well-designed they turn out to be. He and his colleagues had built various pressure and displacement sensors that fed into a huge multi track FM recorder and then digitised over hours producing washing baskets full of punched paper tape. These were subsequently submitted to Fourier analysis to determine the frequency spectrum of pressure waves using the University’s SILLIAC and KDF9 computers. The point of this is that SILLIAC was the replacement for the first computer in the southern hemisphere the CSIR Mk 1! These were computers that took up the whole basement of a very big building! Of course now this can now be done on your phone.

What was to be my honours year however, saw Taylor move to be Deputy Vice Chancellor and so I joined his student,
Barry Gow, who had inherited the laboratory. With Barry, I looked at the conundrum of why aneurysms formed on the low pressure side of a constriction in arteries. Barry was a dentist who made organs and harpsichords in his spare time but in the lab we built our own microprocessor-based computers including a DEC LSI-11 and used these to drive machines to prod and scan arteries as well as for real-time Fourier analysis of vibrations. Grant Carter, a medical student, helped with the programming of the Intel 8080 microprocessor following his success at writing the BASIC compiler for the Australian Microbee.

Arthur Guyton, arguably the last person to have a complete understanding of known human physiology, also visited during this time and gave us his FORTRAN dynamic model of the human cardiovascular system; we were able to run it on our home-grown machine. The laboratory next door was David Read’s, a respiratory physician who had formed a relationship with Ita Buttrose and the Australian Women’s Weekly in support of his cot-death research. Needless to say we were jealous of their funding. David, who was a good scientist and great teacher, attracted a number of bright young clinician-researchers keen to be associated with this cutting edge laboratory. Among them were those who were well recognised now in health informatics and the medical technology sector, including Vince McCauley, David Rowed and Colin Sullivan. Vince and David were programming then in assembler (the bits and bytes level) because that was the only way to make the computer work fast enough for the experiments.

Pathology

You may be wondering now how this has anything to do with pathology informatics. Where I had seen myself as an academic and was set to go to UNSW in what was, and still is, an exciting area of research, Functional MRI, the project collapsed when at the last minute the Australian research leader, who was returning to Sydney after working with the Nobel Prize winning Nottingham Group, got an order-of-magnitude better offer from GE in the US. After a spirited New Year’s party I found myself being interviewed for the role of Coordinator of Computing and Quality Control in the largest NSW pathology laboratory (Macquarie). In many respects this was a role and job title well before its time. It showed a clear recognition of the link between quality and informatics in pathology.

Macquarie Pathology was founded in the early 1970s by Tom Wenkart. Tom was, and still is, a visionary in what has become known as e-health. From the outset Tom had the vision for the digitally connected health system. Indeed in the very early 1970s he had printing computer terminals in surgeries for pathology reports but these were removed because they were seen as inducements.

Times were interesting in Sydney and pathology then. It was the ‘underbelly period’, during which a principal of a Sydney pathology practice was shot outside his Concord laboratory over a ‘business related matter’ and a couple of others ended up doing time. Interestingly, many remember these news items but few could tell you that seven of the 10 Australian Nobel prize winners were pathologists or physiologists.

At Macquarie, I specified a laboratory information system and it was put out to tender. Relying on contractual promises and a judgement that the ‘new’ language ‘C’ with an approach then called ‘parameter driven’ (and now called archetypes) was the way to go, and following my forecast of the demise of MUMPS, we embarked on implementation with a partner – the specification was okay but the implementation a failure. For the record the successful non-winners, Alex Anderson’s Déterente and Sonic’s Apollo system, still use MUMPS (Cache) today very successfully.

At Macquarie we also tested the value of computerisation to a pathology laboratory with a somewhat unnatural experiment.
I arrived one day to find the place on fire – an arsonist had broken into the secure data centre, opened the data safe and set it and the computer centre alight. The laboratory, which was downstairs, was saved and continued to function but it took a week of 24-hour days to rebuild a computer room and to get the system running again. There was a disaster recovery plan and no loss of patient data but we went manual and it was absolute mayhem.

No pathology practice would think of starting (even 25 years ago) without electronic health records and no laboratory can operate now for more than a few minutes without its information systems. On the subject of records, another well-known health informatician George Margelis later joined Tom at Macquarie as CIO and together they worked on an early version of the Personal Health Record. Klaus Veil was a CIO before George. In a twist of fate I came back some years later leading the ‘occupation team’ after Mayne bought Macquarie laboratory.

**Medicheck**

After Macquarie I moved to be CEO at another highly innovative organisation, Medicheck. In 1970 after having sold his transformer business to GE, Sir William Tyree established a trust. With Sir Eric Willis and Sir George Halliday the funds were used to build a preventative health facility which had the dual aims of systematising medicine and moving the emphasis toward prevention. Medicheck broke new ground in many areas. It introduced mammography to Australia, created the first mental health atlas of Sydney and, relevant here, it was the place that many Sydney-siders saw a working computer for the first time. A patient would sit in a perspex pod to answer a computerised questionnaire in full view of the computer with spinning tapes and flashing lights behind glass. This was highly controversial and on a number of occasions made front-page news. There was real concern from the less well-informed profession that computers were being pitched to replace doctors. Of the many eminent people associated with this organisation, Branko Celler, who was Director of Research, and Bruce Barraclough, who was a leading breast surgeon at the associated Sydney Square Diagnostic Breast Clinic, have important roles in health informatics now.

I arrived at Medicheck in the mid-1980s and led the third generation replacement of the information systems in this organisation that had always had...
In depth

fully electronic records (replacing one from BUPA). Having learned from my previous experience and with a talented computer scientist\(^1\) we used prototyping directly with the doctors, nurses and scientists who were working in the organisation to build an information system from the ground up including a laboratory information system (LIS). From the technology point of view this was a time when relational databases were just becoming commercialised. We purchased Oracle before they had established an office in Sydney, ran it on one of the first MicroVAX’s and had networked PCs attached.

Medicheck became a technology showcase with weekly visits from people mostly outside health. Because of my role at Medicheck I became a director of the International Health Evaluation Association with Morris Collen after whom the highest honour of the American College of Medical Informatics is named. That also meant I got the privilege of visiting with him at Kaiser and using those learnings in the Medicheck system.

In the next issue I will complete this personal history of informatics in pathology and how these developments influenced the broader application of ICT in healthcare. \(\Rightarrow\)

References

2. Mathematicians is a branch of informatics. Taylor would play chess with the head of the electronics workshop by making moves as they passed in the corridor – without a board! \(\Rightarrow\)
3. The Basser Department of Computer Science (so named because Harry Messel was able to procure part-funding for the computers from the Melbourne cup winnings of jeweller Adolf Basser) was located in the basement of the Physics building
4. A fellow called Bill Gates had done a similar thing, but for the IBM microcomputer. Grant went on to do biomedical engineering. He developed CRS, was IT Director for Western Sydney, headed GE’s Medical IT group and was a VP at ResMed, and is now Qld State Manager of Medical Services with the Red Cross
5. Intel’s second-generation 8 bit microprocessor
6. Emergency doctor; developer of a laboratory information system; Past President of the Medical Software Industry Association and current Chairman of IHE; and standards developer
7. Electrical Engineer, GP; one of the OpenEHR founders and standards developer
8. Respiratory physician and ResMed co-founder
9. Entrepreneur, GP, private hospital operator, PHR developer and now with an interest in Pen Computing - he was also a one-time large-scale computer bureau operator for local government and provided microfilming and microficheing for the NSW police among others
10. Now Integrated Software Solutions
11. Optometrist; medical practitioner; informatician and now lead of the Intel GE Healthcare Alliance in Australia
12. Informatician; standards developer; past Chairman of HL7 Australia and Board member of HL7; current President of the Australian College of Health Informatics
13. Electrical Engineer; Entrepreneur
14. Former Premier of NSW
15. ENT surgeon and former President of the BMA in Australia. I was the only member of the Board without a knighthood for some time
16. Medicheck and its sister organisation in Melbourne, the Shepherd Foundation, were closed down when medical benefits were withdrawn by DoHA because the value couldn’t be demonstrated to their satisfaction – the protocols and testing have since been well-proven but no organisation exists where it can all be done in a single visit including counselling in 90 minutes
17. Electrical engineer, computer scientist, founder of Telmedcare and now Executive Dean of the College of Health and Science at the University of Western Sydney
18. AO, past President The International Society for Quality in Health Care, past Chair of the Clinical Excellence Commission and current Chair of the CSIRO Australian E-Health Research Centre
19. Mark Abel - still an Oracle contractor

Take home messages

Here are some morals to the story so far:

- There are more than 40 years of history in health informatics in Australia;
- Health is not a laggard as some argue when it comes to the application of information technology;
- Some pretty smart and dynamic people have and continue to contribute to the development of e-health;
- There is more to health informatics (and e-health) than shared records;
- Pathology has been at the vanguard of health informatics and computer science development;
- Australia has been keeping pace intellectually and has led at times but does not always realise its potential when it comes to recognising the value of what it has and commercialising that;
- One of the reasons there hasn’t been more progress is because it is hard; and
- It would be inefficient not to learn from the history so we must provide specific education in what is a knowledge domain in its own right – health informatics.
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Where’s the evidence?

David More asks is the Personally Controlled Electronic Health Record an evidence based intervention?

A consequence of a series of recommendations in the National Health and Hospitals Reform Commission’s *A healthier future for all Australians – Final Report June 2009*, the subsequent Commonwealth Budget allocated almost half a billion dollars over two years to make a Personally Controlled Electronic Health Record (PCEHR) available to all citizens who wanted one by July 2012.

As the PCEHR has evolved – largely away from the public gaze and in secret – it has morphed into a conceptual Health Summary and a series of Event Summaries. The Health Summary contents are intended to be the basic individual demographic details and the information that is normally held, either electronically or on paper, in the General Practitioners Summary Record. This would include allergies, regular medications, key elements of history and current diagnoses. The Event Summaries are envisaged to be such things as a set of pathology results, referral letters and so on.

The idea is that the patient will be in control of this information and will, if they agree and consent, make the information held in this record available to clinicians caring for them.

The patient PCEHR record is to be held by a PCEHR system, presumably run by the Commonwealth Government, that will be accessible via a web portal for the clinician, with permission, to review. At a later date, the patient will also be able to contribute their personal information and comments should they choose. The system is apparently intended to be a lifelong record that will be accumulated over time.

At present the system is intended to be available to patients who choose to have a PCEHR and register for access by July 2012, now just 14 months away. The system is presently planned to operate in an ‘opt-in’ fashion where an individual takes a positive decision to register for and establish a PCEHR.
Concerns regarding the concept

In mid-April the Department of Health and Ageing released the draft PCEHR Concept of Operations for public review and this information has been considered in the following comments.

On the basis of what is presently known, just how based in evidence of real positive clinical impact are the present proposals?

I would suggest they are not and that the claimed rationale for this very substantial program is based on a combination of wishful thinking and ignorance. My reading of the global literature leads me to the following conclusions.

First, there is no working example anywhere in the world of a parallel longitudinal patient-controlled electronic health record. There are successful examples in small countries (Wales and Scotland) of emergency health summaries derived from GP systems being implemented, but the information content is designed as the minimum necessary for emergency care, not as an information rich long-term longitudinal record.

Second, the evidence from the UK suggests that even when such summary information is made available, actual use of the information is quite low and the clinical impact, if any, is hard to determine.

Third, designing systems to be ‘opt-in’, while politically easier, means adoption is slow – over years – and for this reason few will bother to look up such systems.

Fourth, the present plans for seeking consent for both access and for information provision into the PCEHR will have very significant clinician workflow impacts, i.e. slow clinicians down, which will ensure that without major financial incentives to compensate for the time costs, clinician usage will be minimal.

Fifth, while there has been much research on the topic, it has not been possible to consistently demonstrate positive clinical outcomes through the use of Personal Health Records (PHRs). On the other hand, the evidence for the value of provider Electronic Medical Records (EMRs), especially with embedded clinical decision support, is very strong indeed.

Sixth, adoption of and the value of patient access to their clinical records is best seen in situations where the PHR is a linked extension of the provider EMR (as in Kaiser Permanente in the US) and where other functions are possible.

Seventh, it is clear that the so-called ‘digital divide’ is alive and well with patient portals, where often those who need them most are the least likely to be able to obtain access.

Eighth, it was obvious from a recent workshop conducted by NEHTA on the PCEHR that there was considerable concern and disquiet from clinicians regarding just how well the available funds were planned to be deployed given other perceived priorities in e-health, such as improved standards, better clinical systems and improved information flows between clinicians, are very high on the list.

Key points of the PCEHR

Key points to be noted about the presently proposed model of the PCEHR include:

- The PCEHR is an additional and clearly parallel health record to that held by the health care provider. The PCEHR is conceived of being a secondary record in some senses – as far as clinician contributed information is concerned – and a primary storage of some consumer generated content.

- The PCEHR will contain a summary of the full patient record, with a variety of other information (lab results, discharge summaries and so on).

- There is no clarity just what arrangements are intended to ensure the copy of the clinical information held in the PCEHR is properly synchronised and consistent with the current practitioner record.

- All the documentation made available to date has been silent on just how the situation of a patient attending multiple practitioners is handled.

- The PCEHR is not linked / attached to the practitioner record in any direct way. This means that functionality such as secure direct communication between clinician and patient, appointment and repeat prescription requests, and access to current information in the provider system is not available.
Ninth, there is no mention so far from anyone on just what advantages the PCEHR proposal has over the wide range of alternatives that have been successfully implemented elsewhere and just why clinicians would find access to a record of this sort of any great value compared with known alternatives. Indeed the claimed benefits have in no way been proven for the planned approach as pointed out above.

Finally, again from the recent workshop, it is clear many stakeholders recognise that the scale and complexity of the PCEHR program means successful delivery in the politically determined time frames is very unlikely. It is thus my contention that the PCEHR proposal lacks an evidence base in circumstances where there are evidence based interventions that would make a more significant and important difference to health care delivery in Australia.

In response to a direct question at the Health-e-Nation Conference in early April, the Department of Health and Ageing confirmed that there was not an evidence base supporting the planned approach but that Australia had chosen to proceed down its own path.

The PCEHR has been termed by one wag the ‘Politically Correct’ EHR. I would suggest it is a proposal that requires very active evidence based review that it is presently not receiving – due in part to the very large sums of money being splashed around by the Department of Health and Ageing on the project – which seems to be resulting in some form of unthinking and uncritical e-health ‘goldrush’.

As presently announced, the entire program has unrealistic timelines, lacks clear objectives, is excessively politically driven and will, when it inevitably fails, set the prospect for rational adoption of e-health back a good decade.

You can read David More’s blog on e-health at www.aushealthit.blogspot.com.

Useful links

Australian Government website
Your Health. The draft PCEHR Concept of Operations document can be found here – http://bit.ly/3mUayY


David’s submission to the NHHRC on the PCEHR – http://bit.ly/efu2HN
The healthcare community's current relationship with computerisation may be the biggest challenge in the future of e-health
The political, technical and economic ‘challenges’ facing the federal government’s e-health plans might be mere speedbumps compared to the more deeply ingrained workplace culture issues that any future e-health or personally controlled electronic health record (PCEHR) will have to contend with. Put bluntly, is it possible that hospitals and health services just don’t like computers?

The relationship between health professionals, patients and computerisation is infinitely more complex than convincing people that an electronic version of something is better than a paper one and there are some treacherous fallacies abound. E-health is not primarily a technical or electronic issue – it is a human and meaning issue and the trail of costly and failed e-health and health informatics projects over the last few decades testifies to this.

Some years ago I conducted a national project interviewing nurses and midwives about their experiences and perceptions of using computerised information systems. Hearing these clinicians describe the place and purpose of computers in their everyday practice was a revelation. Predictably, given the IT world’s historical aversion to partnering with and learning from clinicians, there were the numerous technical problems experienced; different ‘systems’ that couldn’t communicate or speak to each other (even within the same hospital), unrealistically steep learning curves, user interfaces that bore no resemblance to anything the clinicians already used, inability of the systems to do ‘simple’ things such as copy and paste or print out, difficulty in getting technical support when it was immediately needed and more.

The human or meaning dimensions were as keenly felt and go to the heart of any proposed e-health initiatives. Many clinicians actively distrusted the ‘new technology’, seeing it as some kind of managerial ploy or ‘trojan horse’ for more sinister clinical or organisational changes that they knew nothing of. Other clinicians saw technology as being antagonistic and oppositional to their essential professional orientation of caring for patients. On an imagined sliding scale, you could be a caring, human, health professional or you could be sitting at a computer all day – what one participant called the ‘checkout chick nurses’.

It would be a mistake to dismiss such clinicians as simple technophobes or Luddites as these same clinicians were working in ICUs, ERs and many other ‘high-tech’ environments where complex machinery is a welcome and omnipresent part of their job. Somehow, for them, computers, e-health and computerised records were different. Perhaps they had been jaundiced in their views by the everyday ‘computer says no’ culture of IT use and service in their hospitals.

One of my main concerns about e-health is that the average hospital IT Department might be involved in it. This is not a slight on individuals but on an organisational IT culture driven by risk aversion rather than creativity, fixated on standardisation rather than flexibility and operating from the default position that they are the bulwark between essentially ‘dangerous’ staff and disaster, or ‘some idiot doing something stupid’. Regardless of how tightly a system is ‘locked’, restricted and regulated, at some point, someone will do something wrong or inappropriate. The question for any future e-health or informatics strategy is, do you dumb your entire system downwards to try to prevent that one event happening?

Health IT blogs are replete with IT staff explaining how they are the professionals in this area and not the clinicians who wonder why their workplace IT experiences cannot be even half as smooth, coordinated, user-friendly and accessible as that of even their mobile phone. Staff will be compelled to buy aging $3000 computer systems and wait months for better equipment could be had from the major retailers for half the price and delivered the next day. Staff are essentially locked out from doing the simplest of IT tasks and yet IT departments complain that the workload on the ‘helpdesk’ is unmanageable. I wonder why? This year alone I have met staff who were ‘forbidden’ from buying or using an iPad, were not allowed to install Skype or Dropbox on their computers and who had the Survey Monkey website blocked. These are the very staff that will be expected to ‘embrace’ the promises of the brave new world of e-health and the PCEHR.

Over the last decade, people’s personal computing experiences have changed and improved dramatically. Social media sites show possibilities for communication and connection that hospitals often try to outlaw rather than learn from. Mobile devices are fast replacing the ‘standard desktop’ yet some hospitals still try to ban mobile phones and users no longer require, nor should they have to rely on a ‘IT person’ in the building to meet their support needs.

If Nicola Roxon is looking for a system that is beautifully designed, obsessive about confidentiality and privacy, has minimal problems with security and viruses, is so user-friendly that everyone from nippers to nanas can use it, is so popular that people will be queuing round the block to become part of it and that integrates seamlessly between mobile and fixed applications, maybe she should forget about NEHTA and just make a phone call. I don’t know the number but ask for a Mr Steve Jobs, Cupertino, California.

References

2 Leviss, J., ed. H.I.T. or Miss: Lessons Learned from Health Information Technology Implementations. 2010, AHIMA Press: Chicago
In depth

The e-health IMPERATIVE

Peter Fleming writes about the latest e-health news and developments

In Australia we enjoy a health system that up to now has ensured we have access to quality health care when we need it. However, maintaining or improving the health outcomes of Australians requires a fundamental change in approach to the way health care is delivered.

As part of the health reform process, the National Health and Hospital Reform Commission (NHHRC) identified that e-health has a major role to play in:

- Fostering genuine participation by consumers by allowing them to better manage their own care and be more informed in decision making about their health care and people they care for;
- Supporting providers in the delivery of safer, more effective and more efficient health care; and
- Enabling a more agile, self-improving and sustainable health sector.

The National E-Health Strategy commissioned by Australian Health Ministers in 2008 defines the transformation of the Australian healthcare system from a ‘paper-based’ records system that limits access to a patient’s critical healthcare information to an electronic system that ensures the right information, at the right place and the right time.

Sources:
Historic data: OECD (all countries)
UK projections: PWC
US projections: Centres for Medicare and Medicaid Services, Office of the Actuary
Australian projections: AIHW
The rising cost of health care

In most OECD countries, spending on health is a large and growing share of both public and private expenditure:

- The average share of GDP that OECD countries devoted to health stood at 9 percent in 2006.
- Australia is not alone among OECD countries in projecting such profound and sustained growth in expenditure on health services.

Why do we need e-health?

- Up to one in six (18 percent) of medical errors are due to inadequate patient information;
- 187 procedures involving the wrong patient or body part occurred in Australian hospitals in 2007 due to failures to properly identify patients and match them to intended procedures;
- Nearly one in three (30.4 percent) unplanned hospital admissions in patients over 75 years are associated with medication mistakes;
- Up to one in six pathology and diagnostic tests in hospitals are unnecessary duplicates, which cost up to $306 million annually; and
- The lack of information sharing and care management for chronic disease sufferers costs the healthcare system up to $1.5 billion a year.

A recent report published by Booze and Company on global e-health investment said: “e-health programs could cut healthcare spending by 3 percent annually, saving at least $7.6 billion in 2020 alone. And commitment to a full e-health program now could help save an estimated 5,000 lives annually, once the system is fully operational.

“The patient journey today is hampered by disjointed communication and limited access to quality information. As a result, the ability to make sound decisions about care is often impaired, and there are a significant number of adverse effects and high levels of frustration, particularly among patients who are elderly, disabled, or suffering from chronic conditions or mental health disorders.”

Key benefits for consumers

- Consumers or their carers will have electronic access to information to better manage and control personal health outcomes;
- Consumers will have confidence that their personal health information is being managed within a secure, confidential and tightly controlled environment; and
- Better access to healthcare services will be achieved for all Australians including those living in remote, rural and disadvantaged communities.

The NEHTA work program

The National E-Health Transition Authority’s purpose is to lead the uptake of e-health systems of national significance by delivering urgently needed integration infrastructure and standards for health information. NEHTA was funded by the Council of Australian Government (COAG) to develop the national infrastructure components of terminology, secure messaging, identifiers and authentication. We are also developing e-health solutions that will use the infrastructure: referrals, discharge summaries, diagnostics and medications management.

E-health programs could could cut healthcare spending by 3 percent annually, saving at least $7.6 billion in 2020 alone.
In depth

The NEHTA work program also supports the national personally controlled electronic health record (PCEHR) system. The Australian Government is investing $467 million over two years to develop the critical national infrastructure for e-health records as a key element of the national health reform agenda. This will give all Australians from July 2012 the option to sign up for a personally controlled e-health record. This will enable better access to important health information currently held in dispersed records around the country. It will mean that patients will no longer need to unnecessarily repeat their medical history every time they see a doctor or other health professional.

For the first time, all Australians who choose to participate will be able to see their important health information, when and where they need it. They will be able to share this information with trusted healthcare providers.

Bringing the PCEHR system to life

The Australian Government’s vision for a national, secure e-health system will benefit Australians in many ways. The intention is to establish a secure system of personally controlled electronic health records that will provide:

- Summaries of patients’ health information;
- Secure access for patients and healthcare providers to their e-health records; and
- Rigorous governance and oversight to maintain privacy.

Implementing e-health across the nation

The states and territories have collaborated with NEHTA in a joint approach to integration of the healthcare identifier (HI) service. The cornerstone of this approach is early implementations to build experience in applying the services and specifications across the healthcare provider and vendor community.

Steps for early implementations include:

- Implementation planning study including high level business and architecture analysis and advice as to how NEHTA services and specifications should be integrated into clinical information systems and business processes in healthcare settings;
- Development of business requirements and functional specifications for system software modifications (based on an Implementation Planning Study);
- Vendor integration within existing systems in states and territories; and
- Development and maintenance of implementation and deployment guidelines covering software modifications (specifications), lessons learned, testing regimes and business processes (including ongoing quality management).

E-health sites

There are 12 e-health sites currently being funded by the Australian Government to achieve national demographic coverage, widespread coverage across the healthcare sector, deliver early benefits and demonstrate new and innovative e-health concepts. Together, these e-health sites offer:

- Targeting of a broad number of key groups such as mothers and newborns, aged care, people with chronic conditions, palliative care and Indigenous populations;
- Coverage of all states and territories and rural and regional communities;
- Inclusion of a number of healthcare sectors, including public and private, primary care, aged care and private specialists;
- Broad coverage of the ICT vendor community, with vendors comprising the majority of the market in acute and primary care involved in one or more of the sites;
- Projects which test and support broad consumer engagement and registration;
- The broad set of functions that the PCEHR will need to provide so that lessons and foundations can be derived to support the development of national infrastructure. In addition to Health Summaries, Discharge Summaries and Medications, the portfolio also includes Personal Health Diary and Consumer Portal implementations; and
- Delivery of early benefits in a range of areas, including improved coordination of care, enhanced continuity of care, improved medication management and the delivery of sustainable components, which will enable later integration with the national infrastructure.

These e-health sites will be required to demonstrate tangible outcomes and benefits from e-health projects, to build stakeholder support and momentum behind the system work program, and to provide a meaningful foundation for the national PCEHR system’s further enhancement and roll-out.

References


For more information about NEHTA visit: www.nehta.gov.au

For more information about the PCEHR system visit: www.yourhealth.gov.au.

You will find the recently released Concept of Operations document for the PCEHR on this site.
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It is crucial that directors, senior managers and clinicians understand the common fundamentals of good governance, and then keep abreast of changes. It is their responsibility to ensure that the organisation remains compliant with its legal and regulatory obligations, implements best practice risk management, achieves its strategic objectives and meets public expectations for high quality healthcare.

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• Convergence of governance, risk and compliance
• The role of Board and Councils in corporate governance
• Duties and responsibilities of directors, executives and clinicians
• The difference between directing and managing
• Conflicts of interest and how to manage them
• Stakeholder engagement.

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Our program examines the means by which health facilities and practitioners can ensure high standards of health care, continuously improve the quality of their services, and create and maintain an environment in which clinical excellence can flourish.

Topics include:

• Standards for better healthcare
• Relationship with corporate governance
• Developing a model for sustained improvements in quality
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• Aligning clinical governance with vision and strategic effectiveness

• Consumer participation in service planning and evaluation
• Developing a culture of clinical leadership and lifelong learning.

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HARTMANN creates your wound care solutions
Patrick Bolton urges an increased focus on real evaluation of e-health interventions

I’m a reasonably clever fellow. Not super-smart, but smarter than Bill Gates: I didn’t happen to be in the right place at the right time as he did, I looked for the place that was going to be right and went and stood there. Graduating from medical school in the mid-eighties, I missed genetics, and biotech had not yet come over the horizon, so I chose to develop a speciality in health informatics. I got a Graduate Certificate in Computing Sciences, did a PhD which incorporated computerised medical records and found myself Computer Fellow for the RACGP. But guess what? The promise of health informatics never materialised to my satisfaction.

In about 1997 I went to an international conference in Amsterdam, the title of which was along the lines of ‘20 years of computers in medicine: Why have we not achieved as much as we expected?’ Despite my hopes, not much was said on the conference theme, the speakers were mostly gunners: “I’ve got money for computers in health and I’m gunner use the money in this or that way!” In my experience this is, sadly, what most people doing things in IT in health say.

About once every five years since that conference systematic reviews of the impact of IT on health outcomes have been conducted. They have all said that evidence of gain from the introduction of IT is limited and, arguably worse, evaluation is almost non-existent. Those in the health IT industry have been quick to point out methodological weaknesses in these reviews. Of course there isn’t an interest group making money out of not implementing IT in health, only the community, which collectively gets to foot the bill for these experiments.

Part of the reason that I got into health informatics is that I wanted to make a difference. Disillusioned, I sought to achieve my aims through health policy and found myself working as a medical administrator, although I still do occasional GP locums. From those perspectives I have only ever encountered one clinical application of IT that hospital doctors value, and that is computerised access to medical images (“PACS”). Many doctors will concede the potential value of computerised prescribing to avoid medication mishaps, and would be prepared to put up with the additional work that computers seem to create in the clinical environment to achieve these benefits. I am aware that computerised prescribing systems have been introduced in hospitals at a number of sites in Australia where they seem to be working well and of course they approach ubiquity in general practice. While I am sure computerised prescribing offers the same potential for quality improvement in general practice that it does in hospital medicine, my experience has been that it is often just a fancy way of carbon copying a patient’s last script, saving time in the consultation and thereby increasing throughput and billing. The risk in this situation is that medications continue to be prescribed without the prescriber’s brain being engaged, and this can lead to risks of harm.

Now, you might not guess it to read my column, but I am inherently optimistic. So I remain hopeful about the application of IT to health care, but my experience leads me to issue three overlapping caveats about this area. These are:

1. The risk of failure is high, higher than most of those making decisions to invest in IT in health care allow. Business cases for IT in health need to be discounted appropriately for this risk;
2. We conspire to allow the risk to be high because we don’t evaluate the outcome of projects that seek to introduce IT into health care. Business cases for IT in health need to be discounted appropriately for this risk;
3. We need to fit in with the practices and habits of healthcare users and providers, not the reverse.
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Please visit www.healthcollab.org.au to register your interest.
Christopher Baggoley reviews the latest book to investigate safety and quality in the Australian healthcare system.

This book is a most valuable addition to the Australian safety and quality in health care literature. Starting with a punchy, balanced yet somewhat unsettling preface, Judith Healy explores her thesis that ‘improving health care involves multiple regulators and multiple strategies, in other words networked governance’ through the ten chapters of this substantial book.

As would be expected this is a well researched, well written, scholarly piece of work. It is no quick page-turner. It requires the reader to think and reflect, while being informed, stimulated and challenged throughout. For those with a deep interest in safety and quality in health care, whether they have policy, board, executive, clinician or consumer perspectives, this is a most valuable read. Others will find it rewarding, even if they read chapters, or sections of chapters to pursue their particular interest. Of assistance to all readers is the chapter layout: each ends with a conclusion that acts as an executive summary. A boon to the time-challenged.

The author draws on her international knowledge, study and research to put the Australian situation into a broader context. She demonstrates an understanding of all participants in the Australian scene and no one is spared critical analysis. The concept of ‘deference regulators’ (Chapter 3, Regulatory actors) who see people as ‘amoral calculators’ is most salutary, although given the description, I doubt many readers would identify themselves as such!

In spite of this critical analysis, Judith Healy clearly understands the reality and complexity of modern health care and understands the role and nature of the key players, as well demonstrated in Chapter 2, entitled ‘How safe is health care?’. Her views on medical organisations (Chapter 4, Regulating the health professions) are sure to be controversial and to stimulate debate. Most doctors would regard the comments in this chapter about them ‘signing up for conference points in a desirable tourist site’, as unnecessary and hopefully an outdated cheap shot.

The author devotes a chapter to safety culture and safety systems, the inclusion of which is both essential and helpful. References to patient-centred care throughout reflect well on current thinking. The text is current, an achievement given the fast pace of change and development of events in Australia recently. There are some situations where events have overtaken the text, such as the conclusion of the Patel trial, the implementation of the Australian Health Practitioners Registration Agency and the most recent changes to health reform. Such are the hazards of writing text books.

The book ends by discussing the important concepts of trust and transparency in some detail, an excellent way to finish, and with an optimistic observation that can be missing in discourses on the safety and quality of health care. Judith Healy writes ‘The amount of activity in the short space of a decade is very impressive. The intention is to ensure that health care is of a high standard and as safe as possible – which is good news for patients’.

In short, I highly recommend this book.

Declaration: Judith Healy has undertaken contracted work for the Australian Council for Safety and Quality in Health Care. This work has been presented to the successor body, the Australian Commission on Safety and Quality in Health Care, of which I am Chief Executive.
Who’s moving?

Readers of The Health Advocate can track who is on the move in the hospital and health sector, courtesy of the AHHA and healthcare executive search firm, Ccentric Group.

Tony Sherbon has moved from his role as CEO for the Department of Health in South Australia to the Health Reform Transition Office as Deputy CEO.

Mary Bonner is moving from her role as District CEO at Townsville Health Service District to be the CEO at Capital and Coast District Health Board.

Andrew Currie has joined Healthscope as State Manager, Hospitals Victoria.

And up north, Richard Lizzio has moved from his position as CEO of Greenslopes Private Hospital in Queensland to be State Manager Hospitals Queensland, also with Healthscope.

Meanwhile, Paul Williams has joined – you guessed it – Healthscope as CIO.

Warren Berry, a Regional Manager with the I-Med Network is off to the big smoke of Melbourne to be General Manager, Heart Care Victoria with Genesis Care.

In New Zealand, Ken Whelan is departing as CEO of the Capital and Coast District Health Board in Wellington, to become CEO of the Wide Bay Health Service in Queensland.

Greg Rochford, the former CEO of Ambulance NSW is the new National CEO of the Royal Flying Doctor Service.

Ian Maytom moves from CEO, Northpark Private Hospital to be CEO, Newcastle Private Hospital.

Katarina Drazumeri, CEO Mosman Private Hospital, is on the move too – as the new CEO of Como Private Hospital, while John Tucker has started as CEO of Nepean Private Hospital.

Dr Heather Buchan has swapped roles from her position as Executive Knowledge and Development Officer at the National Health and Medical Research Council (NHMRC) to be Director of Implementation Support, Australian Commission on Safety and Quality in Health Care.

Dr Sonj Hall, formerly Director of Policy, Strategy and Service Planning at the Department of Health and Human Services in Tasmania is now Deputy CEO of the Bureau of Health Information (part of NSW Health).

Matthew Double has joined the Department of Health and Human Services in Tasmania as Human Resources Director.

The world-renowned co-inventor of the cervical cancer vaccine, Professor Ian Frazer, has been appointed Chief Executive of the new $345 million Translational Research Institute.

Kevin Bate, currently General Manager, Central Patient Services with SA Ambulance, will be joining Ambulance Tasmania as Deputy CEO and Director of Emergency and Medical Services.

Chris Went has moved from being Assistant Director of Clinical Services at Greenslopes Private Hospital to CEO at St Andrews Private Hospital, Ipswich.

Heading in the opposite direction, Chris Murphy has moved from being CEO at St Andrews Private Hospital, Ipswich and Caboolture Private Hospital to his new position as CEO at North West Private Hospital.

Jill Gleeson, CEO at Linacre Private Hospital will soon be CEO at Waverley Private Hospital.

Jude Emmer is heading to the north of Sydney: from Director of Clinical Services at St George Private Hospital to a new role as CEO, Mt Wilga Rehabilitation Hospital.

Linda Allen has moved from being Director of Clinical Services at Mitcham Private Hospital to CEO at Linacre Private Hospital.

Filling a gap, Darren Rogers has moved from being General Manager at Darwin Private Hospital to CEO at Mitcham Private Hospital.

And during exciting times in NSW government and health policy, we wish all the best to Dr Mary Foley who has been appointed as the Director-General of NSW Health having moved from National Health Practice Leader at PricewaterhouseCoopers.
For more than 60 years, the AHHA has upheld the voice of public healthcare. The Association supports your access to networks of colleagues. It provides professional forums to stimulate critical thinking. It facilitates a collective voice across Australia and develops innovative ideas for reform.

Network and learn
As a member, you have access to regular professional development activities and to networking opportunities with colleagues across Australia through our stimulating and innovative events. You also receive the Australian Health Review, Australia’s foremost journal for health policy, systems and management (paper copy and online), our magazine The Health Advocate, up-to-the-minute news bulletins and other professional information.

AHHA values your knowledge and experience
Whether you are a student, clinician, academic, policy-maker or administrator, the AHHA values your skills and expertise. The AHHA reflects your views and gives them a voice. Your ideas will help shape the AHHA’s policy positions and our highly influential advocacy program.

Our focus is on improving safety and quality for patients and consumers in all healthcare settings. To do this we are working to achieve better service integration; enhanced information management systems; efficient financing models; targeted performance measures and benchmarking; and a sustainable and flexible workforce.

Your knowledge and expertise in these areas are valuable and you can have direct input to our policy development.

As a member, you and your organisation play a role in reforming the public healthcare sector by contributing directly to the AHHA’s leading edge policies. We develop policies that reflect your views. Join our think tanks or participate in our national seminars or conferences. Our voice is authoritative and influential. It is heard via our high-level advocacy program and extensive media exposure.

For more information:
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T: 02 6162 0780
F: 02 6162 0779
A: PO Box 78
Deakin West, ACT 2600

Membership Fees 2011-2012

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*Companies providing products and services to healthcare providers

Institutional / Academic Members (Australian healthcare providers)

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*Fee includes GST - valid from 1 July 2011 to 30 June 2012
2011-2012 Membership Applications and Renewals
Australian Healthcare & Hospitals Association

Tax Invoice
PO Box 78 Deakin West ACT 2600     t: +61 2 6162 0780
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Institutional     (See 2011/12 fee scale)

*Documentation required to verify status as a student. All prices for Australian membership include GST and are in Australian dollars.

Member Details
Name ___________________________
Position _________________________
Organisation ____________________
Postal address ____________________
Suburb ___________________ State __________ Postcode ________
Phone __________________________ Email _____________________

Institutional members may specify an IP address: _______________________________

E-Subscriptions (optional)
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☐ AHHA Events Newsletter - Regular notification of upcoming AHHA events including the annual Congress

Payment Details
Amount in AUD$ to be paid by credit card, bank transfer or cheque.
☐ Cheques should be made payable to Australian Healthcare & Hospitals Association
☐ Bank Transfer: BSB 662 900 Account 008 00811 AHHA
☐ Credit Card Payments: (Please note – an additional 3% processing fee applies)
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Amount __________________________

Cardholder Name ________________________________________________________
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Expiry ___________ Validation Number __________________________

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Please contact us on admin@ahha.asn.au if you require further proof of purchase.
Please retain a copy for your records.
Consumer perspective on e-health possibilities

Health consumers in Australia have waited many years for the arrival of a highly sophisticated Information and Communications Technology Strategy to improve the safety quality and efficacy of health care, of which the Electronic Health Record is an important part.

The opportunity of having the right information in the right place at the right time has the possibility of transforming the way we participate in and receive services. However, unless the policy settings and development by government involves active consumer participation at all stages and every level of decision making on the critical issues of integration across the primary, secondary and tertiary sectors, access, ownership, privacy, consent and public information, e-health technology will founder and sink weighed down by a lack of public trust and confidence.

Michele Kosky
Health Consumers’ Council WA

What’s happening in e-health around the world?

In 2004 the European Commission recognised that healthcare systems were becoming increasingly reliant on information and communication technologies. In response it developed its eHealth Action Plan, which set out the steps needed for widespread adoption of e-health technologies across the EU by 2010. This plan covered everything from electronic prescriptions and health cards to new information systems that reduce waiting times and errors.

The Commission is now updating this plan and public consultation has begun as part of the preparation of the new eHealth Action Plan 2012-2020. Through the consultation the Commission is seeking comment on the barriers to the large-scale deployment of electronic healthcare systems and the actions needed to overcome them. It also wants respondents to consider ways to improve interoperability and how the legal issues surrounding e-health should be handled.

The Commission says the new plan provides “an opportunity to consolidate the actions which have been addressed to date, take them a step further where possible and provide a longer term vision for eHealth in Europe”.

In the US, a new federal centre has been set up to launch the US healthcare system into the digital age.

The Bipartisan Policy Centre, set up under the Health and Human Services Department, has already certified more than 600 new health information technology products and opened 62 regional ‘extension centres’ that aim to help providers understand and set-up health IT programs. The Centre has also started curricula at 82 community colleges around the country to focus on health IT.

Healthcare providers using a certified health IT product can receive up to US$44,000 in incentive payments for Medicare and Medicaid Services over five years, but they must start using electronic health records next year to be eligible. After 2015, providers will take a cut in their Medicare reimbursements if they are not using health IT up to government standards.
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