australian osteopathic association

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PERSONALLY CONTROLLED ELECTRONIC HEALTH RECORDS BILL 2011

Submission to the Senate Community Affairs Committee

by the

AUSTRALIAN OSTEOPATHIC ASSOCIATION

January 2012

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EXECUTIVE SUMMARY

- The Australian Osteopathic Association (AOA) supports the principle of a patient-controlled, electronic health records system.

- Our profession will do its best to cooperate with the system outlined in the Bill.

- However, we have serious concerns with some aspects of the legislation.

  - We sought clarification on these but the Department of Health and Ageing ignored our correspondence and has declined to respond to our concerns submitted as an FOI request.

- Therefore, this submission brings to the Committee's notice what we believe are ambiguities in the Bill

  - if our interpretation and understanding of the Bill in its present form are correct, then, if enacted, it appears to diminish the professional standing of many health practitioners, including osteopathy.

- In our view, our profession's concerns are capable of resolution. So much in the Bill is left to subordinate legislation, the content and effect of which are unknown.

- We ask the Senate Committee to require the Department to disclose the detail of its intended subordinate legislation, so that interested parties can assess how the legislation will operate.

- For allied health professionals (those registered under the National Scheme), the Bill when enacted will affect not only their professional clinical practices, but also the operation of their businesses.

  - Therefore, we believe that any financial or other help to be provided by the Commonwealth not be confined to medical practitioners and/or hospitals.

- At the time this submission was lodged, AOA had received no advice from the Department of Health and Ageing about our concerns. Should the Department provide some response to our requests, it may be that we would wish to ask the Senate Committee for leave to present a further submission.

THIS SUBMISSION

The Australian Osteopathic Association (AOA) appreciates the opportunity provided by the Senate Committee to comment on the PCEHR Bill ("the Bill").

In general, AOA supports the principle in the Bill. Our support, however, is conditional.

The scheme must not discriminate between classes of health professionals. And all professionals and their patients (called "consumers" in the Bill) must have equal access to and participation in the scheme.

In our view, the issues of concern to the osteopathic profession could have been addressed and doubts clarified, had the Department of Health and Ageing responded to our reasonable requests. Instead it ignored our correspondence. Our subsequent FOI request received no substantive response whatsoever.[1]

THE AUSTRALIAN OSTEOPATHIC PROFESSION

The practice of osteopathy is about 100 years old. Its focus is on treatment of the musculo-skeletal system. Osteopaths in Australia number about 1600. Most practitioners are young (under 40) and more than half are women. All must complete a five-year Masters degree and must be registered under the national registration scheme (NRS).

While there are no legal or clinical reasons why osteopaths should not practise in hospitals, few have ever done so. The preferred mode of service delivery is through private practice clinics with two or three professionals, within the community.

OSTEOPATHIC CLINICAL PRACTICE

It is very important for the Committee to appreciate that practically all our patients seek osteopathic treatment of their own free will. Our estimate is that 85% of patients come to our clinics "off the street". Referrals by other health practitioners – where perhaps a diagnosis has been arrived at – are thus in a minority.

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[1] Copies of the entire correspondence are at Attachments 1, 2 and 3. There was no substantive reply to any of the reproduced letters and the subsequent FOI request was in substance declined.

Osteopaths' professional training focuses on the musculo-skeletal system. But they must know – and do know – enough to detect in patients other conditions for which they are not qualified to provide treatments.

The effect of the situation described above is that osteopaths are primary healthcare providers. Some of our patients may not have a GP to alter or monitor their e-health records.

CLINICAL RECORDS

The implications for preparation and maintenance of patients' clinical records will be apparent to the Committee. The records of individual osteopathic patients will either start with their first consultation; or they may be referred with a pre-existing history; or on-referred with a condition treated by (or not) an osteopath but requiring (in the osteopath's professional judgement) other healthcare options.

One kind of on-referral that every osteopath has to make quite often is for diagnostic imaging. The antiquated and restrictive Medicare rules mean osteopaths can only refer patients directly for x-rays, and then for the spine only. Any MRI or CT scan and x-rays of all the other body parts we treat can only go on a GP's recommendation. This situation is insulting to osteopaths' professional integrity and actually costs Medicare and patients more.[2]

AOA asks the Committee to note that, for the e-health system to provide a complete picture of "consumers" who choose osteopathic services, our profession and our patients must have equal access to each person's record.

"SHARED HEALTH SUMMARY"

This concept, and the limit on who can "share", is of considerable concern to the osteopathic profession. Our understanding of the effect of clause 10 of the Bill is set out in general in our consultant's letter to the Department dated 4 October 2011,[3]

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[2] In a submission to the Department of Health and Ageing, AOA estimated that sensible referring rights would **save** Medicare about $5m p.a.

[3] Attachment 1.

and in more detail and with the benefit of legal advice, in our submission to the Department dated 28 October 2011.[4] Our conclusions were that

- clause 10; and
- the definition of "nominated healthcare provider" in clause 5

will assign a second-class standing to all "healthcare providers" other than the three listed in paras (c) (i)-(iii) in clause 5.

For reasons flowing from the way the osteopathic profession operates, **this situation is of concern to the AOA.**

It may be that there is an intention to make regulations under para (i) (iv) but the Department has declined to answer our request for detail. We have no confidence, however, that any regulations, when and if made, will deal with our concerns.

We therefore request the Committee to recommend to the Senate that the intention be made clearer to show the professions included or excluded and the reason why.

TRANSITIONAL ARRANGEMENTS AND COSTS

It will be apparent to the Committee that a scheme as massive and pervasive as that contemplated in the Bill will need a great deal of effort to start up. "Teething troubles" can be expected.

Obviously, a heavy burden will fall on "healthcare providers" and their office and IT staff or consultants. This burden is not confined to medical practitioners but extends to all professionals covered by the scheme.

Osteopaths receive next to nothing from public subvention – a situation which contrasts sharply with that of medical practitioners. Yet they will be bound by the PCEHR Act when it enters into force, in the same way and to the same extent as any other "healthcare provider". If the Health Department were to follow its usual practice of funding GPs and pharmacists and leaving everyone else to fend for themselves, the effectiveness of the scheme will be at risk.

We ask the Committee to recommend to the Senate that the Government be requested to ensure that all "healthcare providers", as defined in the Bill, rank equally for any financial or other help being provided, to ensure a smooth transition to the new arrangements.

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[4] Attachment 2.

ATTACHMENT 1

GEORGE BROWNBILL CONSULTING
PROPRIETARY LIMITED

4 October 2011

Ms Fionna Granger
First Assistant Secretary
eHealth Division
Department of Health and Ageing
By email: ehealth.legislation@health.gov.au

Dear Ms Granger

I act for the Australian Osteopathic Association. This may be verified from the DPMC Register of Lobbyists.

Since their recent publication, we have been examining the exposure draft bills and the accompanying explanatory document. In relation to the latter, I have some questions about the following passage on pp. 19-20:

> "Nominated healthcare providers
>
> A nominated healthcare provider will be responsible for creating and managing a consumer's shared health summary, and is nominated by the consumer. It is intended that a nominated healthcare provider is involved in the ongoing care of the consumer.
>
> Not all healthcare providers will be eligible to be a nominated healthcare provider. This restriction will ensure the utility of shared health summaries for use by other healthcare providers.
>
> In order to be eligible to be a nominated healthcare provider, a healthcare provider must have an HPI-I (within an organisation that has an HIP-O) and must be a medical practitioner, a registered nurse or an Aboriginal health worker (i.e. Aboriginal and/or Torres Strait Islander health practitioner). The healthcare provider must also agree to be the consumer's nominated healthcare provider.
>
> Additional types of healthcare providers may be added by the regulations.
>
> Only a consumer's nominated healthcare providers [sic] will be permitted to upload the consumer's shared health summary".

Here are my questions:

(a) By what process was it decided that medical practitioners, nurses and AHWs would be "nominated healthcare providers" and others not?
(b) By what process will "additional types of healthcare providers" be selected; by what criteria; and after what consultation and with whom?

(c) Will the selection in (b) be made before or after the Bill has been enacted and enters into force and when will that selection be publicly announced?
(d) Will the draft Regulations and draft Rules be the subjects of exposure drafts and public consultation; if so, what is the timetable for this?

I now refer to this sentence in the passage quoted above:

> "This restriction will ensure the utility of shared health summaries for use by other healthcare providers".

I must confess some puzzlement at this proposition. In fact, it seems to me to lead to the exact opposite. Are you able to provide any amplification or clarification to help me resolve my difficulty, please?

My clients intend to make a submission on the drafts. As you know, these are required by 28 October. Therefore it would be very helpful if your response to this letter could be provided in good time to enable us to meet the end of month deadline.

If you feel it would be helpful, I would be happy to discuss these issues with you or your staff.

Yours sincerely

George Brownbill

ATTACHMENT 2

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25 October 2011

Ms Fionna Granger
First Assistant Secretary
eHealth Division
Department of Health and Ageing

By email: ehealth.legislation@health.gov.au

Dear Ms Granger

Thank you for inviting the Australian Osteopathic Association (AOA) to comment on the draft Bills and related material.

AOA submits the following for your consideration.

Osteopathy in Australia

It is apparent from the papers we have examined that those who have prepared them have a rather incomplete understanding of the osteopathic profession and how it is practised in Australia. First, therefore, we make these points:

- Osteopathy is a primary healthcare profession;
- About 85% of our patient presentations arrive "off the street". That is, they have not been referred by a GP or other practitioner;
- Many of our patients do not "have" a GP. Some may even be actively opposed to doing so;
- Osteopaths treat the musculoskeletal system. But our people have, and must have, sufficient clinical skills to decide to on-refer a patient.
- Because the Medicare system is discriminatory against osteopaths, some diagnostic imaging can only be requisitioned by a GP. This imaging, and the need for it, is matters of clinical judgement, which osteopaths are trained to exercise.

This brief description shows that osteopaths play, and must play, a primary healthcare role. As qualified professionals, osteopaths are trained to keep proper, detailed, clinical records. As appropriate, these records, or elements of them, will be provided to other health professionals.

By the same token, patients who present to an osteopathic clinic may have:

- been referred by another practitioner, for example, under the Medicare extended treatment plan; or

- terminated on their own initiative, treatment (which they may have seen as ineffective) by some other practitioner.

It is the AOA's clinical judgement that it is essential for the ehealth records generated in respect of each person who has had, or seeks, osteopathic treatment to be available to the treating osteopath. Of course, with the patient's consent.

It is likewise our clinical judgement that the reverse should also apply.

"Shared health records"

It is with the above principles in mind that AOA has directed much attention to Part 2, Div. 3 of the draft Bill. Our members are very concerned at its current provisions.

In this respect, the draft legislation seems unfortunately vague. However, we have inferred from the full package of materials that a distinction is to be drawn between the 'shared health summary", on the one hand, and other health records. Only "medical practitioners", registered nurses and Aboriginal Health Workers (AHW) can prepare the "shared health summary". We infer that it is intended that other healthcare providers can prepare other health records. We infer this from section 39, which places certain conditions on the registration of a healthcare provider organisation. Inter alia, the section requires that the healthcare provider organisation does not upload a record:

- to any repository other than the national repositories service or a repository to which the registration relates;
- a record purporting to be a shared health summary, unless the document is a shared health summary;
- a specified record, unless the record has been prepared by an individual healthcare provider with a healthcare identifier;
- in breach of copyright, or
- without the consent of the consumer.

The clear implication of the section is that healthcare providers may upload materials which meet these conditions. That is, while healthcare providers other than nominated healthcare providers may not upload shared health summaries, they can upload other documents. Clearly, the PCEHR rules (which are to be issued by the Minister and which will specify kinds of records) will be of some importance in clarifying what materials may be uploaded. The comments on the draft legislation observe at page 40 that the PCEHR rules will prescribe which types of PCEHR records can be authored by which types of healthcare providers.

Our understanding in this regard is reinforced by the "Concept of Operations" document. Figure 2 of that document (on page 13) suggests that "healthcare providers" will be an "information source" of "shared health summaries, event summaries, discharge summaries, pathology result reports, etc". Figure 3 (page 14) is an example of a "consolidated view of a PCEHR". The index indicates that the clinical information available includes a shared health summary, but also includes discharge summaries, event summaries, referrals, specialist's letters, pathology result reports, imaging result reports, prescriptions, advance care directives, Medicare documents and a consumer entered healthcare summary. The consolidated view itself refers to the shared health summary, but also to "items from other clinical documents". The consolidated document refers to an event summary which appears to have been uploaded by a pharmacist. The Concept refers to the need for functional capability to support the collection of health information from a range of points of care (page 25). Figure 6 (page 38) also suggests that healthcare organisations can load new records.

Section 4.2 (commencing on page 43) also seems consistent with our understanding. At heading 4.3, the Concept notes that "the Shared Health Summary... is complemented by the "Consolidated View". At 4.3.2, the Concept notes that "any participating healthcare provider can submit [sic] Event Summaries ... for example ... an allied health clinic" (at page 51). The document also suggests that healthcare providers will be able to upload or authorise the uploading of pathology reports (see page 55).

The Concept Note does reinforce that only nominated healthcare providers may update shared health summaries and that in most cases, the nominated provider will be a GP (at pages 50-51).

That limitation is unacceptable to the AOA.

It may be that the scheme is not intended to prevent osteopaths putting any documents on the patient/client record, and the documents osteopaths can upload would be available to other health providers (although it appears that the rules will prescribe what types of documents might be uploaded by what types of healthcare providers). But it would be up to the GP or a registered nurse etc to add anything based on those uploaded documents on the patient's "shared health summary". **This is not acceptable to our profession.**

Who is, or may be, a "nominated healthcare provider"?

A "nominated healthcare provider" is defined in s. 5 as including three named professions and, possibly, other *individuals* (not "types of healthcare providers" (p. 20) who may be prescribed.

In our view, as the Bill is now drafted, each individual registered osteopath would need to be prescribed if they are to be allowed to deal with "shared health records".

We ask that registered osteopaths be included in the definition of "nominated healthcare provider" in s. 5. The possibility of our profession being prescribed at some later time, by means of some unknown and unaccountable process, is unacceptable.

"Individual healthcare provider"

This term is nowhere defined in the Bill. But the explanatory paper appears to distinguish them from "organisations".

The Australian osteopathic profession operates mostly on the basis of small, local, clinics. While we are advised that osteopaths can practise in public hospitals, few have ever done so.

In reality the osteopathic practice may be a sole trader, corporation sole, a trust, or an incorporated company. Practising osteopaths may be the principal, an employee or a contracted service provider.

It is thus difficult for us to see how Div. 4 of the Bill will operate. **AOA reserves its position on this matter.**

Assistance with transition costs

The changes to the way practitioners treat their patients, and to the way they manage their businesses, will be extensive. Transition to one unified, national, system will be complex and is bound to be expensive.

It is not unusual in our experience to find that, although all healthcare practitioners face costs in running their practices, only medical practices are considered eligible for public subvention. All Allied Health Professionals, including osteopaths, will be required by the Bill, when enacted, to make many changes to their clinical record systems.

AOA recommends, therefore, that all practitioners be eligible for assistance under any scheme the Commonwealth may devise.

Conclusions

In general, AOA commends the concept of the PCEHR. To the extent possible, osteopaths intend to participate in, and cooperate with, the scheme.

Our present ethical and clinical principles recognise the need for patient confidentiality. Provided the PCEHR can maintain people's privacy, we will do our best to make it a success.

However, doing so will be difficult if osteopaths and other allied healthcare professionals have only a second-class standing within the process.

Yours sincerely,

Antony Nicholas
Executive Director

ATTACHMENT 3

GEORGE BROWNBILL CONSULTING
PROPRIETARY LIMITED

30 November 2011

The Freedom of Information Officer
Department of Health and Ageing
GPO Box 9848
CANBERRA ACT 2601

Dear Madam/Sir

Under the provisions of the FOI Act, I wish to apply for access to:

(1) Copy of my letter dated 4 October 2011, to Ms Fionna Granger, in relation to the provisions of the draft PCEHR Bill and explanatory material, showing when it was received and to whom it was referred;

(2) Any documents showing what consideration was given to the letter; whether legal advice was sought or obtained; and what reply was drafted and/or sent;

(3) Copy of submission made by the Australian Osteopathic Association, dated 25 October 2011, in relation to the PCEHR Bill, showing when the submission was received and to whom it was referred;

(4) Any documents showing what consideration was given to the submission and by whom; whether legal advice was sought or obtained; whether the Minister or her office were advised in relation to the submission and, if so, what the advice was; and whether consideration was given to amending the draft Bill; if so, with what outcome.

I attach cheque for $35 and would be obliged to have your response in good time.

Yours sincerely

George Brownbill

Australian Government

Department of Health and Ageing

Mr George Brownbill
George Brownbill Consulting
PO Box 336
BUNGENDORE NSW 2621

Dear Mr Brownbill

Freedom of Information Request: No. 207-1112

I refer to your request of 30 November 2011 seeking access under the *Freedom of Information Act 1982* (the FOI Act) to:

1. A copy of your letter dated 4 October 2011 to Ms Fionna Granger in relation to the provisions of the draft Personally Controlled Electronic Health Records Bill (PCEHR Bill) and explanatory material, showing when it was received and to whom it was referred;
2. Any documents showing what consideration was given to the letter, whether legal advice was sought or obtained and what reply was drafted and/or sent;
3. A copy of the submission made by the Australian Osteopathic Association, dated 25 October 2011, in relation to the PCEHR Bill, showing when the submission was received and to whom it was referred; and
4. Any documents showing what consideration was given to the submission and by whom, whether legal advice was sought or obtained, whether the Minister or her office were advised in relation to the submission and, if so, what the advice was, and whether consideration was given to amending the draft Bill and, if so, with what outcome.

This letter sets out my decision on your request for access. I am an authorised decision-maker under section 23 of the FOI Act. A schedule of documents within the scope of this request is at **Attachment A**.

Decision

In relation to the first item, I have decided to release a copy of your letter to Ms Granger, dated 4 October 2011, which I have attached in full (**Attachment B**). This letter was received by ehealth.legislation@health.gov.au at 3:01 pm on 4 October 2011. It was referred to a departmental officer for action at 8:35 am on 5 October 2011. However, no action to respond to the questions you posed was subsequently taken. This was an oversight on the part of the officer and I apologise for this oversight.

With regards to item 2 above, requesting documents showing consideration of your letter, no specific documents relating to your letter of 4 October 2011 are available because of the oversight in responding to the letter. Access to this part of your request is refused under section 24A of the FOI Act as the documents to which you are seeking access do not exist.

In relation to item 3, the submission made by the Australian Osteopathic Association in relation to the exposure draft PCEHR Bill, the document is available via the *YourHealth* website at http://yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/PCEHRLegSubmissionsReceived#.Tu6NRlnVa0Y. A copy is attached for ease of reference (**Attachment C**).

Under item 4 you requested any documents showing what considerations were given to the submission. There are no internal documents relating to the distribution of the submission as this was an internal administrative process. Each submission received by the Department was circulated to three senior executive officers and five senior officers for consideration. Submissions were also circulated to the National Health Information Regulatory Framework (NHIRF) working group, which consists of representatives from the Commonwealth and each state and territory health department, the Department of Human Services—Medicare, the National E-Health Transition Authority and the Australian Institute of Health and Welfare. The senior officers and NHIRF members considered the issues raised by the submissions and the policy implications of those issues. Policy issues were considered within the context of the arguments put forward within the submissions and stakeholder consultations and subsequently, where appropriate and practical, reflected in the PCEHR Bill.

The only documents concerning the issues raised in the submissions are deliberative documents with implications for future policy developments and are exempt from release under the FOI Act under section 47C.

I have decided that the documents 1 to 8 listed in **Attachment A** are exempt under section 47C because the documents would disclose information considered and developed by internal and jurisdictional committees and working groups. The information, if disclosed, would identify indicative policy options, instructions to legislative drafters and advice to the Minister on legislative form. The documents, therefore, are clearly part of the deliberative process in that they concern Government policy and decision-making processes.

The documents are therefore conditionally exempt under section 47C.

Public interest

Access must generally be given to a conditionally exempt document unless it would be contrary to the public interest (see section 11A). In considering this issue, I have taken into account the following public interest factors in favour of and against disclosure:

Factors in favour of disclosure

Factors favouring access to the document in the public interest include whether access to the document would:

a. promote the objects of the FOI Act (including all the matters set out in sections 3 and 3A);
b. inform debate on a matter of public importance;
c. promote effective oversight of public expenditure; and
d. allow a person to access his or her own personal information.

I have also taken into consideration any guidelines issued by the Australian Information Commissioner issued under section 11B(5) of the FOI Act.

Factors against disclosure

Factors against disclosure which have been taken into account include:

a. The interest in preserving the efficient and proper functioning of government;
b. The interest in protecting the integrity of the decision making process by separating the final decision making policy from the opinions and advice of the officials who contributed to the consideration;
c. Advice from advisers would tend to be more circumspect rather than frank; and
d. Jurisdictional representatives are likely to be less inclined to participate in consultative processes where a view or an opinion is to be expressed and this would undermine the cooperation between and with jurisdictions.

In my view, in relation to documents 1 to 8 listed in **Attachment A**, the factors against disclosure outweigh factors for access. Were these documents released, the integrity of future consultations with officials and jurisdiction representatives would be undermined because it would collapse the opinions and advice of officials with the final decision of government, potentially limiting the receipt of future advice and opinions. In addition, the content of the documents is speculative and does not represent the final Government position as do those documents which are publicly available.

Taking these matters into account, I find that it would, on balance, be contrary to the public interest, to release the documents listed in **Attachment A** and I have decided, therefore, that the documents are exempt under section 47C.

Purely factual material

I have also considered whether the documents contain purely factual material or operational information. To the extent that they do, no claim for exemption is made under section 47C.

Excluded reports

I have also considered whether the documents contain reports of scientific or technical experts, reports of a prescribed body or organisation, or the record or reasons for a final decision given in the exercise of a power or adjudicative function. To the extent that they do, no claim for exemption is made under section 47C.

Charges

There are no charges associated with the processing of this request.

Review rights

You are entitled to seek review of this decision. Your rights are set out at **Attachment D** to this letter.

Relevant provisions

I have enclosed a copy of the provisions of the FOI Act relevant to your request (**Attachment E**).

Publication

I take this opportunity to remind you that the Department must publish information that has been released in response to each FOI access request subject to certain exceptions. This publication is known as a 'disclosure log'. The disclosure log requirement does not apply to personal information about any person if it would be unreasonable to publish the information, or to information about the business, commercial, financial or professional affairs of any

person if publication of that information would be unreasonable. The Department is not required to consult you on any decision to publish information that is released to you and the decision to publish information is not subject to internal review by the Department or the Australian Information Commissioner. Any person can, however, make a complaint to the Australian Information Commissioner about how an agency handles an FOI request.

Contacts
If you require clarification of any of the matters discussed in this letter you should contact me on (02) 6289 1944.

Yours sincerely

Liz Forman
Acting First Assistant Secretary
eHealth Division
12 January 2012