Aboriginal Health Council of Western Australia

Committee Secretary
Senate Standing Committees on Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600
Australia

10 January 2012

Contact Details

Name of Organisation: The Aboriginal Health Council of Western Australia (AHCWA)
Postal Address: P.O. Box 8493, PERTH WA 6000

Contact Details: Dr Pendo Mwaiteleke, Principal Policy Officer-Office of the CEO
Telephone: (08) 9227 1631
Fax: (08) 9228 1099
Email: Pendo.Mwaiteleke@ahcwa.org

Submission Team

Dr Pendo Mwaiteleke, Principal Policy Officer-Office of the CEO, AHCWA (Submission Coordinator)
Mr Des Martin, Chief Executive Officer, AHCWA
Mr Simon Scartes, IT&C Consultant, AHCWA
Mr Mitesh Patel, IT Officer, AHCWA

List of Glossary

ACCHS – Aboriginal Community Controlled Services (also known as AMS)
AHCWA - Aboriginal Health Council of Western Australia
AMS – Aboriginal Medical Services
AMSANT - Aboriginal Medical Services Alliance Northern Territory
Communicare – Software commonly used by some of the AMS providers in WA
DoHA – Department of Health and Ageing
IT&C – Information Technology & Communications
MMex - Software commonly used by some of the AMS providers in WA
PCEHR – Personally Controlled Electronic Health Records
OATSIH – Office of Aboriginal and Torres Strait Islander Health
OCHRESTstream - Government clinical reporting software for AMS managed by OATSIH

1.0 Introduction

The Aboriginal Health Council of Western Australia (AHCWA) wishes to thanks the Parliament of Australia for providing an opportunity for input into the current Parliamentary Inquiry currently being conducted by the Senate Standing Committees on Community Affairs on the *PCEHR Bill 2011* & the *PCEHR (Consequential Bill) 2011*. First, AHCWA contextualises the role of our organisation in relation to this submission, and provides a summary of matters raised in our previous public submission to DoHA on the mentioned Bills. AHCWA's ongoing engagement with NEHTA is noted, followed by articulation of current issues pertinent to this Inquiry. The submission also makes productive key recommendations to the Parliament and ways in which our sector can collaboratively and productively continue to engage with the government in meeting eHealth needs of Aboriginal peoples in the context of the PCEHR reform.

The Aboriginal Health Council of Western Australia is the state peak body for 19 Aboriginal Community Controlled Health Services(ACCHS) in Western Australia that are also known as Aboriginal Medical Services (AMS). Our 19 member organisations are spread across Western Australia's massive land mass estimated to comprise about a third of the Australian continent. A detailed list of organisations represented by the AHCWA is included at the end of this submission (see *Appendix 1*). AHCWA maintains one full-time IT&C position. In addition, as a peak organisation with a strong commitment in representing Indigenous healthcare sector needs, last year, AHCWA commissioned a nine-months IT infrastructure & operations audit project of Aboriginal Community Controlled Health Services across the State. Through this current IT audit and through feedback from or Affiliate organisations, AHCWA is further well placed to comment on the relevance of the legislative proposals to our sector in connection to the needs of Aboriginal population groups navigating the healthcare system.

2.0 Background - Previous Submission

In late October 2011 AHCWA made a submission to the Department of Health and Ageing (DoHA) in response to a government call for submissions to the draft *PCEHR Bill*. AHCWA reiterated its support for the proposed legislation, specifically for its potential in fostering better patient outcomes and as a useful contributor in Closing the Gap in a range of areas of patient care and management, including issues relating to geographical mobility amongst Aboriginal peoples. However, AHCWA made it very clear in its submission that despite PCEHR's good intent, the federal government had fallen short of recognising crucial IT communication infrastructure issues in Western Australia that need to be addressed so as to

optimise functional and quality participation in the PCEHR system. Through AHCWA's IT audit it had become clear that vast geographical regions in this state were not going to be covered by the National Broadband Network (NBN). As a result, it would appear most of the regions where Aboriginal Community Controlled Health Services are based will continue to rely on mostly domestic service satellite technology. The sector foresaw potential problems of **system saturation** arising as the PCEHR systems will be expected to compete with other data on already saturated satellite links, a problem that could substantially slow the system and result in the electronic communication systems becoming intermittent.

We recommended positive ways forward, whereby the legislation needed to ensure Aboriginal Community Controlled Health Services are financially and legislatively supported in investing in appropriate new business technologies, such as *WAN* optimisation tools and high end routing equipment to minimise the deficits that are likely to be amplified during PCEHR roll out given continued reliance on dated and slow satellite communication technology.

Our submission also pointed out that the draft legislation is silent on budget allocations regarding installation costs, IT replacement, maintenance and software. It is clear from the sector that that we are going to be charged for installing, licensing, upgrade and maintenance. Our sector also drew attention to issues that remain unaddressed regarding **Software compatibility and related costs** - this appears to be a critical issue in WA as there is scarce information required to clarify how the legislation will ensure compliance given the extensive software systems in use that need to operate in a compatible fashion within a national PCEHR system. Whilst it is our understanding that technical interfacing solutions can be provided, it is still unclear who is meeting the costs. For Aboriginal Medical Services which try to deliver optimal services with minimal resources, our sector will benefit from government budgetary allocation on relevant additional software to support the implementation process. It is also clear to our sector that an important legislation change such as this would inevitably require to provide for **training costs** - we will need to train GPs and other clinical and administration staff how to use new software, some kind of recurrent funding maybe necessary to support these activities. AHCWA pointed out that the Bill in its current form does not appear to recognise or provide specific budgetary allocation in terms of IT. So far, we are not aware these issues are being addressed. Supporting IT budgetary allocations legislatively will ensure these essential services are not left behind.

The government was encouraged to consider issues of compatibility in order to facilitate better information flow. Concerns were also raised about lack of information regarding what bandwidth the government intended to adopt, information necessary to our healthcare providers in their ongoing PCEHR planning. We drew to government's attention that WA the Divisions of General Practice use their own systems [i.e. MMex, Best Practice, Medical Director (MD), and Med Tech 332], the hospitals use different systems. The Aboriginal

Medical Services also use Communicare, MMex and and Ferret. We are aware that at least 10 AMSs use Communicare, whilst 9 use MMex. As a result, we felt the sector could be better placed if given indication that these software used by different healthcare provider groups will be compatible in facilitation/transfer of patient data under the PCEHR system.

The submission indicated Western Australia's limited readiness due the fact that the government has not conducted any trial runs in this state, unlike other states. This means the state is less technically positioned to assess complex implementations issues that are likely to arise during the roll out process.

In this context, AHCWA also asserted in the earlier submission that the draft legislation seemed oblivious to issues facing WA's remote areas, and fell short of taking account to such geographical differentiation or considerations. Ironically, the PCEHR system is put forward as intending to improve health outcomes to these remote populations that in turn are not being fully enabled to participate fully due to infrastructure gaps.

3.0 Engagement with NEHTA

AHCWA has actively engaged through NEHTA consultative processes in a bid to represent the needs of Western Australia's Aboriginal Medical Service sector in order to optimise effective future participation in the PCEHR system. To this end, over the last 12 months our IT&C staff and two of our most experienced senior regional AMS Executives have attended three national interstate meetings convened by NEHTA to promote greater awareness of the PCEHR program and also to seek advice and guidance on how best government can engage with the Aboriginal and Torres Strait Islander healthcare sector. Indeed, AHCWA continues to engage with NEHTA with a hope of encouraging government measures that can promote improved responses to However, although the vision embedded in the PCEHR draft legislation is clear, and despite on commitment to ongoing participation, a number of limitations have been noted by our key sector representatives leading up to the implementation phase.

3.1 Integration and consistency in software functionality

3.1.1 Recently sector stakeholders drew to NEHTA's attention that the government's Office of Aboriginal and Torres Strait Islander Health (OATSIH) within DoHA has just rolled out a new nation-wide software reporting system for known as OCHREStream. The Aboriginal Medical Service sector has sought clarity whether or not this new reporting mechanism is going to be compatible with PCEHR and other related systems. A response to this will be helpful in planning for PCEHR sector readiness.

3.1.2 Timely planning preparations leading up to PCEHR roll out would require a coordinated system aimed at encouraging & promoting transparency across vendors (potential contractor supplies of sector software). AHCWA and the WA ACCHO sector are not aware of any coordinated systematic approach in place **in place that jointly engages provider organisations, IT&C vendors and government parties.** Our Aboriginal Medical Service healthcare providers use two major software systems namely Communicare and MMex – presumably a tripartite dialogue that brings together software vendors, AMS and NEHTA representatives could be useful in facilitating a productive dialogue intended facilitate better planning on issues of mutual interest. In other words, whilst all stakeholders take some responsibility in planning for PCEHR readiness, a productive tripartite dialogue would enable opportunity to increasingly align our operations in in more effective and efficient way. This has future operational implications as any future IT&C investment plans using public funding are best undertaken in consideration that they will deliver the best outcomes for WA Aboriginal populations.

3.1.3 While it is expected that Communicare is compatible with the PCEHR system through a coming software release, at this point it remains unclear to what extent MMex will be compatible. AHCWA is also aware that if aiming for compatibility, this is not going to be simplistically solved by a mere switchover from one system to another (e.g. from MMex to Communicare or vice versa) since there is some variation around various software functionality. For example, some of our AMS report that on one hand Communicare is advanced in terms of compatibility with PCEHR system, on the other hand, the MMex software also reportedly include other feature such as pharmaceutical functionalities and so forth that may not be part of Communicare. That means looking closely at issues of functionality and proposing workable solutions requires expertise and resources. But who is funding this? Who is analysing these issues and how they being fed into the preparation framework for WA?

3.2 **Cost implications relating to vendors' software modifications** – Lack of integrated trial runs and coordinated responsive dialogue has also left us unclear about issues of cost and who is going pay for it. For example if a

vendor like Communicare make modifications to its software to optimised PCEHR requirements, presumably in doing so they invest and will pass onto our AMS sector costs relating to programming, analysis, etc. All this costs money. It will be helpful if the government makes it clear that it intends to absorb this added implementation cost. The Parliament can ensure relevant government agencies such as any PCEHR authorities, DoHA and OATSIH clearly includes this in their funding mechanism.

3.3 Ideally, we encourage NEHTA to undertake some sorting out, including providing the sector with a clear roadmap about how individual issues identified throughout last year are being followed up. The lack of clarification on queries raised by WA about what software the Government intends to use in the PCEHR roll out continues to hamper informed preparations, mindful that any resources invested in this area need to be allocated wisely by being mindful of PCEHR technical and budgetary requirements. In making this point, we are also not sure if this is NEHTA's responsibility as we are not versed with governmental parameters for NEHTA's technical mandate or its policy and budgetary capacity to fully address issues we have identified. For example, we are not sure whether or not NEHTA had a view on what might be the preparation implications of the vast WA state with extensive infrastructure issues not having had an opportunity to be part of Wave 1 or 2 of the national trial runs. There is still opportunity for our WA ACCHS as primary end user of the PCEHR system to be enabled to participate in the trials. Among other things, this will also ensure multiple WA software are going to be tested at points delivery if are PCEHR capable. As ACHWA is already engaged in supporting the WA AMS sector in building capacities and monitoring ongoing adoption of Quality Assurance in clinical governance, we are well placed to coordinate this initiative provided the government provides appropriate resourcing. Failure to do any state-based trials could prove costly for all involved. It is AHCWA's belief that trial runs are good way of ensuring future public IT&C and general health expenditures adheres to notions of accountability, efficiency considerations and pursuit of evidence-based practice.

3.4 In attempt to play our role in supporting the sector gain readiness for PCEHR potential eventual adoption, previously, AHCWA in collaboration with MMex software providers (University of Western Australia) submitted a trial run bid in preparation for the upcoming PCEHR roll out. Unfortunately, Western Australia was unsuccessfully in gaining consideration. The sector sought formal feedback from the government driven by concerns that lack of

any state-based trial run(s) would impinge on readiness leading up to the implementation phase. However, AHCWA is not pointing a finger at NEHTA or anyone else for that matter as we believe the issue is perhaps more of a broader systemic awareness of the variation, vastness and overall infrastructure challenges facing our state, and trial runs would have been useful in determining any issues in advance of the PCEHR implementation date.

3.5 Two areas of WA bordering NT and also SA have since linked to a trial run coordinated through AMSANT in the NT. Whilst we applaud the lessons that might have occurred through this link, it is still unclear to our broad AMS state sector what is the federal government view or strategic position regarding whether or not WA is to pursue a consistent approach and enhance compatibility at a state level. In addition, we also urge the Senate Inquiry to pay some attention to the AMSANTS' NT previous public submission to DoHA as the content of their submission still has relevance to Aboriginal and Torres Strait Islanders that variously move across the two states. A coordinated federal approach would assist in the PCEHR implementation, and would ensure that any money allocated would be wisely spent.

3.6 Some of our stakeholders believe that greater transparency into how government allocates resources during this planning and preparation phase is something that could equitably serve the needs of our populations. The 12 national trial runs under Wave 1 & 2 are a case point.

3.7 As half of our sector uses *Communicare* and another half *MMex*, our stakeholders wish to see the two systems being allowed to smoothly communicate under a PCEHR system. At a basic level that would promote quality and consistency for the patient population groups. As part of this, Western Australia's AMS *Communicare* users would benefit from having this software system trialled and tested at specific sites in WA for its functionality and operational compatibility under PCEHR prior to formal roll out. There are underlying technical reasons why Communicare and MMex are not interoperable, and cannot share data. This also prevents any meaningful sharing of data between populations who are likely to be transient and who will attend a medical practice which could be using either software. A consistent approach to interoperability would assist in alleviating concerns about which software is used, and would allow practices to share data across regions. We would request that this element be given some thought, and for

vendors to be encouraged to build in the ability to share data between software from different vendors.

3.8 We need future trials that can also test level of compatibility in sharing information with other key mainstream systems including hospitals, GPs, pathology, and regional clinics run by the State health Department's Country Health Services (WACHS). A concern has been expressed by some of our Affiliate operators at the coalface that without ensuring that the PCEHR systems will enable functional and optimal communication across these systems, effective participation and access for Aboriginal populations will be limited. For example, it has been communicated to us that in a couple of instances particular summaries that are being produced by key healthcare player(s) have no relationship to users of MMex.

3.9 **Difficulties with the National Identifiers** – National Identifiers are central to an effective and functional PCEHR system. Under the proposed legislation consumers are required to provide their Healthcare Identifier Service with particular documentation for verification purposes. This involves verification of a full name, Date of Birth, Medicare or other Healthcare Identifier documentation. Our stakeholders have drawn to AHCWA's attention the complexities this presents for our population groups. It is reported that many present various chosen first names that reflect words in their own primary language. There is also a difficulty in certainty over Date of Birth that makes the registration and identification process difficult. Moreover, it is not clear how many Aboriginal Australians have identifications when presenting at hospital for emergency admission.

3.10 **Engagement process** - a key concern is that Indigenous Australian may be the last to have access to the PCEHR. The Kimberley region which now links with NT trials reports that a shift in government funding from a salaried model to a fee-for-service activity based model (i.e. Indigenous Incentives) has led to limited resources being available for management and trained clerical services. As a result the implementation of current Medicare numbers is incomplete. Moreover, for successful engagement into the National Identifiers and into the PCEHR there will need to be a well-designed engagement program that involves all Aboriginal Community Controlled Health Organisations in the engagement process. Unless resources and programs are developed quickly then the group that has the most to gain from the PCEHR will be the last to obtain access.

3.11 Lessons being learnt from the Kimberley through its links with NT– according IT reports from these areas, under existing trials, the *National Identifiers* is only specific to the hospital system. It is also reported by technical leaders involved in the trial that the government has no intention of bringing identification numbering system into MMex. This is a serious issue as currently AMS MMex users receive less than 30% of hospital discharge summaries in remote and primary care. The rate is even lower on discharge summaries received from tertiary hospitals. We now understand that $2 million was allocated to facilitate this linkage involving WACHS, KAMSC and NT. Clearly, to derive greater public value-for-money, this is one instance indicating that without enhancing software compatibility across provider groups, and without sorting out issues around *Identifiers*, Aboriginal groups will not receive optimal benefits under this system.

4.0 The sector has identified a strong need for a senior IT&C FTE position based in Perth to provide advanced technical expertise and champion the PCEHR agenda through engagement with key national, state and regional stakeholders. AHCWA believes such a position is closely aligned with the government PCEHR agenda and the need to promote better healthcare outcomes for Aboriginal people in the context of the broad National Health Reform Agenda.

5.0 **Compatibility, Market Power & Competition** - so far the view in WA is that given the software diversity already in existence; and given the need to promote notions of value-for money, the government need to promote an IT&C supply environment conducive to competition, innovation, and quality delivery aligned with broad national healthcare objectives.

6.0 **Review regional & remote internet services** - in order to facilitate communication with the PCEHR and any other health information sharing there needs to be a careful government-initiated review of internet access in most of remote Western Australia. This needs to ensure that there is adequate bandwidth to support internet to the level of Telemedicine as a minimum in all locations. Some of our stakeholders have reported that at present the systems they have in place supports a mere 2MB for uploads as well as 2MB for downloads. At a minimum, they have indicated an upgrade taking them up to 5MB capacity holds potential to effectively support a better system suitable to meeting a multiplicity of healthcare data needs.

7.0 Recommendations

7.1 Preparations for this legislation need to support WA based trials that promote test runs involving key software that are currently is use within our healthcare system. This will ensure eventual PCEHR suppliers/vendors contracted by the government are likely to produce products that work in alignment with systems run by AMS providers and others.

7.2 It is essential that the government supports AMS in WA in strategies and process that will promote and encourage the ability of Communicare, MMex and other medical practice software systems to build PCEHR-conforming products with built-in ability to share data between software from different vendors.

7.3 Future government contracting and tendering decisions involving software supplies should take account of software specifications that deliver optimal healthcare outcomes for Aboriginal people, in alignment with the spirit of the *PCEHR Bill*.

7.4 It is important for government to require its agencies to demonstrate increased transparency in how IT&C resources are allocated across various states. For example, we have been informed that apart from WA not being enabled with state-based trial runs, our AMS Communicare users have been most disadvantaged by being omitted from any national test links.

7.5 That the government fund a state IT&C position through AHCWA to support state-wide local coordination of the IT&C roll out. The position will also provide leadership involving other regional IT&C infrastructure relating telehealth

7.6 That the government allocate necessary IT&C budget to AHCWA to ensure the WA ACCHO sector is adequately supported to promote future state-wide IT&C Quality Assurance practices across the ACCHO sector (i.e. aligned with IT&C best practices in clinical record-keeping, continuous improvement and sustainability

7.7 That the government examine the concept of National Identifier in relation to certain Aboriginal groups more closely, and allocate appropriate engagement resources to AMS providers to ensure optimal access and participation by Aboriginal people.

7.8 Test runs to be implemented to determine how PCEHR will interface with other mainstream healthcare systems

7.9 The government needs to empower or encourage NEHTA to be upfront with a systematic progress of what is being addressed by way of every issue being raised being tracked with a formal response, and provide timelines for intended action plans

7.10 NEHTA needs to support the sector by providing a clear roadmap about issues and follow-up

7.11 As software vendors will be competing as suppliers for very substantial public resources in the PCEHR national operations, it is in the public interest that the Parliament builds legislative mechanisms to ensure software license and other fees remain both fair and competitive. The governance of this could be done through a combination of *regulation* and *market mechanisms*.

7.12 Adoption of key recommendations that AHCWA articulated its previous submission (see *Appendix 2* under Section 6: Summary of Recommendations)

7.13 It is suggested the government consider reviewing regional & remote internet services in the context of PCEHR and other broader eHealth needs.

Appendix 1 – Aboriginal Community Controlled Health Services

- Beagle Bay Community Health
- Bega Garnbirringu Health
- Bidyadanga Aboriginal Community Health Service
- Broome Regional Aboriginal Medical Service
- Carnavon Aboriginal Medical Service
- Derbarl Yerrigan Health Service Inc
- Derby Aboriginal Health Service
- Geraldton Regional Aboriginal Medical Service
- Jurrugk Aboriginal Health Service
- Kimberley Aboriginal Medical Services Council
- Mawarnkarra Health
- Ngaanyatjarra Health Service
- Nindillingarri Cultural Health Service
- Ord Valley Aboriginal Medical Health Service
- Palyalatju Maparnpa Health Committee
- Puntukurnu Aboriginal Medical Services
- South West Aboriginal Medical
- Wirraka Maya Aboriginal Health Service
- Yura Yungu Aboriginal Medical Service

Appendix 2 – Previous submission made to DoHA, 27 October 2011

Personally Controlled Electronic Health Record (PCEHR) System: Exposure Draft PCEHR Bill 2011

SUBMISSION TEMPLATE

Thank you for taking the time to consider the PCEHR System Exposure Draft PCEHR Bill 2011. We value and appreciate your constructive comments on Australia's PCEHR system, so the department can further refine the design and improve the quality of the information we provide.

Individual responses to submissions will not be provided.

Submissions will be made public and shared with relevant Commonwealth, state and territory government agencies to inform consideration of the PCEHR legislative framework. Submissions that are intended to remain confidential should be clearly marked as such and submitters should be aware that confidential submissions may still be subject to access under Freedom of Information law.

The closing date for comments and submissions is 10:00am. (Australian Eastern Standard Time), Friday, 28 October 2011.

*****Mandatory fields*

***Name**

Aboriginal Health Council of Western Australia (AHCWA)
Contact: Dr Pendo Mwaiteleke, Principal Policy Officer – Office of the CEO, AHCWA

(*First name is mandatory and will be displayed if submission is published.)*

***Postcode** 6849

***Indicate the theme(s) of your submission**

Participation	☒	Security	☐
Access	☒	Governance	☐
Privacy	☐	General comments	☐

***Indicate the stakeholder group(s) you represent**

Member of public	☐	Hospital care	☐
Research and academic	☐	Healthcare providers	☒
General practice	☐	Aged and community care	☐
Peak body representative	☒	Union and community care	☐
Allied health	☐	Union representative	☐
Indigenous representative	☒	ICT/Software industry	☐
Government	☐	Other	☐

***Do you agree to your submission being published and made public (including on the www.yourhealth.gov.au website)?**	☒ Yes	☐ No

***I agree to the submission terms of use (read terms of use on www.yourhealth.gov.au website).**	☒ Yes

Your submission/comments:

Aboriginal Health Council of Western Australia (AHCWA)

Submission to the Draft Personally Controlled Electronic Health Records Bill

Submission prepared by:

Dr Pendo Mwaiteleke, Principal Policy Officer – Office of the CEO (Submission Coordinator)

Mr Simon Scates, ICT Auditor, Consultant

Sue Cristopoulos, Development and Member Support

Mr Mitesh Patel, IT Officer

Contents:

1. AHCWA & Representation Base

The Aboriginal Health Council of Western Australia (AHCWA) is the peak body for 19 Aboriginal Community Controlled Health Services in Western Australia (ACCHSs) that are also known as Aboriginal Medical Services. AHCWA has been operating since 1997. A detailed list of organisations represented by AHCWA is included at the end of this submission (see *Appendix 1*). As a peak organisation with a strong commitment in representing Indigenous healthcare sector needs, this year, AHCWA commissioned a nine-months IT infrastructure & operations audit project of Aboriginal Community Controlled Health Services across the State. Through this current IT audit, AHCWA is further well placed to comment on the relevance of the legislative proposals to our sector in connection to the needs of Aboriginal population groups navigating the healthcare system.

Aboriginal Medical Services & the Significance of PCEHR

Aboriginal Controlled Health Services have maintained a significant role in healthcare provision over the last three decades. They have embraced use of electronic patient information in recognition of the role this plays in fostering better patient outcomes. As clearly understood, and explicitly prioritised under the government's *Closing the Gap* policy, Aboriginal people experience disproportional higher rates of chronic disease conditions. The healthcare needs of mothers and newborns are also identified as issues of priority in the government's quest to *Close the Gap* and enhance health outcomes for Indigenous people. The geographical mobility issues common amongst some of the Aboriginal populations means that the proposed PCEHR systems stand to potentially contribute towards consolidation of integrated healthcare. This includes the promotion of primary care and patient management, ranging across clinical interventions, management and review of medication, referral systems, use and promotion of discharge care plans and general improvements in information flow across general practice, allied health and tertiary care. To this end, AHCWA applauds the intent of the PCEHR draft legislation seeking to address information fragmentation through a legislative framework in a bid to enable individuals to make their health information accessible to different healthcare providers involved in their care.

3. Access & Key Infrastructure Factors

Some of the crucial IT communication infrastructure issues in WA need to be understood in the context of much of remote areas' continued reliance on satellite technology. Moreover, this reliance is likely to continue as substantial geographical remote areas in WA are not going to be covered by the National Broadband Network (NBN), which is largely earmarked to cover coastal regions, and a few inland areas. These excluded areas coincide with locations where the majority of our member organisation providers, the Aboriginal Medical Services are to be found. Whilst AHCWA clearly embraces the PCEHR Bill, we believe it is still critical that decision-makers remain mindful of the contextual infrastructure milieu that our Aboriginal Community Controlled Health Services are operating in. That is, for this sector, a sound PCEHR legislative base would be one that gives recognition and enable ways to bridge major implementation disadvantages likely to occur due to infrastructure variation.

Such awareness clearly aligns in translating the spirit of social inclusion and *Closing the Gap* for the target group under discussion. With that in mind, our submission highlights pragmatic ways forward to ensure the PCEHR needs of Indigenous people in WA are catered for. In this section we highlight challenges, but also make tangible suggestions to progress the government PCEHR objectives.

- **Saturation** – as the proposed PCEHR legislation is going to include extensive parts of rural and remote of WA – areas that under current arrangements will remain reliant on satellite technologies, here, decision makers need to recognise a problem of system **saturation**. Saturation comes about simply because it means we are putting PCEHR systems on top of email, OATSIH and OCHREstream. The current hardware (i.e. Quality of Service, QOS) used by the Aboriginal Medical Services is basic in comparison to metropolitan based providers, and extra data loads will lead to saturation of the current data connections. These findings are clearly evident in AHCWA's ongoing audit of the IT

infrastructure and operations of our providers groups across the West Australian regional sector.

- If the issue of saturation remain unrecognised, unfortunately, despite current best intention, the introduction of PCEHR is not going to level the playing field. Indeed, some of our sector participants expressed that in fact the introduction of PCEHR is likely to impact on some of the current Aboriginal Medical Services communication systems (i.e. that is to say emails and basic internet services within AMS could be slowed due to the additional data transmission requirements). In addition, it is also noted that the electronic communication services are intermittent, and regular transmission and receipt of PCEHR related data could be affected by loss of connectivity which is common in remote regional areas. This is obviously not the best outcome we are seeking for those we wish to benefit from PCEHR, since we consider the ability to receive and transfer patient information very critical, and core to the healthcare services provided by our sector.

- **Positive ways forward** – our sector requires special communication related hardware such as high end routers (e.g. CISCO) and WAN (Wide Area Network) **optimisation** hardware. If we want to be smart in managing PCEHR we need such better hardware to enable parity with metropolitan based providers. As long as we remain reliant on satellite, and other regional internet access services, the installation of these new IT business hardware systems is essential to ensure PCEHR benefits reach their target.

- **Legislative budgetary allocation for hardware** - the Bill in its current form does not appear to recognise or provide specific budgetary allocation in terms of Information and Communication Technologies (IT&C). Yet, given that this draft legislation intends to meet the needs of disadvantaged populations, it is unclear how this is going to be achieved without such budgetary allocation. What is clear to us though is that without installing optimisation hardware solutions stated above, a substantial number of Indigenous populations are going to be disadvantaged in the expected everyday usage of the PCEHR. Hence, we request the Bill make provisions for ways of meeting these additional needs, which may not be fully applicable to some of the mainstream healthcare providers that are benefitting from the public investment in the NBN, or who have access to metropolitan or large regional infrastructure.

- **Unintended benefits** - It is worth pointing out to decision-makers that in the event reasonable IT&C systems are put in place (e.g. CISCO/WAN OPTIMISATION), this will also offer unintended positive gains such as enabling video-conferencing of Aboriginal Medical Service clinicians and other mainstream healthcare professionals/providers for the benefit of their patients, e.g. involving follow-up, care coordination planning and various aspects of communication facilitation requiring transfer of patient information.

- **Legislative budgetary allocation for software, installation and maintenance** – the draft legislation is silent on budget allocations regarding installation costs, IT replacement,

maintenance and software. It is clear from the sector that that we are going to be charged for installing, licensing, upgrades, modification to existing clinical practice software and ongoing maintenance costs. In a number of remote areas Aboriginal Community Controlled Health Services are the main healthcare provider in their localities, often operating holistic services with minimal budgets. Supporting IT &C budgetary allocations legislatively will ensure these essential services are not disadvantaged by virtue of their relative location in Western Australia.

- **Software compatibility and related costs** - this appears to be a critical issue in WA as there is scarce information required to clarify how the legislation will ensure compliance given the extensive software systems in use that need to operate in a compatible fashion within a national PCEHR system. Whilst it is our understanding that technical interfacing solutions can be provided, it is still unclear who is meeting the costs for these modifications. For Aboriginal Medical Services which try to deliver optimal services with minimal resources, our sector will benefit from government budgetary allocation on relevant additional software to support the implementation process. Providers of Communicare, MMEx and other clinical practice software providers will modify their software and pass this cost on to the end users (in this case, the Aboriginal Medical Services)

- **Ensure systems are compatible & facilitate planning information flow** – although the government may have conducted test run trials, our consultation leading up to this submission indicate that, as yet it is not clear what PCEHR software the government intends to use, and what the bandwidth requirements are for any future implementation. Without this information being made available to providers, some of those we have consulted believe there are likely to be more hiccups at an implementation level. Timely access to this information will assist with ongoing planning. It is worth noting that at present, in WA the Divisions of General Practice use their own systems (i.e. MMEx, Best Practice, Medical Director, and Med Tech 332), the hospitals use different systems. The Aboriginal Medical Services also use Communicare, MMEx and and Ferret. We are aware that at least 10 AMSs use Communicare, whilst 9 use MMex. We also note that although these systems in our sector we understand maybe compatible with the upcoming PCEHR, however, comprehensive assessment and planning about compatibility can only be ascertained once it is clear what systems are going to be used in various states (e.g. refer to patient movement across different states), and also the multiple fields of healthcare practice.

- **Training costs** - we will need to train GPs and other clinical and administration staff how to use new software, some kind of recurrent funding maybe necessary to support these activities.

Given potential opportunities connected to PCEHR, participation and effective delivery for Indigenous populations can potentially be maximised by embedding legislative elements that are mindful of IT connectivity issues and notions of access.

Recommendations:

i. Provide specific budgetary allocation to AMSs for IT and communication related hardware such as CISCO/WAN OPTIMISATION
ii. Provide budgetary allocation for related IT installation, software, maintenance and training
iii. Provide for systematic review IT needs review at least every 3 years.

4. Advisory Mechanisms

Our consultations indicated the significance of the role played by the advisory groups aiding and guiding ongoing decision-making and monitoring implementation progress. To this end, it is believed that any Ministerial/Departmental advisory committee should include at least two (2) members that are experienced and familiar with IT challenges and scenarios common to rural and remote areas such as a number of our Aboriginal Community Controlled Health Services localities WA. It is also suggested that the committee should be selected in terms of proportional representation, taking full account of geographical variation so as to ensure the Minister is appropriately kept abreast of experiences common to rural and remote WA and similar states. Skills/expertise or background maybe issues of relevance to ensure the representative(s) are well versed with Aboriginal Medical Services IT settings.

Recommendations:

iv. Ensure appropriate Indigenous and remote area representation, evidenced by local understandings of the infrastructure needs of the large remote parts Western Australia
v. The legislation need to provide for a systematic periodic review of the PCEHR implementation every 3-5 years given the changing technological and social contexts

5. Attention to Geographical Variation

The draft legislation appears not to make any specific mention of remote areas. It could be worth for the legislation to make at least broad provision drawing attention to geographical differentiation or considerations.

Greater clarity could also be indicated at a legislative level whether the PCEHR is intended as a universal provision or residual, as this may also give indications to population groups intended to benefit from this legislation.

Recommendations:

vi. Draw attention to PCEHR being a universal provision that need to maintain responsiveness to healthcare needs of Australians living in remote areas especially those identified under Closing the Gap.

6. Privacy protection

Whilst it is clearly intended that privacy and information security should be maintained, the nature of current technological risks means that no one can guarantee such level of security with 100%

certainty, particularly at the point of entry for data (i.e. practice PCs). It is suggested that the government continue looking at this issue and review levels of security periodically given the changing technological risks and contexts. Realistically, this may require a certain level of budgetary allocation.

Recommendations:

vii. That the government maintain a review strategy in the ongoing monitoring of privacy and security issues

6. Summary of Recommendations:

AHCWA believes the following summary of recommendation will serve to optimise service access, efficiency and patient outcomes. AHCWA also believes these considerations will assist the government in aligning its *Closing the Gap* agenda with practical steps taken on the ground to ensure Indigenous populations equitably benefit from the PCEHR legislation.

i. Provide specific budgetary allocation to AMSs for IT and communication related hardware such as CISCO/WAN OPTIMISATION
ii. Provide budgetary allocation for related IT installation, training, software modification and maintenance
iii. Provide for systematic review IT needs every 3 years
iv. Ensure appropriate Indigenous and remote area representation, evidenced by local understandings of the infrastructure needs of the large remote parts Western Australia
v. Draw attention to PHCER being a universal provision that need to maintain responsiveness to healthcare needs of Australians living in remote areas especially those identified under Closing the Gap
vi. The legislation need to provide for a systematic periodic review of the PCEHR implementation every 3-5 years given the changing technological and social contexts
vii. That the government maintain a review strategy in the ongoing monitoring of privacy and security issues

Appendix 1

- Beagle Bay Community Health
- Bega Garnbirringu Health
- Bidyadanga Aboriginal Community Health Service
- Broome Regional Aboriginal Medical Service
- Carnavon Aboriginal Medical Service

- Derbarl Yerrigan Health Service Inc
- Derby Aboriginal Health Service
- Geraldton Regional Aboriginal Medical Service
- Jurrugk Aboriginal Health Service
- Kimberley Aboriginal Medical Services Council
- Mawarnkarra Health
- Ngaanyatjarra Health Service
- Nindillingarri Cultural Health Service
- Ord Valley Aboriginal Medical Health Service
- Palyalatju Maparnpa Health Committee
- Puntukurnu Aboriginal Medical Services
- South West Aboriginal Medical
- Wirraka Maya Aboriginal Health Service
- Yura Yungu Aboriginal Medical Service