The Medical Software Industry Association

Submission to the Community Affairs Legislation Committee

on the

Healthcare Identifiers Bill 2010

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Healthcare Identifiers (Consequential Amendments) Bill 2010

5th March, 2010

Introduction

The MSIA (Medical Software Industry Association) thanks the Senate Community Affairs Legislation Committee for the opportunity to contribute to the discussion and inquiry on the Bills and related matters.

The MSIA is the national peak body for software vendors who provide a wide range of software for all clinical settings and for a range of services that support care. Our 90 plus members develop and provide software for aged care, hospitals, GPs, specialists, allied health, secure messaging, e-prescribing, radiology, pathology, pharmacy, psychology, smartcards, clinical guidelines, electronic health records, e-health terminology, electronic billing, clinical audit and clinical trials. For many years our vendor members have provided "representatives"[1] who work closely with Medicare, DOHA, NEHTA and other departments to assist them in preparing and rolling out various programs such as "Closing the Gap", Specialised Medicines, managing PBS and MBS changes and Practice Incentive Programs as well as the joint development of standards for e-health. We currently have some 40 different consultative engagements with government and peak bodies. Our commitment to these largely volunteer activities demonstrates our willingness to move the e health rollout forward. It has been proven that MSIA industry involvement at the beginning of such initiatives results in a significantly greater chance of success and industry/health provider uptake.

Overall Position of the MSIA

The MSIA and its members provide in-principle support for the development and implementation of a unique health identifier system for patients, health care providers and organisations providing care. In both the Australian public and private health sectors, e-health records are already widely spread – in pathology for example a large proportion of all information is exchanged electronically. The challenge is to manage the roll out of the Healthcare Identifier Service in a way that maintains privacy whilst ensuring positive health outcomes within a computerised environment containing legacy systems. To improve interoperability and outcomes, all parties must further develop and comply with standards and support and implement Healthcare Identifiers, secure messaging and e-health terminologies.

The MSIA understands that this is the first step to introducing the Healthcare Identifier Services. There is however, some difficulty in responding to legislation and supporting documentation that cannot be completed until the review of the privacy legislation is completed. Although many of our members have considerable experience in dealing with the existing frameworks for handling patient information, it is not the place of the MSIA to comment on the privacy issues as it is not expert in that area but to focus on how the legislation may impact on effective roll out and what barriers exist to implementation and roll out.

[1] See the Representative Code of Conduct on the MSIA website at www.msia.com.au

It is 5 years since NEHTA started (10 years since the HealthConnect projects) and we believe that the legislation should be passed to reduce the current risks to patient safety and increase the likelihood of better patient outcomes through improved accuracy in information availability for the right patient at the right time. There will be modifications and regulations required as unforseen hurdles appear – but we should not delay in order to get a perfect start. In order to achieve an effective system, given the diverse interplays in appropriate access and sharing of patient information, we believe that there are a number of areas which need further clarity in order to start to implement the new system following the passing of the legislation – we recommend that the public consultation about the related regulations should cover the following issues if the Bill cannot be changed at this time.

- **Accountability and Consistent Programme Management**
  MSIA notes that the Federal Privacy Commissioner will be providing independent regulation including the handling of complaints about privacy and the operation of the Healthcare Identifiers Service against Medicare Australia, (as the service operator) and complaints against private sector healthcare providers[2]. There is already a tangled web of accountability for the e-health roll out – NEHTA is nominally in charge but is a corporation not a government agency, and appears only accountable to DOHA through one NEHTA Board member (DOHA Head). It also only represents the state and territory jurisdictions, not the other two thirds of the health sector in Australia. This large portion of the health sector is where the Healthcare Identifiers are supposed to be bridging the gap with effective and secure information sharing as people move through the healthcare system from primary and secondary care in the community and into institutions such as hospitals and aged care settings.

  We are also concerned that Medicare may only be operating the Healthcare Identifier service for 2 years under the proposed legislation. Given the complete rollout is expected to take longer than 2 years, we believe it poses a significant risk to the success of the programme to allow for a change in the management of such an important service mid-stream with possible losses in expertise, rigour and accountability if an "outsource model" or other agency was to take over the management.

- **Commitment**
  Page four of the Explanatory Memorandum acknowledges "*costs associated with upgrading of IT systems to ensure they incorporate appropriate minimum standards and security features to access the Healthcare Identifiers Service"* however it incorrectly states Medicare infrastructure will assist in alleviating required changes to these external systems. Implementers and providers of the Healthcare Identifier Services in systems outside of Medicare will need to see the benefits and commercial business case before they build or modify existing external Medicare systems and change their current business processes. It is not clear that Providers are convinced and ready to change yet. We would draw the Committee's attention to the successful PBS Online

[2] See pg 5 -6 of the Explanatory Memorandum

program that was funded and implemented by the vendor community in three months compared with most other unfunded programs that can take 10 times as long.

- **Definition of "ORGANISATION"**

  There is no clear definition of what constitutes an "organisation" for the purposes of accessing an individual healthcare identifier and how those "organisations" may be accredited. There are many healthcare provider organisations that do not currently have a relationship with Medicare. It is not clear what organisations beyond the "hospitals, medical centres, diagnostic services and others"[3] may be included.

  It is clear to us that under certain circumstances, such as when medical software vendor companies provide managed services on behalf of many provider organisations, there would be a case for the medical software vendor companies to be registered healthcare provider organisations but there may be other views.

  Where organisations such as meals-on-wheels and charities contributing to basic support services fall is unclear. Health technology infrastructure such as EHR repositories and organisations providing audit and quality testing in e-health such as the Australian Healthcare Messaging Laboratory would need to be included.

  In the Bill the definition of "healthcare provider" includes not only all individual healthcare professionals AND healthcare organisations and an "identified healthcare provider" means individual healthcare providers OR organisations that have been assigned a healthcare identifier.[4] It seems that the lack of definition in this area may well prove problematic in the future.

- **Timing of NASH or individual provider identifier roll out**

  From July 2010 a national scheme is to be established for the registration of health practitioners in 10 professions[5] (medical, nursing and midwifery, pharmacy, physiotherapy, dental, psychology, optometry, osteopathy and chiropractic). The timeframe for the staggered rollout needs to be communicated so those individuals that work in dentistry, or psychology for example, and their vendors can know when their take up can begin.

  It is not clear how the migration from the existing Medicare PKI to the federated NASH will roll out – MSIA members who have invested in supporting providers adopt and then support the current PKI will be keen to know the shelf life of their investment.

[3] See pg 9 of the Explanatory Memorandum
[4] Definitions at Clause 5 of the Explanatory Memorandum p.9
[5] See pg.10 of the Explanatory Memorandum

Why are we waiting until 2012 for Aboriginal and Torres Strait Islander Health Practices[6] when the Closing the Gap initiative focuses on that area and starts on July 1?

There is provision for additional provider groups but no indication of the process to include them. Current business models suggest that Medical Practice Managers will need to be able to access identifiers as will other "non-providers".

- **Communication of the Implementation Timeline**
  There is a requirement for a public communication strategy for the implementation process, including stages, places and timelines. At the time of writing this is only known to the extent ***"South Eastern Australia without a big bang"***[7]**.** It is not clear who is responsible for such communications and who is accountable for their timeliness, clarity and completeness.

  The initiatives must be considerate of the commercial and logistical impacts to software vendors. Vendors only want to incorporate the changes once and not be required to develop a different approach in each state with a further "twist" for the private hospital, radiology or pathology sector in each state.

- **Public communication of testing processes.**
  Has the implementation, testing, validation, evaluation and proof of concept of each of the three identifiers been completed? Is there a clear line of accountability for meeting these requirements? These processes appear to not be in line with the NEHTA/Industry consensus agreement.

- **Standards applicable**
  An understanding of the standards that will apply and how those will be tested and maintained is critical. It has recently become clear that whilst basic web technology standards have been used, the specific International e-health standards for accessing patient, provider and organisation identifiers have not been implemented. This will provide barriers to rollout especially for International vendors and will mean that investment by local vendors will not translate to international rollout. Communication of the development of the software access mechanism and control has been poor. A recent survey of MSIA members indicated that none felt they had sufficient information to commence software development related to the identifier program.

- **How will success be measured?**
  A clear understanding of the audit processes that will measure success in terms of safety, effectiveness and coverage has not yet been articulated.

[6] See pg 10 of the Explanatory Memorandum – Clause 8
[7] Medicare/NEHTA/MSIA meeting on 26th February

- **One 'Use Case'**

  The Bill only appears to address one 'use case' – the "getting" of an identifier. It is not clear how a provider claiming the right to access the Healthcare Identifier Service will be authenticated? Will there be an ability to present a healthcare identifier to the service for verification? What the provider then does with the Healthcare Identifier to deliver the national e-health agenda is unknown.

Relationship to national e-health agenda and electronic health records

There appears to be no relationship with the EHRs already in use in Australia .It is of concern that at this stage Medicare has no plans to use the Individual Healthcare Identifier in their clinical registries (for example, the Australian Childhood Immunisation Registry – ACIR) which will require software systems to continue to maintain dual patient identifier systems even if they do not implement Medicare billing.

Further those programs such as Project STOP (reporting of pseudoephedrines) and the mandatory reporting to the jurisdictional authorities which Pharmacy must perform when dispensing S8's, drugs of addiction and other reportable items are also prone to identity error as the current systems are not allowed to use the Medicare number (as it is only to be used for claiming). There appears to be no plan to use the Healthcare Identifier in these areas.

Contacts:

Dr Geoffrey Sayer
President
MSIA
president@msia.com.au

Dr Vince McCauley
Treasurer
MSIA
treasurer@msia.com.au

Jenny O'Neill
Secretary
MSIA
secretary@msia.com.au

Bridget Kirkham
CEO
MSIA
ceo@msia.com.au