



HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Health Information Management and Telemedicine

CANBERRA

Friday, 16 May 1997

OFFICIAL HANSARD REPORT

CANBERRA

HOUSE OF REPRESENTATIVES STANDING COMMITTEE
ON FAMILY AND COMMUNITY AFFAIRS

Members:

Mr Slipper (Chairman)
Mr Quick (Deputy Chairman)

Mr Ross Cameron	Mr Kerr
Ms Ellis	Ms Macklin
Mrs Elson	Mr Allan Morris
Mr Forrest	Dr Nelson
Mrs Elizabeth Grace	Mrs Vale
Mrs De-Anne Kelly	Mrs West

Matters referred for inquiry into and report on:

The potential of developments in information management and information technology in the health sector to improve health care delivery and to increase Australia's international competitiveness with particular reference to:

the current status of pilot projects already commenced and an evaluation of their potential for further development;

the costs and benefits of providing advanced telecommunications and computer technology to general practitioners and other health care professionals throughout Australia, particularly in rural and remote areas;

ethical, privacy and legal issues which may arise with wide application of this technology and transfer of confidential patient information;

the development of standards for the coding and dissemination of medical information;

the feasibility of Australia becoming a regional or international leader in the development and marketing of this new technology; and

the implications of the wider development and implementation of medical practice through telemedicine for public and private health outlays, including the Medicare Benefits Schedule.

WITNESSES

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Health Information Management and Telemedicine

CANBERRA

Friday, 16 May 1997

Present

Mr Slipper (Chairman)

Ms Ellis

Mrs Vale

Mr Forrest

Mrs West

Mrs Elizabeth Grace

The committee met at 9.00 a.m.

Mr Slipper took the chair.

CHAIRMAN—Good morning. I understand one of our witnesses had a problem gaining entrance to the building this morning. I also had a problem gaining entrance to the hearing room. They seemed to have locked off all of the exits and every time I headed towards the door it was locked and I had to find another way, it was rather like finding one's way out of a maze. I would like to apologise to the witness who also had a problem.

I am pleased to open this public hearing on the committee's inquiry into Health Information Management and Telemedicine. This is the second day in Canberra since the commencement of the inquiry. This officially marks the end of the capital city round of public hearings and allows the committee to conclude the information gathering part of the inquiry before the final appearance of federal government witnesses next month.

The main issues to be resolved by the inquiry are: to establish an appropriate role for government in setting standards and guidelines for the evolving industry; to address issues of data security and privacy rights of patients; to examine the impact on the medical profession and the community generally of new procedures enabling medicine to be practised across state, national and international boundaries; and to look at the strength of current Australian knowledge and expertise in the area.

The committee has received a total of 130 submissions from a wide range of organisations and individuals. I would like to take this opportunity to thank all those who have made a contribution and whose cooperation has greatly assisted our efforts to come to grips with the complex issues being considered by this inquiry.

The evidence to be given today will provide a good opportunity to explore some of the key issues with a range of organisations based in Canberra. To assist us in this task, I now welcome representatives of the Australian Capital Territory government who are appearing before us today.

[9.01 a.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

ALI, Ms Louise Judith, Departmental Information Officer, Hospital Information Systems, ACT Department of Health And Community Care, Canberra Hospital, Yamba Drive, Garran, Australian Capital Territory 2605

LEE KOO, Mr Gordon, Executive Director, Financial Management and Contracting, ACT Department of Health and Community Care, GPO Box 825, Canberra, Australian Capital Territory 2601

CHAIRMAN—While the committee has already authorised the publication of the majority of submissions, I seek leave of the committee to authorise the publication of submissions No. 115 from the ACT Department of Health and Community Care, and No. 130 from the Consumers' Health Forum of Australia in the transcript of evidence at today's proceedings.

That being agreed, we would just like to place on record the trouble that Ms Ali had in entering the building. We will certainly make inquiries of the Sergeant and on the record, on behalf of the committee and on behalf of the parliament, I would like to express an apology to you for the discourtesy which was expressed to you this morning.

Ms Ali—Thank you.

CHAIRMAN—We have received your submission. We have looked at it very closely. We were wondering if you would like to give us a brief opening statement to focus our questioning.

Mr Lee Koo—I believe the value of information in the delivery of health and community care services cannot be overstated. We need information in our systems for clinical decision making, as well as for management of the health services. The ACT Department of Health and Community Care has undertaken a number of projects, some of which we have outlined in our paper to you, in relation to making the system more efficient and more effective by the timely provision of information. I guess that is what we have set out in our paper.

CHAIRMAN—The committee notes that you define Telemedicine as:

. . . a method for health care delivery where there is a geographical separation between a provider and a consumer.

Does your definition of Telemedicine include the gathering and management of health data and information technologically?

Ms Ali—Yes, that is correct.

CHAIRMAN—What role do you think the federal government should play in facilitating the expansion of this technology and usage?

Ms Ali—One of the things that we probably need the federal government to do is look into legislation into privacy, control mechanisms regarding the structure and configuration of network systems to enable areas external to the hospital to gain access to information.

CHAIRMAN—Is all this concern about privacy a bit of a furphy? Privacy is very important but, given the way in which medical records at present are found in compromising situations—on dumps and so on—maybe this is just a problem to be managed rather than a problem to thwart the advance of the technology.

Ms Ali—That is correct. I think the technology needs to be taken into account, particularly as that information has great benefits to the patient that may be being treated. There are benefits to the patient, but the patient needs to understand, and has the right to understand, that that information is going to be protected and not abused in any way.

CHAIRMAN—Could you outline Telemedicine trials in the Australian Capital Territory and how you have been able to share the results of those trials, if any, with other states and territories? Do you feel that we tend to be continuing along a program of pilots when we are really at a stage where we should be implementing the technology nationally?

Ms Ali—In the ACT at the moment, particularly at the Canberra Hospital, there is no real Telemedicine in its entirety. Teleradiology takes place, whereby information is transferred regarding ultrasound reports and those sorts of things. That is done internally in the medical imaging department. Telemedicine, with regard to watching operative procedures, is not under way.

The main issue for the Canberra Hospital is the clinical school and the ability to have information transferred from students at the university to students at work on the ground in the hospital. The hospital is reviewing the structure of the networking system to determine whether or not we are able to do it. There are problems with bandwidth that have just been taken into account in an RFO process with INTACT, who are our outsourcing organisation.

CHAIRMAN—Many medical practitioners seem to be quite phobic about technology. I know some of the medical schools are bringing in quite innovative courses, so future generations of general practitioners and other medical practitioners no doubt will be much more competent than their colleagues are today. Under 15 per cent of practitioners use technology in a clinical setting, a much higher percentage use it for administration. How as a nation should we approach this problem? Can we afford to wait until the older practitioners retire or do we need some kind of national strategy to educate

the profession, both for more efficient administration of the medical system and better health care?

Ms Ali—I can answer that. Having been a lecturer at a university and also on the ground implementing an optical disc imaging system in a large hospital, I know there is undoubtedly a phobia about using technology in the workplace. The biggest issue that we had—

CHAIRMAN—Some politicians suffer from it too.

Ms Ali—One of the things that we have gone through is intensive education. I hate to use this word, but it is a lot of ‘handholding’. It is being on the ground, being in outpatient clinics with—

CHAIRMAN—A good bedside manner.

Ms Ali—That is exactly right—a lot of promotion, a lot of marketing. Education is the biggest thing. It should really start at the university stage so that, when they hit the ground in the hospital, they already know how to use a mouse and a Windows-based system. They do not have that. We teach them once they get on the ground. We just have to hope they have used a PC.

Mrs ELIZABETH GRACE—You mentioned teleradiology. It sounds to me as if it is working only internally within the hospital.

Ms Ali—That is correct.

Mrs ELIZABETH GRACE—You are not using it outside.

Ms Ali—That is correct. We are unable to on the network set-up at this stage.

Mrs ELIZABETH GRACE—Do you envisage expanding that to work further afield by having people being able to access it from outside the area?

Ms Ali—We would like to. We have not set up a project plan for that at the moment. We are trying to get the network established so it is a possibility. Undoubtedly, it has been discussed as an opportunity that the hospital has to take.

Mrs ELIZABETH GRACE—Are there other Telemedicine—Telehealth—type programs starting or being used within the hospital at all in the ACT?

Ms Ali—Not at the moment. The only thing is that, to get the network up, our pathology area particularly is interested in doing that and some of the other very advanced practitioners are interested as well. So we will set up an interest group, once we are

assured by our outsourcing that the network can cope.

Mrs ELIZABETH GRACE—Has there been any interest in the area of telepsychiatry?

Ms Ali—I cannot answer that. I have not spoken to psychiatry.

Mrs ELIZABETH GRACE—They seem to be the main areas that we are noticing where there is a little bit of innovation and progression.

Mr Lee Koo—Certainly, in my time as a regional director of health in Queensland, in the Mackay health region, we were increasingly using telepsychiatry as you call it. Mackay did not always have psychiatrists. You would understand, if somebody had to be committed or whatever, we needed a psychiatric opinion and we did that in conjunction with a telelink with Townsville. It was increasingly coming in vogue when I left 12 months ago.

Mrs ELIZABETH GRACE—It seems to be an area that they are using it in quite regularly now, and it is very good, particularly in places like Queensland where we have the tyranny of distance to get from point A to point B.

The other thing that I have been interested in is that it has been put to the committee that a lack of professional indemnity is also a major barrier in preventing the practice of Telemedicine. What views do you have on that? Do you think the medical benefits schedule should be amended in order to take account of the practice of Telemedicine?

Mr Lee Koo—In terms of the medical officer, there is nothing like the personal touch. In my time in the Northern Territory—and hate going back to my previous employs—doctors would consult with Aboriginal health workers on the radio each morning and have to make a decision whether they should fly a patient out of a remote community into a centre. The doctor usually, on the balance of not actually seeing the patient, would generally fly the patient in.

Telemedicine would improve the situation somewhat because the doctor would be able to sight the patient, but there are still some flaws in not being actually able to talk to the patient and examine the patient more closely. So I think there is some limit there in terms of what can be done.

Mrs ELIZABETH GRACE—Is the indemnity side of it a barrier? Are people reacting—

Mr Lee Koo—It is a vexed issue, that comes also in respect of privacy and access issues. In that regard, I have brought along a discussion paper that was released by the

Chief Minister for the ACT on health access, privacy and records. The Chief Minister is looking to changes to the legislation for the ACT to more formally protect people's privacy and access and make it equitable for all areas of the health sector.

Mrs VALE—I would just like to ask you some questions on the development of standards. It has been put to the committee that the HL7 system is the appropriate national standard for hospital communications. Could you expand on exactly what the HL7 system is, just for the record? As hospitals are included in the information systems you are developing, are you using the HL7 system?

Mr Lee Koo—I will field the question to Ms Ali.

Ms Ali—HL7 is in use at the hospital, in particular for the patient master index, which is an ACT-wide initiative. As you are probably aware, each hospital generally has its own unit record number. In the ACT, a project was implemented to have one unit record number represent each patient across the territory. HL7 is in use for that system. HL7 is a software linking package that enables you to actually connect information between various systems. The PMI, patient master index, for Royal Canberra Hospital has been implemented. Calvary Hospital is to go on line this year.

Mr Lee Koo—And there is to be a linkage with that to the community health information system, which is currently being developed.

Mrs VALE—Will the standards that are being envisaged for telepathology and teleradiology comply with what is going on in other states? Also, has Standards Australia given advice to the ACT about the development of standards?

Ms Ali—We have not received advice from Standards Australia. We would undoubtedly ensure that any standards that we have in the ACT comply with those in other states so we are compatible. Otherwise it would defeat the purpose of trying to communicate with others, so undoubtedly we would review that.

Mrs VALE—Could I also ask you about the role of government? It has been put to the committee that a national coordinated approach is necessary if the benefits are to be realised from the introduction of a telecommunications technology to the Australian system. What do you think is the appropriate role which Australian governments can play in this emerging field?

Ms Ali—Certainly guidance and coordination on a national level to ensure that if one state does make a decision that other states are in agreement with that decision, particularly in regard to software standards and information exchange. At the moment, since Information Technology moves so quickly, everyone goes off and does something and then nobody communicates with anybody at all. Certainly internally in the hospital we have to grapple with that, so nationally it would be a lot bigger problem.

Mrs VALE—It is going to be a big problem, yes.

Ms Ali—The government would play a coordination role and establish and audit standards to ensure that everybody does comply with those standards.

Mr Lee Koo—There are, of course, national minimum data sets where we try wherever possible to keep our dictionaries very much the same so that on national reporting systems they are all reporting on the same thing. There are various national working parties under the Australian Health Ministers Advisory Council that look into those issues and they look at common coding systems and commonality of approach.

Mrs WEST—Mr Lee Koo, the submission notes that the information systems being developed in the ACT are designed to improve information management and overall productivity of health care delivery systems. Could you elaborate on the statement and discuss in which areas you see benefits and where the likely costs are likely to occur?

Mr Lee Koo—As I said in my opening statement, the information to inform the decision making process is essential in our health systems. Many of the initiatives we are driving these days need to ensure continuity of care and a continuum of care between the hospital and the other sectors in the health sector. For example, the coordinated care trial, which is a Commonwealth initiative with the states, is attempting to pool funding so that Commonwealth and state dollars are pooled. The coordinated care trial then provides an opportunity for GPs to determine a care plan for patients and purchase that appropriate care, unlike our current system where you have to actually access the system at many points. That project in the ACT will be up on 1 July.

Hopefully that will provide better care—not necessarily cheaper care, but certainly better care. The efficiency in the system, though, will be to cut down the administrative costs of tracking the people through the various entry points to the system. Also it is about letting people know about resourcing and what resources are available. It is about appropriate measurement. Casemix or diagnosis related groups is a prime measure these days in hospitals for both resource allocation and appropriate counting of patients. There are the PMI project that we talked about and the fax gateway project, which I think the Division of GPs might talk to you about later on today, where we are putting in a system to cut out a lot of the paperwork and to allow GPs with patient consent to receive details of patient submissions and case notes et cetera.

The issue for people in the public sector health services is that demands on the system grow year by year and far outstrip population growth. We need to find a way to manage that. We spend 8.7 per cent of our gross domestic product on health and I think that is probably all we are going to have in the near future so we need to find better ways of doing our job and providing our services.

Mrs ELIZABETH GRACE—The coordinated care project; is that one of the 11

pilots they have got going around Australia? Has the ACT scored one of those?

Mr Lee Koo—Yes, and our's will probably be up by 1 July this year.

Mrs WEST—The committee understands that insufficient cost benefit evaluations have been undertaken because an appropriate model has yet to be devised. Will the proposed systems be formally evaluated in order to identify costs and benefits? Has an evaluation model been developed as part of the overall strategy?

Ms Ali—Yes. We certainly do a cost-benefit analysis for every system prior to it going live. We have a standard that all information systems and information management projects go through prior to them being agreed by the IT committee. They are then staged and checked at every stage. Post-implementation audits are also done. In the case of the optical disc imaging system, we did a cost-benefit analysis prior to it going live to determine whether we had stuck to what we had originally agreed to. At the time there were some changes to those costing and we looked at why that came about.

Mr Lee Koo—That particular project that Ms Ali just mentioned is a very good project that is only running in the ACT. It is a project whereby paper records are scanned and held electronically.

Mrs WEST—Which one is that?

Ms Ali—It is called the optical disc imaging system or, as we call it internally, the patient record system. It is the first of its kind in Australia. It means that, when a patient arrives in the emergency department, their record can be called up on screen within seconds instead of having to wait 25 minutes, as we previously had to, for a paper record to be located, couriers to be found and records to be sent around. It is a more secure system. You cannot alter records and all of those sorts of things. It is very innovative.

Mr Lee Koo—As to your question on the benefit of cost analysis, you would be aware that, in most areas in health, determining cost is relatively easy. The difficulty is in determining what the benefit is and that comes down to how you measure quality of life, et cetera. It is very hard in our game to be able to determine that.

Ms Ali—There are a lot of hidden costs.

CHAIRMAN—It has been put to the committee that multistate registration of health care professionals would be desirable. I suppose one would include the territories within that term 'multistate'. Do you see that as being a realistic prospect or do you think that private interest groups in the various states and territories would prevent what appears to be a fairly sensible reform?

Ms Ali—I find that most health professionals regard compulsory registration as a

very good thing. I have not heard that there is anything contrary to that.

CHAIRMAN—I was not saying compulsory registration, I was saying that, at the present time, it is necessary for someone to be registered in, say, the Australian Capital Territory and then in each of the other states and territories if one wanted to practice everywhere throughout Australia. Many people would not bother but I understand that it is fairly automatic that one gains an interstate or interterritory registration but of course there is a cost involved. How would the ACT government view the prospect of national registration of medical practitioners?

Mr Lee Koo—Without speaking for the ACT government, because I have not asked the Minister for Health what her view is, it is my experience in Queensland and in the Northern Territory that, while there are not a lot of problems gaining interstate registration, it certainly is problematic in terms of paying the registration fee for each of the states that you are registered in.

CHAIRMAN—Exactly.

Mr Lee Koo—Of course, the other major issue is people from overseas gaining access to our registration, and how that has applied across states and territories.

CHAIRMAN—I think the government has endeavoured to restrict oversupply through use of medicare provider numbers. The Commonwealth clearly does not have any control over registration. But, with Telemedicine, often involving medical imaging across state and territory borders or possibly even across international frontiers, this is something we are going to have to look at, particularly when one considers liability questions.

Ms Ali—Undoubtedly.

CHAIRMAN—The submission mentions a number of information management systems, one of which is PMI, which proposes to use a single patient identifier for all clients. Will that be the Medicare number or is another number envisaged as the patient identifier?

Ms Ali—No, it is another number. It is called a unit record number. Due to the structure in the ACT, and since the Canberra Hospital is the largest hospital, most of the population in the ACT already had a unit record number at the Canberra Hospital. That number is a eight-digit identifying number that is used across the territory.

CHAIRMAN—Why would you not use the Medicare number?

Ms Ali—Mainly because of the logistics in changing current information systems and paper that held the original number. It was the most cost-effective measure.

CHAIRMAN—Do you feel that there is an adequate pooling of results of pilot trials in Telemedicine? Or do you think that, for various research reasons, universities and others tend to sit on the knowledge that they have gleaned so that, across the next border, someone else carries out the same pilot at great expense?

Ms Ali—I cannot say personally; although, I have heard from those who have been involved that that is the case, and that they find it difficult to gain access to information that may have benefits for the patients that they are treating.

Ms ELLIS—The ACT health system, because of its location in New South Wales, serves a fairly large geographic area. Do you have an idea of the numbers of referrals that come into our health system from our outer regions? Can you outline the size and description of the region that the ACT health system interacts with?

Ms Ali—The Canberra Hospital serves about 330,000 people in the ACT and a further 200,000 externally to the ACT, so that would include about 200,000 in the New South Wales area.

Ms ELLIS—What areas do they come from?

Ms Ali—They come from the coast areas, from Batemans Bay, from Wagga, Temora and those sorts of areas.

Ms ELLIS—So it goes as far as Wagga?

Ms Ali—Yes, it does.

Ms ELLIS—So in excess of 200,000 a year come in from those regions?

Ms Ali—That is correct. That is the catchment area.

Ms ELLIS—Do you know how many are serviced by our health system?

Mr Lee Koo—The exact figure escapes me but I think 20 per cent of our admissions to hospital are from New South Wales.

Ms ELLIS—Do you have any idea of the sorts of medical reasons that they come here?

Ms Ali—The majority of them are trauma cases. Others come for haematology, the treatment of cancer, medical oncology and radiation oncology.

Ms ELLIS—I notice from your submission that the general practitioners are currently going through a pilot program of some kind. But there is no such pilot program

or similar thing being done by ACT Health at the moment in relation to Telemedicine, outside of the information systems; is that right?

Ms Ali—That is correct.

Ms ELLIS—Can you see benefit in the inevitability that we are going down the track, as a community at large in Australia, of Telemedicine of one sort or another? Given the geographic location of the ACT, and given that we now have the clinical school here and an almost brand new hospital getting improved services all of the time, what is the prospect of ACT health involving itself, sooner rather than later, in the development of Telemedicine in this region?

Ms Ali—As I mentioned, the hospital is at the stage of looking at our network and our infrastructure so that the hospital can partake in Telemedicine. As you mentioned, the clinical school is one of the major driving forces in that at the moment. With the outsourcing of operation support and IT, through INTACT in the ACT, they have gone through a RFO process and that is one of the key factors in the selection.

Ms ELLIS—Are you in a position to say how far down the track, in terms of time, the ACT health system would be in having a Telemedicine pilot or project?

Ms Ali—I cannot really give you a time, apart from the fact that, in order to ascertain and keep security of the systems at the Canberra Hospital, we need what is called a fire wall installed on our information system structure. There is a meeting today to discuss that and we will probably commence with that in the next few months. Once that is installed, then we can actually look at timing for Telemedicine.

Ms ELLIS—Can I be bold enough to suggest that, given the speed of movement in the Telemedicine area that this committee is finding as we travel around, there is an impetus from several different directions. Also, the ACT's position is that it may be worthwhile for the ACT health system and government to consider quite seriously whether or not it wants to participate actively in this before it gets rolled over by the major centres in Sydney. Do you have a comment to make on that?

Mr Lee Koo—My comment is that on the information systems front we are advancing in a number of areas. The government in its recent budget committed \$4 million over the next three years to a community health information system. Throughout Australia there are not many, if any, good community health information systems operating. That also will be linked via the PMI to our total system. So there is a \$4 million investment there. We have other investments in IT currently proceeding and bringing Calvary Hospital on to the PMI is one of them. The GP access program is another.

Ms ELLIS—That is the pilot one.

Mr Lee Koo—Yes.

Ms ELLIS—How long is that going to run?

Ms Ali—It is actually to commence and go live on 10 June. That will be in full operation. From there we actually hope to review it in so far as that looks after emergency patients only. With the optical disk imaging system there is the availability for us to do it with all in-patients as well and to be able to fax off a discharge summary through that system as well.

Mr Lee Koo—Like anything else, Information Technology costs money and we are attempting to get our own house in order at this stage and make the appropriate linkages throughout our system while still guaranteeing privacy and access. Telemedicine is another project that is on the drawing board, but we have not advanced too far yet.

Ms ELLIS—Can I just say for the record that I am not being critical of any of those processes. But, given the speed that things tend to be going along, I would hate to think the ACT region lost an opportunity. I am not critical of the process.

Mr Lee Koo—Yes. That speed is evident in most areas within our health system, not only Information Technology. One cannot always keep up in every area. For example, in late July there will be cardiothoracic surgery available in the Canberra Hospital and previously we would have had to send people to New South Wales.

Ms ELLIS—Yes, I understand.

Mr Lee Koo—We are gaining a few super specialities at the Canberra Hospital and we no longer have to have our people going to Sydney or whatever, even though it is not very far away.

Ms ELLIS—It is a long way if you have to visit someone in hospital.

Mr Lee Koo—That is true.

CHAIRMAN—Are there any further questions? Is there anything else you would like to tell the committee by way of summary?

Mr Lee Koo—No.

CHAIRMAN—Thank you very much for appearing before the committee this morning. We will send a draft of your evidence for you to check. I want to place on the record that after morning tea we will have with us some representatives from the Indian Rajya Sabha, the Indian parliament. These people are: Mr Joshi Naresh Chandra, the director/supervisor, research and library services, sales and archives unit; Mr Singh Anand

Kumar, executive officer responsible for administrative matters, court cases and disciplinary proceedings; Mrs Vanjula Govinda Rajan, executive officer responsible for general administration of the secretariat team; Mr Garg Surinder Kumar, senior parliamentary reporter responsible for the supervision of the reporting function of the parliamentary proceedings; Mr Devi Dass, undersecretary/manager, parliamentary secretariat, dealing especially with parliamentary questions, salary allowances and per diems for members of parliament; and Mrs George Agnes Momin, undersecretary for accounts and general administration in the secretariat. I will formally welcome those visitors later.

[9.36 a.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

FRANK, Mr Ian Bjarne, Executive Officer, Australian Medical Council, 13 Napier Close, Deakin, Australian Capital Territory 2600

KALUCY, Professor Ross Stewart, Deputy President, Australian Medical Council, 13 Napier Close, Deakin, Australian Capital Territory 2600

McINTOSH, Dr Angus John, Member, Australian Medical Council, 13 Napier Close, Deakin, Australian Capital Territory 2600

CHAIRMAN—Welcome. We have read your submission and we thank you very much for it. Would you like to summarise some aspects of it or elaborate slightly to focus our probing questioning afterwards?

Prof. Kalucy—The main point we wish to make is that we have come to see, both from personal usage and through the people we have talked to, that Information Technology can be a very valuable addition to the practice of medicine in this country both for rural and remote sectors, across state boundaries and within large cities. It also, obviously, has a major international potential which is partly being realised already in Australia.

Its potential is both for clinical practice and for education and training. In some states such as South Australia and in the Northern Territory it is actively used for the supervision of trainee registrars, for example, in psychiatry and medicine and surgery. So we have no doubt about its value and its potential and we can easily see that it will also have important economic potential for the country.

I should explain that the Australian Medical Council consists of a representative, which so far has always been the president, of each medical board of each state and territory, it has representatives of the Australian Vice-Chancellors Committee who are deans of medical schools, it has representatives of the Australian Medical Association and of the royal colleges so that it brings together that body of people. Its particular interests in this case are in the medico-legal issues.

CHAIRMAN—How many members are there in all, Professor?

Mr Frank—Seventeen.

Prof. Kalucy—The major issue as we see it is to develop a regulatory and standards framework that would allow this to develop whilst at the same time protecting the community of patients and the community of those who are being educated and supervised.

We make a distinction, as you have noted, between remote medicine, which means the transmission of materials such as pathology specimens for interpretation across states, and Telemedicine which is the direct interaction and usually an assessment, although it could be a treatment, at a distance.

The first issue we would draw to your attention is that state medical acts in Australia do not all define what a medical service or treatment is, and that will become necessary. You may wish to look at the current ACT medical act which has the advantage of having been drawn up recently and therefore has a more contemporary feel to it. Its definition of a medical service I think is probably the best in Australia. Many of the other acts direct attention to what doctors can do and what is a medical condition that only a doctor can treat. It does not define a service, and we think that will be necessary.

I draw your attention to the fact that the medical boards in Australia are responsible for registration of doctors. Registration in practice and not just by implication means that standards are applied to qualifications and to ongoing practice and to disciplinary matters. All medical boards are open to receive complaints and to pursue disciplinary matters in relation to unprofessional conduct and unethical conduct.

We have a system of mutual recognition in this country which was introduced so that doctors could cross state boundaries and, if they are registered in one state, that registration will apply in a second state. They merely need to inform the registering board in the second state that they intend to practise and they are issued with a licence to practise.

CHAIRMAN—Is there a payment of a fee?

Prof. Kalucy—Yes.

CHAIRMAN—What fee?

Prof. Kalucy—It varies from state to state but a range might be \$150 to \$200.

Dr McIntosh—We are less than that. We are \$125 at the moment, but we will try to catch them up.

CHAIRMAN—Is that competitive federalism?

Prof. Kalucy—Tasmania, for example, is \$200. I think that would be the highest.

Dr McIntosh—Yes, it is.

CHAIRMAN—And that is an annual fee.

Prof. Kalucy—Yes, that is an annual fee.

CHAIRMAN—Actually, you are the people we have been waiting for because quite often we have been asking people whether a national system of medical registration would be sensible. A lot of people say ‘Yes’, but suggest that the medical boards might seek to frustrate what to us seems to be an obviously sensible reform. I am going to ask you: do you believe that there should be a national system of registration? You have pointed out it is quite easy to gain interstate registration, but at a cost.

Prof. Kalucy—You have chosen the ballpark to play in by saying it would frustrate. This is a thing that has been debated very seriously within the AMC. I think the general feeling is that the acts under which the boards work in each state do differ—the populations differ, and their needs differ. To date it has been felt that it works, that the most satisfactory solution is to have separate acts with separate registry authorities, but to have a central what is called an NCMR—I have forgotten what it stands for.

Mr Frank—The National Compendium of Medical Registers.

Prof. Kalucy—That is held by the AMC on behalf of all medical boards and it allows for a very important fundamental purpose—that is, if a doctor transfers, say, from New South Wales to Victoria, any conditions that apply to that doctor’s registration or any constraints or undertakings or disciplinary actions that have been engaged in transfer with him, and the rules that are applied to that are applied by, certainly in this case, Victoria.

CHAIRMAN—I understand that you have tried to ameliorate the situation as much as possible, but what advantages for the nation can you tell us exist in having separate territory and state registrations? How do we gain as a nation?

Prof. Kalucy—I will tell you what it feels like. What it feels like when you are a president of a medical board, running a board, and you are trying to deal with a problem that is in Queensland, it is extremely difficult because an awful lot of it relies on investigation and inquiry and so on. We just find that very hard, so we have found it easier to deal with it within our own states, with our own expertise and our own experts. That is what it feels like.

Dr McIntosh—There are also an enormous number of other acts that come into this—poisons acts, mental health acts. All of these are state based and you cannot have agreement between the states on how these should be changed or managed. You cannot write Schedule 8 drugs unless you are registered in that state to prescribe them. A national register would be very difficult.

CHAIRMAN—Would it not just be a question, though, of altering the regulations to say, ‘A medical practitioner, registered according to the national registration of Australia, is able to carry out these functions in each of the states and territories of

Australia'?

Dr McIntosh—If the states would alter a lot of their legislation. The Commonwealth's legislation overrides, but it still has to have cooperation in implementation in the states.

CHAIRMAN—In matters that are a state responsibility, certainly. I think it would be impossible, without entering into some obscure treaty, to force a national registration without a cooperative effort. We do have a standing committee of health ministers and other national health peak bodies, such as your own. It seems to me that it is something that ought to be addressed. You have already told me that it is possible to be registered in different states just by the payment of a fee. It seems to be a problem that ought to be solved. Or are you advocating the maintenance of the current situation?

Prof. Kalucy—It is an unfolding one. It took us, the various states, AHMAC and all that group something like six years to get mutual recognition in place. To get changes in the acts that apply to it often takes between 10 and 15 years. It is a very slow and difficult process. This step does ameliorate the situation. For us it seemed like a bit step forward. I would not be surprised if eventually there is some kind of national register. I would think that is probably 10 or 20 years down the track.

CHAIRMAN—With the use of Telemedicine crossing state and territory boundaries and increasingly even international boundaries, what do you see the implications being in the area of liabilities?

Prof. Kalucy—We believe that it will start by those doctors that are involved being registered in each state that they work in. We believe that eventually regulations will come into play which will ameliorate the cost of that for the doctor. The question of liability and indemnity is a very difficult one. Probably the best way to go would be if the doctor is involved in remote medicine—they are providing, say, a pathology service—and they do something which is unprofessional, they would be liable in the state from which they work.

Where they are involved in Telemedicine and are providing a service to a patient and something unprofessional happens, we would think that the patient would most likely complain to their own state board. Therefore, that doctor would be liable in the state to which the service arrived and in which the patient lives. That would be the easiest way of doing it.

CHAIRMAN—It could be like the legal situation where you can be sued where the contract was made or at either end in certain circumstances. It is something that has to be addressed. You mentioned that there were substantial economic advantages to the country from Telemedicine. Clearly, that might involve, in the longer term, images being sent from countries in South-East Asia or elsewhere to Australia. I imagine that you could

have liability questions there. Are you suggesting that the doctors might have to be registered in, say, Malaysia and Singapore as well as Australia?

Prof. Kalucy—Not all South-East Asian countries have a registration system. Indonesia does not, for example.

CHAIRMAN—Can anyone go up there and be a doctor?

Prof. Kalucy—I do not know the answer to that, but I know that they do not have a registration system.

Mr Frank—There is no formal register of medical practitioners as we understand it here. They have a method of licensing, but it does not involve the disciplinary and the oversight capacity that you have, say, in Australia or the UK or North America.

Ms ELLIS—I was getting worried that you were about to leave for Indonesia and don the rubber gloves, Mr Chairman! I want to ask about pilot projects. The committee notes from your submission that you were unable to discuss the status of technical developments in the area of health generally. However, in your introduction you make a number of observations about the capacity of advanced technology to substantially alter the delivery of medical services. If the AMC has no information about pilot trials being undertaken around Australia in Health Information Management and Telemedicine, could you discuss with us on what basis you make your assertion that technology will substantially alter the delivery of medical services?

Prof. Kalucy—I am surprised that we said it in quite that way, if that is the way we did say it. I do not doubt it.

Ms ELLIS—I was going to clarify it for you if I could.

Prof. Kalucy—I will speak personally. South Australia is a leader in this area and we have a huge amount of experience in Telemedicine on almost a daily basis from, say, Adelaide to the riverland, Whyalla, Darwin or Alice Springs, as treatment modalities for the exchange of information about X-rays or pathology, for teaching and supervision. I will give you a simple example: my university is setting up a clinical school in Darwin. We do almost all our work on Telemedicine and that saves hundreds of thousands of dollars in air fares. It is just so simple.

Mr Frank—To clarify that point, the Australian Medical Council itself is not directly involved in the provision of medical services, so the point about that was that we ourselves are not involved in any of those projects.

Ms ELLIS—As a body.

Mr Frank—Yes. Members of our council in other guises—as Professor Kalucy has outlined—are involved in some of those things and we are aware of their existence, but we could not provide or furnish the information to this committee on those particular projects.

Prof. Kalucy—I just make the point that we have set up a working party, all the members of which are very actively involved in this area, and we will make sure that the AMC continues to be briefed about it. But our brief, within the AMC, is to try to steer the medicolegal issues.

Ms ELLIS—I understand. On that point, Dr McIntosh, I think you said earlier that you are the head of paediatrics at Royal Canberra Hospital.

Dr McIntosh—Yes.

Ms ELLIS—I asked a similar question of ACT Health when they were here earlier this morning: given the geographic situation the ACT finds itself in, and the fact that they said about 20 per cent of hospital admissions are from out of the ACT, from New South Wales, per annum—we have a catchment out of the ACT of 200,000 or more—given that your area of specialty is paediatrics, do you have a view as to how Telemedicine established in the ACT could assist in particular in your area of speciality? I do not believe we would be lucky enough to have a paediatrician in every one of the remote cities or towns around us.

Dr McIntosh—You have probably unfortunately picked one of the groups that would find it very difficult to be effective in Telemedicine, other than perhaps to facilitate a transfer of a person. One of the biggest concerns that we all have is who has the clinical responsibility once the Telemedicine project is up—in other words, who has the ongoing care of that patient? We would be situated in such an area that what Telemedicine would do for us is say that that child should come into a major centre. The actual management of that child would only be on an acute emergency basis, whereas, with psychiatry and some of these other modalities and other conditions it would probably be more therapeutic.

It does present that sort of problem. Telemedicine is at the moment being run from the new children's hospital at Westmead. They have a Telemedicine set-up with two base hospitals in New South Wales, Dubbo being the main one. The paediatrician there will seek advice from subspecialists in Sydney. That is not quite what Telemedicine has looked at from a practical point of view of determining services in this country; we are looking at more remote areas where there are not appropriate medical services.

The big problem then is Telemedicine, which is directed by a bush nurse or a lay person, diagnosis and treatment is initiated, but then the question is: who has the responsibility for ongoing care and what happens then? That is a very big problem that—

Ms ELLIS—The committee, on one of our visits—and I cannot remember precisely where we were—saw a video Telemedicine link with a paediatrician at one end, if I recall correctly, and a young lass of about eight or nine at the other, whose physiotherapist was seeking assistance in further treatment. It was purely diagnostic and purely in the sense of offering further advice and treatment for the child, rather than the child being brought in from a remote area. That is what you are actually getting at, is it not?

Dr McIntosh—Yes, it depends what you use it for. We are using it mainly for remote areas to help in two ways: one is consultative and giving advice about physio, but for the treatment of a sick child it would be about how quickly you should get that child to somewhere and how you should get it there.

Mrs WEST—On costs and benefits, you state in your submission that Information Technology has the potential to reduce the costs of providing medical services. The committee has been unable to determine the costs and benefits of deploying advanced technology in the Australian health system, apparently because an appropriate cost-benefit model has not yet been devised to allow that analysis to be undertaken. Could you elaborate on your statement by discussing in which areas of health care you think the savings are likely to be made and advise the committee on what evidence you base your assumption?

Prof. Kalucy—An example I could give is rural psychiatry. In many places if a patient is disturbed and thought to be out of control they may need to be detained for their own protection, or for the protection of others. In many states that means that they have to be transferred to a hospital which is accredited to look after detained patients; they cannot stay where they are. I cannot give you the exact savings on this, but they would certainly occur anywhere in South Australia, Queensland or Western Australia—the federal government has in fact put money into pilot projects to look at these kind of questions.

What is happening now is you now get a ring and Telemedicine contact from, say, Port Augusta or Ceduna. The patient is there and the doctor is there and we are at this end. We help them to assess it and it is quite common to say, 'I think that it would be safe to look after that patient for 24 hours and we will reassess in the morning.' Before, you transferred them to Adelaide. The savings in that are enormous because it usually means either an ambulance has to bring them or police have to bring them.

It means in terms of quality of care that they are removed from their own relatives and their own doctor. Quite frequently they are only in Adelaide, as in this case, for two or three days. It is not uncommon for them to have to be transferred by aeroplane or helicopter if they come from the far north of Western Australia or from Kangaroo Island, for example. That is a very big expense and probably one third of them are unnecessary—no, not unnecessary, but they could be prevented. That would be one example.

Dr McIntosh—There is a very extreme example. The Arab Emirates used to fly people to the United States for various medical interpretations, tests and procedures and I understand that cost about \$26 million a year. The Cleveland Clinic in the States has set up Telemedicine to go to several of the Arab Emirates and they have cut the cost to \$5 million.

Prof. Kalucy—We did bring something with us that you might like to look over. It is the evolution of telepsychiatry in South Australia which does go into some of the issues you are raising. You may wish to have that.

CHAIRMAN—If you could pass that on to the secretary we would appreciate that.

Mrs ELIZABETH GRACE—Being from Queensland and having spent some years living in country Queensland I have a rather interesting link and desire to see remote and rural areas looked after in this area. Having lost a babe as a result of being in country Queensland, I have a very personal interest in it.

You mentioned in your submission the ability to deliver high quality medical services to rural and remote areas that do not currently have these services and you feel Information Technology and Telehealth would be very helpful in this area. Would you like to comment on the view put to the committee that the advanced technology may not be able to address the so-called tyranny of distance as many of us would like to think? I am probably looking along the lines of ignorance of the technology that is available and in the inability to use it.

Prof. Kalucy—If I am not answering your question, will you stop me? Obviously, it is the case that not all of medicine can be practised by Telemedicine. That is self-evident. We are addressing the fact that many good things can be done on Telemedicine which would enhance the safety of the rural community and certainly improve the quality of their assessments and, where they required admission, the quality of their admissions and the quality of their discharges, which is very important if you are going home. That is the first thing.

As for the issue of the technology itself, if you are saying that it is because it is too complicated, that is not true. It is very, very simple. Just in a personal sense, I am very backward in computer technology and I find no trouble using it whatever. It does not need huge advances from here. You know how people who play with the stuff love to improve it every day, but what is there at the moment is good. You could do this whole committee on Telemedicine perfectly comfortably, just as you could a consultation. The technology is very simple.

Mrs ELIZABETH GRACE—Therefore you feel it is something that, given our vast distances in Australia, could end up being possible?

Prof. Kalucy—There is a pilot project that has just been funded in the Toowoomba area, which will look at some of those issues, but North Queensland would be one of the really high priority areas for this, as would the north-west coast of Western Australia and that kind of circle that takes in Broken Hill, Mildura, Alice Springs and northern South Australia. Those areas would greatly value that. Obviously, it is not going to stop their ambulance being needed and all those things. They will all be needed, but this would help.

Dr McIntosh—You would use your resources more effectively, rather than solve all your problems. If somebody at one end of a remote area wants some help, advice and treatment and can implement that, then this is going to be an enormous advance. However, if you have to move that person, it is not going to make all that much difference.

Mrs ELIZABETH GRACE—I have one other question. Have you gentlemen thought about what this should be called? We get ‘Telehealth’, ‘Telemedicine’, ‘remote medicine’ and all sorts of comments. Have you people thought of something that we might be able to use as a uniform comment that would cover that whole spectrum of what we are trying to look at?

Prof. Kalucy—We have not really. We just use ‘remote medicine’ for one definition and ‘Telemedicine’ with the other. It is not a bad thought to think about using the word ‘Telehealth’, because that does encompass education, primary health care, public health endeavours and so on, which in the outback would be very relevant. It is not a bad thought, but we have not debated it.

Mr Frank—One question Mrs Grace raised concerned the question of the familiarity of the technology. The AMC has another role where it accredits medical schools in Australia. It reviews and accredits undergraduate medical courses for people coming out for registration purposes. We are aware of the fact that all of the medical schools in Australia for some time now have very active programs involving students with the Information Technology that is around.

All of the medical schools are producing graduates now that are more at home with the Information Technology than perhaps their predecessors were. As Professor Kalucy has outlined, in at least one case the actual teaching itself for those students is undertaken using the technology. There is a group coming out into the medical work force that will be far more at home with this type of technology than was previously the case.

Prof. Kalucy—Would it help you to have an exact example of what it looks like to use Telemedicine? Would that help you or not in terms of the questions you are asking? I do not mind. I am just asking whether that would help.

CHAIRMAN—What were you suggesting?

Prof. Kalucy—I was going to tell you of a case that I was involved in.

CHAIRMAN—Please do.

Prof. Kalucy—We had a ring from the Riverland concerning a woman in her late 40s who was said to be acutely psychotic and we were assessing her for detention. When we looked at the lady on the screen, she was psychotic in the sense that she was hallucinating and delusional. But what became obvious was that she was also very confused in a fluctuating manner. In other words, she was delirious.

Delirium is not the same as the sort of psychosis that these people had thought it was. We said that what she needed was a physical work up first, before she was transferred, because we thought there was a chance of a number of things being wrong. That was done in the next half hour. She had major abnormalities of her serum electrolytes—the salts in her blood—and when they were corrected she was not psychotic anymore. That is a very powerful example. That lady's health would have been jeopardised by the six-hour drive from the Riverland to Adelaide—there is no question about that. That is the kind of thing we are talking about, if that helps you.

Mrs VALE—Yes; and that is a phenomenal benefit not just in cost, but also in human terms. I would like to ask you two questions, one on health insurance and the other on the role of government. As the committee understands it, the medical benefits schedule would need to be amended in order to take into account Telemedicine or Telehealth. Would the AMC like to comment on this point and discuss the question of professional indemnity for multidisciplinary telecommunications or teleconsultations?

Prof. Kalucy—Can I make a prior point, that the experience that we are having in South Australia is that the value of the consultation is greatly enhanced if you have got the general practitioner of the patient at the other end as well as the patient. We are saying it works better like that. It is clearly a problem if the psychiatrist, in this case, but it could be the ophthalmologist or the pathologist or the respiratory physician, cannot charge for their services and the GP as the other end cannot either. In the public hospital system, where most of the Telemedicine is and most of the consultants are, that is not an overwhelming issue at all; but for the general practitioner to take an hour for Telemedicine for which he or she cannot be paid, that is a real issue and that must be solved.

On the indemnity issue, we have done a study in my department, by Michael Baigent and Fiona Hawker, where we compared direct interview with Telemedicine interview under three or four different settings. It showed that, from a diagnostic and assessment point of view, there was no jeopardy in Telemedicine. Obviously it is not as perfect, but there is no jeopardy. So the indemnity issues would arise in the same way as it would from a direct face-to-face contact: it would arise because the patient believed that the wrong thing was done and could demonstrate that in court, or there was incompetence or unethical practice. How you go about indemnifying both ends and changing the

medicare act to look after both ends is a very difficult problem. But if you want the best service, you will need somebody at both ends.

The multidisciplinary issue in practice does not seem to be a big problem. In general terms, the doctor is taking responsibility for the patient. As you are well aware, it is the doctor who usually ends up being sued, no matter who made the mistake—and whether that is fair or not is another question. But that does not seem to be a big issue.

CHAIRMAN—It might be an issue for the doctor.

Prof. Kalucy—Yes it is.

Mrs VALE—I would like to ask about your perception of the role of government, because apart from assistance with funds there seems to be a need for coordinating and monitoring the role of government in the development of health Information Technology and management. It has been put to the committee that a national strategic approach with inputs from all governments and the various stakeholders is also necessary. Would you like to comment on the nature of policies which governments should pursue in this area? Is there a role for government as a facilitator as well as a coordinator?

Prof. Kalucy—Yes, definitely. I think if the government does not do it, nobody will coordinate it, and there are major matters of law in this country and of international law which will have to be addressed and which will be thrown up by this as it unfolds. A second area where government can be absolutely fundamentally helpful is in addressing issues like the fact that there are different mental health acts in every state, there are different poisons acts, and the privacy legislation in each state is different. We have solved that problem for registration, but what about when you are doing Telemedicine and all these other things from time to time stand in the way of the practice, of what is in the interests of the patient? If government does not try and do something to coordinate that we will have problems.

Mrs ELIZABETH GRACE—Is it necessary for each state to have a different act for mental health or for poisons or for other things, or can we start to pull the state health departments together to try to get uniform legislation in each state, a bit like we are getting uniform road regulations in each state so that it does not vary from state to state? Is there an impediment there to stop that?

Prof. Kalucy—There are two points I would make about that. One is that, if you are asking me personally, I find it bizarre that we have all these things. I am sure that I do not need to tell any of you that to try to get the states to all agree on something is a monumental task and one which is grossly unrewarding. If you made that your prior condition for getting things done, then it will be forever.

There are a couple of areas where you probably could make more progress than

others. For example, we really missed the boat with privacy legislation. The federal Privacy Act came in and it could have been the model for every state. It was delayed by a year, and two other states brought in their privacy legislation and they are in conflict. I would have thought that would be one which would be fairly readily addressed.

The poisons act is broadly the same in every state except for little bits which could probably be dealt with. There are only a few things in different states that are so fundamentally different that they need their own clause. That often relates to environmental issues and toxicology. There is no logical reason why you would have a different mental health act in each state—there is just no sense to that. It just happens to be there. That can be a genuine impediment. I would guess that that is one area where the states would argue forever because they have different views about civil liberties and suchlike, and arguing those through would be an enormous task.

Mr Frank—There is an even more fundamental problem here as well. The AMC was involved in the mutual recognition developments in 1991 through to 1993 when we were trying to get this system implemented across the country. We found that, even if you had agreement amongst the state health ministers, for example, and the medical boards for uniform terminology, the effect of the appeals court system in different states interpreted certain words in particular ways which meant that when you tried to draft the legislation you could not use the same term right across the country. So there was a barrier that nobody had thought of. Everybody agreed—heads of government agreed, health ministers agreed, the medical boards agreed, but we had not thought about the problem of the appeals committees.

Mrs ELIZABETH GRACE—Perhaps we should go back to Latin.

CHAIRMAN—Thank you very much for appearing before the committee this morning. We greatly appreciate your attendance.

Before I adjourn for morning tea, I would like to formally welcome our visitors and officials from the parliament of India: Mr Joshi, Mr Singh, Mr Garg, Mr Dass, Mrs Vanjula and Mrs George.

We are currently undertaking an inquiry into Telemedicine, which is a fairly interesting inquiry. The secretariat of the committee may have mentioned a little bit about that to you. This committee is a social policy committee which covers the Departments of Health and Family Services, Social Security, Veterans' Affairs and some of Migration and Youth Affairs. We undertake inquiries referred to us by the responsible ministers. The area covered by this committee covers about half of total Commonwealth budget expenditure.

You are very welcome. I hope you meet each of our members individually over morning tea.

[10.30 a.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

HUDSON, Mr Anthony David, Strategic Account Manager, Optus Communications Pty Ltd, 10 Moore Street, Canberra City, Australian Capital Territory

SMITH, Mr Richard Ian, Manager, Representation and Industry Development, Optus Communications Pty Ltd, 10 Moore Street, Canberra City, Australian Capital Territory

TWEEDIE, Mr Bruce, Project Manager, Corporate and Government Division, Optus Communications Pty Ltd, Canberra City, Australian Capital Territory

CHAIRMAN—Welcome. Thank you for appearing before us today. I would like to mention that we have in the gallery, from the Upper House of the Indian parliament, some officials who are studying our committee system, so no doubt you will go away having made a very good impression on them. We have got your submission, circulated it, read it, digested it and enjoyed it. I was wondering if you would like to make a brief opening statement of about 30 seconds to tell us about the better elements of it.

Mr Hudson—Thank you very much. Optus believes that there are substantial opportunities for both business efficiency savings and marked improvements in the quality of service delivery. In our submission we really touched on a limited subset of the terms of reference, notably the terms of reference (3) and (6).

In essence, our view was that, firstly, due to the convergence of business activities across the various industries, it is important that the health industry adopts appropriate data security standards that facilitate the range of electronic business activity and not be solely restricted to the health industry. We believe that government has a role to play in facilitating that. Secondly, recognising that there are inherent efficiencies to be gained from Telemedicine based applications, we feel that it is important that this gained value be fairly apportioned across the value chain, to ensure that appropriate business incentives accrue to all elements of that business chain. Thirdly, we feel that government has a role to play in incentives for developing of services to speed the uptake of Telemedicine.

CHAIRMAN—Thank you very much. The committee has inspected the TARDIS project, which involves your arch-competitor, Telstra, and the Royal Brisbane Hospital and certain other hospitals in Queensland, the Sunshine Coast and Maryborough. Has your company been involved in any similar pilot project?

Mr Tweedie—No, not really. We are looking at pilot projects. I guess pilot projects is a difficult area. There have been a number of pilot projects that we are aware of that have resulted in people investing a fair amount of time and money, but it is quite difficult to see the commercial benefits that can arise from some of those things. Clearly,

we believe there will be commercial benefits in the long run, and also benefits to the community. There are difficult problems for us in that area. One of them is that there are so many pilot projects across Australia that it is difficult to know which ones we should get involved in. It is also very difficult to try and pick the winners, as it were: to figure out which ones would be of lasting benefit.

CHAIRMAN—I think you highlighted the problem: we seem to be doing lots of pilots throughout the country. In many cases, pilots are duplicated in different parts of the country. There seems to be an inadequate sharing of material and evidence from those pilots. In some cases, however, pilots appeared to have worked; and maybe we should be going beyond the pilot stage. It seems that perhaps Optus is prepared to sit by the side of the road and watch Telstra pioneer it and then later you might come in and achieve some commercial benefit.

Mr Tweedie—That is possibly an extreme statement. I think that Telstra has been around longer than we have. That is clear to everybody. Certainly, Telstra took some initiatives in the pathology industry in Queensland some years ago, and Optus was in no position at that point of time to participate in those. We were not a mature enough company. It is quite possible that we will benefit from those things. We certainly do not have a deliberate stance on that. We are certainly contemplating some suggestions to get involved in a managed care pilot, in particular, and in several other things where we have been invited to join consortia.

CHAIRMAN—I have no bias against Optus, my own telephone is with Optus, but I believe we have a number of world-class telecommunications companies in Australia and the only reason Telstra is as good as it is is because of the competition that Optus and others have brought. But I thought it was rather a clever move to let Telstra bear some of the costs of pioneering this technology and then you could come in with projects and benefits subsequently.

Mr Hudson—I think the primary reason that we have not been involved to date in pilots is as Bruce said; it is an element of maturity. Our health industry group, as such, as a stand alone unit really has only been effectively in operation for something like 12 to 18 months and, given the complexity of the health industry, it has taken us quite a deal of time to understand the issues. We certainly believe that we are at that stage now. We are actively progressing in a number of public areas such as Medclaims today, which are somewhat simplistic Telemedicine applications but they tend to provide major business benefit, particularly to general practice and to the government.

CHAIRMAN—I have just one other short series of questions. Mr Forrest, who is another representative of rural and regional Australia, will then ask you some questions concerning rural matters.

The committee understands that both your company and Telstra are rolling out parallel broadband cables. Could you explain to us why both of you are involved in this

same activity—just to show our lack of bias we will be putting the same question to Telstra—and is the broadband cabling being rolled out able to support the most advanced technological systems? Can you also explain to the committee, if broadband cables have a shelf life, what might that be? Is broadband likely to be replaced by more leading edge satellite facilities? It is a grab bag of questions.

Mr Smith—It is. Firstly, let me say we are not rolling out parallel networks—certainly there are some areas where we have both rolled out a broadband network but the two networks are essentially different. The Optus network has a two-way telephony capability whereas the Telstra network does not, and that is an issue that has been long debated in a number of forums. At the moment there are some discussions taking place at the chief executive level of the two organisations with a view to either some sharing arrangements or rationalising the use of these networks. At this stage I do not think it is quite true to say that we have parallel networks deployed, though there is some duplication.

CHAIRMAN—Is broadband cabling being rolled out to support the most advanced technological systems?

Mr Smith—The broadband cable certainly can but it is not the only technology that Optus offers that is capable of doing that. Our fibre backbone and even our satellites have the capability—

CHAIRMAN—The third question was: can you explain to the committee if broadband cables have a shelf life, what might that be and is broadband likely to be replaced by more leading edge satellite facilities?

Mr Smith—As a piece of hardware a cable probably has a finite life. We are not quite sure what that will be. We are told by the manufacturers or the suppliers of that cable that it could be 40 to 50 years or something of that order.

The cable that we have deployed has been manufactured to survive or cope with the most difficult terrains and exposure to sunlight and weather and those sorts of things and to retain its strength. As a piece of physical hardware, it perhaps has a finite life. We are still not absolutely certain what that would be, but it is quite a long life.

The real issue, therefore, is the technology; does that have a life? Yes, it does. You only have to go back to the early 1980s or the late 1970s and ask the question, ‘Would we have satellites at all?’ and very quickly the decision was taken that we would. The advent of broadband overhead cabling is, in fact, the network that Optus is rolling out and it is a world first network of this nature. That is something that certainly was not foreseen very many years ago, either. It is very difficult to predict the life of the technology because of technological advances and demand for services, and there is a whole range of commercial issues that are relevant as well.

Certainly there are a number of developments going into satellite technology in the broadband and high-speed data areas. Our satellites already have the capability of carrying data traffic and there is research and development either being undertaken or proposed to be undertaken to provide far higher speeds for data traffic via satellite.

CHAIRMAN—I see that you say the hardware has quite a long life. It seems that you have had quite a long life yourself in so far as the CV you sent us showed us that you were with the Department of Prime Minister and Cabinet until February 1886!

Mr FORREST—I was interested in Mr Slipper's question there. But just to take it a bit further, broadband will have a limited life, we know that; technology marches on. The problem that isolated rural areas have is that they never ever get the technology. We saw that with mobile phones. We started off with analogue, and remote areas like I represent did not get a very good coverage of that—they got very little. Now there is a moratorium on it and we are waiting for digital; and by the time there is an economic base to launch into rural Australia, there will be some new technology via satellite.

In your comment in your submission about rural practices, you say there is a lack of willingness to take up the technology and move into the whole area of Telemedicine. But we have had evidence put to us, time and time again, that the infrastructure is not there. That has to be the greatest disincentive. We have had evidence of one particular doctor struggling to try and use what he described as a 'POT' system—the acronym he made up for plain old telephone. The speed is not there to be of any advantage.

Sometimes I resent the rush to duplicate services to the east coast while rural Australia is still waiting to have broadband services. What is Optus's program? Are they interested to get out there, or do they want to compete and roll out duplicated services up the east coast and forget about people the other side of the Great Dividing Range?

Mr Smith—Certainly the investors in our broadband network, as a very expensive and perhaps fairly speculative business venture, were only investing in the first phase of that rollout because they needed to see that there was a demonstrable business case to justify further investment. But in terms of what we are doing for the rural communities, there is not one square inch of Australia that the Optus satellites do not cover. As I said, developments are taking place to provide far more capabilities, but we have had a product on the market for some years now called Mobilesat, which is a mobile telephone service provided via satellite—

CHAIRMAN—It is very expensive though, isn't it?

Mr Smith—They are expensive. But, again, this is another area where we are developing the capability of that technology to carry higher speeds of data and the prices are coming down. They were about \$6,000, for example, for single terminals not all that long ago; they are now about \$3,000. On special, you can get them for \$2,000. The usage

rates are slightly dearer than the digital mobile rates, but it is a marginal difference. So the prices are coming down, and these prices are largely driven by the size of the market and the customer base. In fact, as late as yesterday we have been discussing that very point with the regional telecommunications fund board, about what services or capabilities might be available to the rural community.

We will be proposing trials of things like telecentres or centres for Telemedicine, or combining several other facilities at a fixed point and using satellite technology to actually link that back into the types of infrastructure that we do see on the east coast. Optus is in a position to provide a lot of these solutions. The issue really is one of cost and affordability, and we are looking at that as well, but that is largely driven by the customer base.

Mr FORREST—What sort of band rate could you achieve? Is that a broadband service via satellite now?

Mr Hudson—Via that service it is not, but the satellite infrastructure certainly has the capability for broadband type board rates. It really comes down, I believe, to what the cost-effectiveness equation is that drives that. I think there is a role for government to assist in that. Realistically, the user community out there in terms of absolute numbers is quite small. That makes it difficult for commercial enterprises to make that business assessment of whether or not to put the investment in. On the past track record, that is where government has a role to play in assisting appropriate organisations to make the investment.

Mr FORREST—The population base may be small but it makes a disproportionate contribution to the nation's GDP, and I will not let you get away with saying that. If the bottom line is the driver, have you had any discussions at all with communities? There is a willingness out there to share costs. I know my agricultural representative—the VFF—is interested, in order to get some analogue mobile, to share the technology and make a capital contribution. Have those sorts of discussions been held? If you have them, you will find a willingness there.

Mr Smith—We do hold those discussions with communities, particularly in relation to the extension of the GSM network. That is the one that I have mostly seen, but I would imagine that analogue is equally important in some areas as well. We do have those discussions. Generally speaking, sharing the cost of that infrastructure between a carrier and the business community in a particular area would be cheaper than other solutions, such as using Mobilesat. Mobilesat has the disadvantage of being able to be used only by people who have a Mobilesat terminal, so it does not help a trader going into a regional area taking their GSM phone.

We do have discussions, but I cannot give you any numbers or evidence—I am not sure if my colleagues can—of instances where we have entered into sharing agreements.

However, we do have discussions all the time, and I have received, very recently, a number of pieces of correspondence from members of parliament from Western Australia who are interested in discussing these very issues. We are looking at that.

Mr FORREST—Can you offer any crystal ball predictions about when costs will come down? Will it be a decade before it is affordable? I know that when I first inquired, about four years ago, it cost nearly \$12,000 for the unit. You referred earlier to how, if the market is there and more people purchase it, the price will go down. I can see why that would happen. My first facsimile machine cost me about \$3,000 a decade ago and now you can buy them for a few hundred. Can you give us a prediction? Those communities out there are desperate for this technology. The infrastructure committee will be visiting north-west Victoria next week. They will be looking to get as much of that infrastructure fund as they can.

Mr Smith—We are very keen to work with that board. More often than not, the issue is whether we can get over the line with a commercial justification for doing this. In terms of identifying the needs of a community or adding some additional financial input to the process of getting a program over the line to make it a commercially viable venture which could, ultimately, lead to the running costs coming down and the services being more affordable, the assistance that might come from that fund would be valuable. That is what we are looking at achieving through working with the RTIF board. It is not really a lot of money—spread over five years, over all the states in Australia—but it will be a significant help and we hope to see significant improvements through that.

Mr FORREST—I would like to ask one more question that is a bit beyond the terms of reference of our committee, but it is a question to which I need to have an answer. Optus shares with Telstra the infrastructure for analogue mobile phones but not digital, is that correct? I get a lot of complaints from travellers who have digital mobile phones out of Geelong, Melbourne or Sydney. They say that when they drive across to Adelaide they get no service on an Optus account.

Mr Smith—Yes, that is right. The reason is that we resell Telstra capacity on the analog network. We are basically a reseller; we operate on a margin. With the GSM, our licence allows us and, indeed, Vodafone to construct our GSM networks which we own and to provide our own business in that market. The analogue service is a marginal service for us, if you like, because we are purchasing the service and the capacity from Telstra and reselling it.

Mr FORREST—It seems to me that someone ought to knock some heads together. It just does not make sense to me that the digital service is there and Optus accounts cannot use it.

CHAIRMAN—I think what Mr Forrest is saying is that you have got digital services available from one company or another and you could be travelling through an

area where it is technically possible to access a digital service but, because one tends to be locked into one company or the other, you cannot. It is a pity that there could not be some kind of arrangement whereby, when you go through an area where your own company does not have a service, the other carrier could be a reseller.

Mr Smith—We achieve that to some extent by sharing the actual site. We use our own equipment and transmitters and things like that so it is still our network, but we share the site or the tower with carriers. That has been achieved with limited success throughout Australia. The limits on the success of that process can be attributed to a number of things.

CHAIRMAN—Such as?

Mr Smith—We need to reach a negotiated position with the other carrier. Under the new legislation and the new national code, that is a priority. It is not so much left up to the carriers to decide where they will share and where they will not. Under the present regime, it has been subject to negotiation. We share a lot of sites with Vodafone and not so many with Telstra.

CHAIRMAN—Before I call on Ms Ellis to ask a question, I just want to draw Mr Smith's attention to something he said. Mr Smith, you pointed out that Optus is not rolling out parallel broadband cables but there is some duplication. Could you explain where that duplication is, and why?

Mr Smith—I cannot explain specifically. We have deployed that network in Sydney, Melbourne and Brisbane and we are currently deploying it in Adelaide. We have, therefore, deployed it in some areas where Telstra has. I cannot tell you precisely where. Why have we done it? We have done it because of an assessment we did of the market and, as I said, our network has a different technical capability to the one Telstra is deploying. Ours also provides us with our local access network; that is, for local telephony.

CHAIRMAN—It seems a pity that it is not possible to co-locate or share. It would create a lot less angst in the community over the activities of all telecommunications companies.

Ms ELLIS—I have a couple of questions. My first question is to Mr Tweedie. When we were talking earlier on about pilot programs, you indicated some level of frustration at not knowing, as a company, quite how to choose or where to go. How do you know what pilot programs exist and where they exist?

Mr Tweedie—The whole area is a difficult one. I have been working in this area for the best part of 18 months now and I am still trying to figure that one out. We obviously have contacts in the health department and there are long lists of managed care

trials. To a large extent, it is a networking question. We have contacts through, for example, the divisions of GPs and the Health Insurance Commission. People tell us things, but there does not seem to be a central register, although we have subscribed to a private service that purports to publish details of all those things.

Ms ELLIS—This committee is a little bit frustrated as well because there does not appear to us to be a coordination, in an overarching sense, of the pilot programs: there is one popping up here and one popping up there and they all may know, but not everybody knows everything. Can you see a role for government at a federal level in trying to coordinate and somehow be a central point?

Mr Tweedie—I think that would be one of the best and easiest things that government could do in terms of information coordination. But I would like to say that there is a broader difficulty with pilots in that it is such a big gamble. You get involved in a pilot and you have no idea where it is going or whether it is going to go anywhere. It would be much to the advantage of the commercial world if there was a more structured approach to pilots such that, when you entered into a pilot, you knew that if the pilot were successful, there was a very high chance that you would get some possibility of a national roll-out of that pilot. At the moment you go in there and, firstly, you are gambling that it may or may not succeed and, secondly, even if it does succeed, someone else might come in and take the commercial opportunity away. I guess I am arguing the opposite point to the one Mr Slipper made earlier.

It is a very difficult market. I have had specific advice from people in the industry that it is advisable to stay away from pilots because they are something that you can sink money into and get no gain. I do not completely subscribe to that view; I think there is a role to be played. It is a very difficult area, but we cannot afford to ignore it. If we want to be a player in this particular industry, we have to be involved to some extent.

Ms ELLIS—I go on to an ancillary question. I am not sure whether it is to Mr Tweedie or someone else. You have indicated in your submission that, without substantial government capital injections, accelerated technology adoption is unlikely to be achieved within medical practices. Could you please explain that for me? On page 4 of your submission, in regards to a paragraph about the ‘tyranny of distance’ in relation to this whole subject, you say:

Furthermore, the rollout of broadband cable based networks in rural Australia, which will offer substantial enhancements in capacity and potential applications, is not occurring simultaneously with the metropolitan deployments of such networks.

Is that the sort of comment you are referring to when you talk about government capital injection, or what other angle are you getting at in that statement?

Mr Hudson—Our view is that, if there were to be capital injection by the

Commonwealth, it should not be in terms of assisting the deployment of infrastructure but rather should be on a pay-as-you-go basis. The Commonwealth is funding the actual service when it is delivered, so that that service is assessed on its business viability from the point of view of the general practitioner, the hospital or the Commonwealth.

As a result of that, there are appropriate business incentives and some cost-effectiveness in going ahead with that service. Our view is that when the service is delivered is the time that, if there is to be some financial support by the Commonwealth, that should be applied rather than saying, 'Here is a lump of money to invest in infrastructure'—for example.

Ms ELLIS—Forgive my naivety, because a lot of this technical terminology eludes me a little bit. Does that mean you are also saying that we are still going to have to wait on the providers and people like yourselves or other companies to get that infrastructure out to the more remote areas? That is what I am really stuck on. As Mr Forrest said earlier on, to ensure the delivery of these services, we need infrastructure behind them. The cost-effectiveness, which Mr Smith has referred to, is all very viable from a commercial point of view, but where does that leave the people in the remote areas who are trying to link into these services?

Mr Hudson—I think today the limitation is not the availability of broadband fibre. The capability can be provided, to a large degree, by the satellite network. That then says that it becomes the issue of where the cost case is to justify going ahead with the specific application. That, I think, is a role that government can play in terms of facilitating the development of some of those cost cases. Clearly, a commercial enterprise will go ahead with developing their own business cases and making appropriate investment. As Mr Forrest is aware, that quite often overlooks the rural, regional and remote users because it is easier to focus on the higher volume areas. I think there is a role for government to assist.

Ms ELLIS—Yes, it is almost like universal obligation stuff. That is what we are talking about in those areas, isn't it?

Mr Hudson—Yes.

Mr Smith—Certainly the USO does ensure that everybody has access to the basic infrastructure and it really is a matter for government to determine where they set the bar in terms of the USO.

CHAIRMAN—Could we discuss the level of service a telecommunication provider is under an obligation to provide? This links into what Mr Forrest said. Given the advances made in telecommunications, from the delivery of morse code across telegraph wires to leading edge optic fibre, how is a universal based service in 1997 to be defined?

Mr Smith—I am not quite sure I understand what you mean. The universal service obligation is defined in the legislation for telecommunications carriers. The government announced it prior to the last election and has already undertaken a review of the standard telephone service and has received a report from the committee in relation to that. Is that what you mean? Where should the USO—

CHAIRMAN—I was really asking: what level of basic telephone or telecommunications service is a rural and remote Australian entitled to?

Mr Smith—They are entitled to the level that the legislation sets.

CHAIRMAN—What is that? A lot of your responses seem to be purely on a commercial basis, and that is understandable bearing in mind who you represent, but how does that fit in with the universal service obligations?

Mr Smith—Let me answer that in two ways. Firstly, the universal service obligation is a legislative requirement. The industry, if you like, has to comply with that. The government has declared at the moment that Telstra will be the universal service carrier and because Telstra provides these services, other carriers contribute to the cost of providing those services.

Secondly, Optus being a relatively new company—it is five years old—has devoted virtually all of its attention into establishing a world class network and it is at the leading edge in every sense. We are unique in many ways. Because of the extent and cover of our network, which does include our satellites, we do provide the potential for regional areas, particularly those not far outside the heavily populated areas. We have a capability of providing access to the most modern of infrastructure to a very high proportion of the Australian population.

Mr FORREST—Back in 1994 I submitted a private member's bill on this issue, that there is a deficiency in the way that the obligation is defined. A standard telephone service could be an old black, wind-up handset, that is just how out of touch it is with technology. I argued then that it should be centred around the technology which is going to continue to advance. But whilst we have a prehistoric definition, there will never be any sense of drive to bring those smaller communities up to the same standard. Do you agree that it is the definition that is the problem? What is the attitude of the carriers who are in a commercial, competitive market now of having to subsidise other communities?

Mr Smith—If we are subsidising the USO, we would like to be subsidising the most efficient delivery of that service. The government has said that they would be looking at other options for the provision of the USO, opening up for competitive tendering, for example. Because carriers pay a proportion of the cost of the USO, if we can keep the overall cost of that down, then it is in our interest. There is a commercial driver there anyway.

The definition of the standard telephone service extends beyond the actual technology of the handset. It goes to things like service calls, call-up times, availability of technicians, and those sorts of things. The intention is to try to provide the service as equitably as possible without imposing cost on the providers, and also without imposing a technology on the users of the service, that is unwarranted.

Mrs VALE—I have a question on health insurance. On page 4 of your submission it states:

The Medicare benefit schedule rebate for medical services does not differentiate on the basis of the means by which the Medicare service data is provided to the Commonwealth, even though there is a significant cost saving to the Commonwealth for data provided electronically.

Would one of you like to elaborate on that statement and discuss on what basis is that statement made?

Mr Hudson—If the Commonwealth receives data electronically as opposed to receiving it in a paper based form, then clearly they have less manual activity to engage in to put it into a form that they can process and audit, et cetera. Therefore, there is substantial additional saving to the Commonwealth in that example.

The thought behind that scenario is that, to date, the additional value that the Commonwealth, and therefore the community receives from that process if a GP wants to provide it in an electronic form, the additional value to the community is not reflected in what they have paid. Therefore, there is not a huge amount of incentive for them to move to an electronic environment, which is really the basis for a whole range of Telemedicine applications.

A major constraint, particularly at the level of general practice, is the fact that general practice has not had a large uptake of technology in the way of computers, et cetera. Therefore, there is not even the base technology in there to be able to expand the range of applications in the Telemedicine environment that they can take advantage of. If there were a recognition of the additional value and if it were reflected back in what the general practice was paid there would be a greater incentive for them to move to the type of technology which would then benefit the community more broadly.

Mrs WEST—Are the realms of electronic commerce within your brief at Optus? Do you deal with electronic commerce in any way, shape or form?

Mr Hudson—Yes, we do.

Mrs WEST—So, for instance, is the electronic lodgment of Medicare forms a facility you offer?

Mr Hudson—That is certainly within our bailiwick.

Mrs WEST—And Telstra?

Mr Hudson—Yes.

Mrs WEST—So that is the way that it is going, apparently. They will have electronic commerce in doctors' surgeries so they can lodge the Medicare forms. This is mooted as the better alternative. What capacity do you have to cater to those needs?

Mr Hudson—We are able to provide Australia wide coverage for that specific application—in effect, in any community that has access to a telephone service.

Mrs WEST—Do you have any information on that that would be available to the committee?

Mr Tweedie—We could certainly provide information on that. This is part of the central question on what we are doing in the health industry. To our mind there is not a great deal of difference between electronic commerce and Telemedicine; the definitions blur greatly. At one end you have purely commercial type applications such as EFTPOS and so on within doctor's surgeries. At the other end you have video conferencing. But in the middle there are a whole lot of things such as the Medclaims activity where our network is just as capable of carrying those sorts of things out as it is capable of broadband type activities. Certainly that is central to our push into the health industry.

Mrs WEST—Has that been trialled by your company in any practice in Australia?

Mr Hudson—It is actually commercially available today. We do have a number of users on that service.

Mrs WEST—Could I have some information on that: where you have it and how it works?

Mr Hudson—Certainly.

CHAIRMAN—Could you pass that onto the secretary and he will circulate it to everyone?

Mr Hudson—Certainly.

CHAIRMAN—Thank you for appearing before the committee this morning. We enjoyed talking with you. It would be appreciated if you could let the secretary have that material.

[11.09 a.m.]

CHAIRMAN—I ask the secretariat to invite the witness to swear an oath or make an affirmation.

SULLIVAN, Mr Francis John, Executive Director, Australian Catholic Health Care Association, PO Box 57, Red Hill, Australian Capital Territory

CHAIRMAN—Welcome. Would you like to make a brief opening statement highlighting some of the key aspects of the submission, which we have already circulated?

Mr Sullivan—Thank you. On behalf of the association we thank you for the opportunity to make a submission and to be here today. As we said in our submission, we basically restricted ourselves to the term of reference that was looking at the ethical implications of your inquiry. You will note from the submission some of the background references coming mainly out of the United States experience. Near the back of the submission we have appended a series of proposals, 13 of them, from a report in the United States prepared for legislators in that country when they were looking at issues similar to your own.

CHAIRMAN—To what extent has the association been involved in any Telemedicine pilots? Some of your hospitals clearly have been.

Mr Sullivan—A number of our major hospitals, particularly the private hospitals, have been involved in best practice programs with the government for some time. For example, over the last few years St Vincents Private Hospital has been involved in a GP Information Technology best practice program. The Mater Hospital in Brisbane is also involved in something similar. Oftentimes the take up rate in our sector depends on the degree of sophistication of their own IT already.

CHAIRMAN—A lot of concern has been expressed about privacy and ethical considerations. Of course, medical records have not always been private. They have never really been very secure in many medical surgeries and some have even been found in places where they should not have been. To what extent do you think we need to pay more attention to this area?

Mr Sullivan—Clearly, that is the thrust of our submission: that obviously things like Telemedicine and other new technologies can assist access to health care, particularly in rural and remote regions. We are very supportive of that thrust. The major push in health policy and planning everywhere now is to try to integrate what we have across the sectors. The difficulty, of course, is that if information can move so quickly, the capacity to keep it safe and secure needs to be foremost in the minds of legislators.

CHAIRMAN—You have said that infringements of confidentiality have become routine and unfortunately are more the rule than the exception. Would you elaborate on that a little?

Mr Sullivan—In the submission, we are basically saying that to date, if you are talking about, say, the paper transfer of information, what is written on the information, where it is filed, who gets to see it in an office and the like are all examples of where people may or may not be appropriately permitted to have access to that information. That is very much a trend that you will have in any office situation today. That is basically the thrust of that comment.

Mrs ELIZABETH GRACE—Following on with the issue of infringement of confidentiality, in the technology that we have seen and have been exposed to there seems to be a fairly strong emphasis on audit trails—people who have accessed that information in the technological form are recorded at the time and so is who has accessed it—which you do not often get on paper records. With those records you get white-outs and you get rub-outs.

Mr Sullivan—Yes, exactly.

Mrs ELIZABETH GRACE—People forget—‘Oh, we do not remember’—and so you get that type of thing. Would you comment, from your experience, on the security aspect? You are expressing a concern, and yet in some ways I feel that the technology that is now in place is probably more secure than paper records.

Mr Sullivan—We would not be trying to take a position of obstruction here. All we were simply trying to say in the submission is that it needs to be highlighted vis-a-vis any legislative or regulation changes that are needed. Audit trails are a safeguard that would probably meet the requirements of privacy and confidentiality.

Mrs ELIZABETH GRACE—We also found that, from the point of view of indemnity, mistakes and things like that, there is a clearer record and so people can follow through exactly what treatment is being handled.

Mr Sullivan—Yes, the fingerprints are there.

Mrs ELIZABETH GRACE—That is right. Would you like to explain what you would see as both the federal and state governments’ role in this emerging area of health care?

Mr Sullivan—It is a rather broad question because in a sense what we are saying is: what role does government have in health care in the future anyway, particularly in the provision of it? Increasingly, federal and state governments of either political persuasion are wanting to become purchasers of health care and are allowing major providers, be they an individual hospital or a health care system, to provide a series of services across a population.

It would be our view, given the fact that we span both public and private sectors

with our hospital and aged services, that government should allow the development of integrated health care across those two sectors and that funders, be they private funders or even public funders like Medicare, should be in a position to be able to purchase services through provider groups for the population regardless of insurance status.

Ms ELLIS—I have just one question. Do you have a view on the cost impact for the area of health that your association covers? If we saw a dramatic increase or a dramatic demand for an increase in technology through the delivery of health services, what would it do, for argument's sake, to the people in your association? I am asking that question while not quite knowing how much of that association membership is already involved.

Mr Sullivan—Maybe I should just qualify that by saying that the association covers 57 hospitals, 36 of which are private; they are major private hospitals: St Vincents, the Maters, the Calvarys and the like, so they are high technology, sophisticated private hospitals. And they have 22 public hospitals—again including five major teaching hospitals. So the level of sophistication in our hospital sector is extremely high. We have, in the hospitals, consistently upgraded our capital stock, and in that, of course, you would talk about your Information Technology. For example, when issues like Casemix payment was being mooted for the private sector, the Catholic private hospitals were already at the forefront of the technology. They have been doing the costings in that area.

So when you asked me the question 'What is the cost impact for, say a greater uptake?', then there are two things. One is that health costs in general are being driven by technological developments. There is a fallacy around that says it is the ageing population that is driving health costs. The reality is it is a demand driven system that is also heavily influenced by the uptake of medical technologies. That in itself, of course, feeds into the market, which they would argue then is your ageing population. It is a funny way of looking at it.

There are always going to be immediate costs; the question really has to be about the benefits of those costs in the longer term. The anecdotal information that I have—and that is all it would be—is that in most cases the benefits can be sustained. But if you look at the way we are financing health care at moment, if private health care takes on the medical technological developments at a faster rate, which is often the case, those costs are factored into benefit demands from funds and therefore onto premium prices.

Ms ELLIS—Has your association done, or do you plan to do, any analytical work in terms of those cost benefits?

Mr Sullivan—It would depend how much this becomes a big issue to be perfectly frank. It is not an issue at the moment that would be high on our agenda for work that we would do. It is clearly a strategic issue in the health system. From our workload perspective, I suppose, it would not be a high priority at the moment.

Ms ELLIS—My observation in this committee's inquiry, in terms of Telemedicine precisely, is that there is always a question that we attempt to grasp on costs and benefits. Can it be possible sometimes to do that sort of analysis, given what we are actually costing and given the cost of hardware, or are we costing the health outcomes? How far are we willing to go in that, given the statement you just made about the continuing rise in technological advancement? We can almost do anything now and we will do better than that in another year or two, or 10. Where do we stop?

Mr Sullivan—It is a very good observation because—and we went to it a little bit in our submission by saying technology is literally a means to an end—when you are going to make some type of ethical judgments about when to embrace technology or not, you need to do the calculus about the fact that the costs and the driving of those costs may be inhibitive on the overall health system. You know that is a very difficult call. But in the last couple of days when we have been debating the budget—for example, the health minister's initiative on, say, the PBS—people would argue one way or the other on that as either going to restrict access or shift costs to some consumers versus others. And what are the gains? The gains are in using certain medication versus another. Some medication might be more debilitating than others, but at the end of the day is it a level at which we want to fund the system that we would call adequate or is it a level we want to fund the system at which we call optimum?

I think what is happening in the health system at the moment, particularly the private health system, is we are always pushing to the optimum because it is still the system where the main consumer is the medical profession. Competition policy in private health care is not about getting patients; all private hospitals compete for doctors.

Ms ELLIS—Can I take it one step back then. Do you see a benefit in trying to do a cost analysis of the use of Telemedicine as a means of better enhancing the use of dollars when we are talking about medical technology? In other words, could we see the use of Telemedicine at its optimum as being a cheaper, more effective or more equitable way of dealing in some cases and, therefore, it becomes a cost saver in itself?

Mr Sullivan—I can see a benefit in it I think to some degree, as long as you get people prepared to participate in it. The normal thing that happens is someone says, 'Who is going to pay for it?'

Ms ELLIS—We have had that said to us often.

Mr Sullivan—I am sure you will.

Mrs VALE—I am not sure the association is able to give a view, but how do you feel telecommunications technology will improve the equity of access to better health care for people in rural and remote communities?

Mr Sullivan—In theory, we would see that it would have some benefits towards access. Within our own sector we are trying to encourage our hospitals that do have the technology to align in networks with some of our rural facilities and possibly even GPs in nursing services along these lines.

So, in theory, I believe it is possible to improve access. Is it access to essential care? I do not know. They tell us that, in the United States, psychiatry works very well with Telemedicine. I had heard anecdotally that it is probably disposed to that here as well. We would classify that as an essential service. So I think, in theory, it is fine.

The reality is that, particularly in private health care, people are always seeking market niches. When you go for market niches you, by definition, exclude some people. It will all come down to user-pays. As we have already seen the trend over the last 10 years, user-pays in private health care usually restricts access.

So, in theory, it is great. It depends on how we will finance it and how that financing will be integrated into the wider model of paying for health care.

Mr FORREST—Mr Sullivan, let me clear up a point that Mrs Grace raised. You read your submission and you do not hear it embracing and affirming the benefits of this technology. You did say it would not want to be obstructionist—and I think you used that word. You are convinced that there are some merits here that we ought to pursue?

Mr Sullivan—Sure.

Mr FORREST—So it is a cautionary warning about ethics and so forth. I am interested in the suggestions you make at the end of your submission. Point four talks about the establishment of civil and criminal penalties and sanctions for breaches of some sort of regulatory framework. That is an extremely difficult area. If I am the physician and I relay the information that ultimately saves the patient's life, but inadvertently reveal that the patient is HIV positive or something, how do you establish that kind of framework of its civil sanctions?

Mr Sullivan—I will answer the three questions you gave me. Firstly, we did mention in the beginning that we were restricting ourselves to that term of reference to do with ethical considerations. We did say firstly that there would be others who could get into the technicalities.

Secondly, ethical considerations by their nature are not meant to be obstructionist; they are meant to clarify intention. I think that goes to your third answer then. When you have a situation where you have basically two values in conflict, you are, by definition, going to choose one over the other. So in the case you put, the person has obviously chosen the life-threatening aspect of the situation and has chosen to act in that way.

Our point would be that the legislation or the regulation is difficult and does take time to thrash out, but that is exactly why it needs to be thrashed out by a community of representatives. The question Mr Slipper put to the previous people related to the fact that there are more than just commercial considerations here; there are greater goods. We have already had that in questions to me. There are greater goods about the cost to the system in general.

Are these the sorts of costs we are prepared to load into a budget versus costs in other areas of services? Do we need to move information as quickly as possible as a goal in itself or in only some areas of health care should we consider moving the information more quickly? At the end of the day, just like in public health care, we will always need to balance the common good versus individual privacy. There is not a hard and fast rule, but what we do need is a regulatory framework in which people will believe that their privacy will always be the number one concern.

Mr FORREST—We do not have that now. I was in a doctors surgery last week. I was asked to sit in a room and there were three files on the desk. Had I had the inclination to go beyond seeing their name and date of birth I could have done so. Who is in breach there? There was no malicious intent. It is a busy surgery and they plonked me in the room. We do not have that regulatory framework now in terms of the sanction; why would do we suddenly need it with an advance into new technology? Frankly, I think the technology will provide even greater access to security of information than would currently exist with a paper based network.

Mr Sullivan—It may do, Mr Forrest. I think all we would be saying is: let us lay out the arguments. Let us see them sustained one way or the other so people can then move with some certainty and security about it. As to human error, as you have just mentioned, in a doctors surgery, welcome to the human race. That is not an excuse for us to become complacent.

CHAIRMAN—Thank you very much for appearing this morning, Mr Sullivan.

[11.27 a.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

BASTIAN, Ms Hilda, Chairperson, Consumers' Health Forum of Australia Inc., PO Box 52, Lyons, Australian Capital Territory 2606

MOORE, Ms Kate, Executive Director, Consumers' Health Forum of Australia Inc., PO Box 52, Lyons, Australian Capital Territory 2606

CHAIRMAN—Thank you for appearing before the committee this morning. We have your submission. Would you like to make an opening statement to give us some idea of where we ought to focus our questions?

Ms Bastian—There is still a lot of confusion amongst people and different community groups about this issue. People can see a lot of benefits, but there is some caution and concern. There is a feeling that it is like a honeymoon phase with a lot of excitement and people saying, 'This is possible,' but perhaps not quite enough discussion of how many of these things we should do—not just what we can do. There is a fair bit of concern that things are moving fast.

CHAIRMAN—Are you suggesting it is not consumer driven?

Ms Bastian—No. I think we are talking about so many different kinds of things under this one heading. Some things are more popular than others and other things arouse more concern. Overall, there is a concern with anything when you are in a honeymoon period that you not just be concerned about the theory but that you stop and evaluate what happens in practice beyond everybody's ideas about how well this is going to work out. There is concern that paying for some of these things may take pre-eminence over more basic things that are still terribly needed in the health care services area. There are concerns about privacy and a few other issues such as that where we are moving into some minefields quite quickly without actually bringing the community along and working through these things so that people do not need to feel concerned.

CHAIRMAN—Mr Forrest asked the previous witness about privacy and pointed out that he felt more privacy might be afforded to patients under the new technology than was previously available under the old paper based system. You may have heard him speak about his own visit to a medical practitioner recently. Do you think that privacy concerns are overstated?

Ms Bastian—No, I do not. I think that Mr Forrest is right when he says that the current system, the paper based information and so on, is not that crash-hot. I think that is part of the reason that people are concerned about adding some of these things, because are you are adding an ability to broadcast to a lot more people quite quickly. When you are putting things through on computers, you can see things quite quickly that relate to a

lot of people. It is not a situation where everything you are talking about is carefully coded and you need some access word to get it, and so on. Certainly by the time you have things on videos, and so forth, it is a lot more attractive and interesting to people than boring little bits of paper records and so on.

There is also a real use of a lot of these materials in teaching medicine, and so on, when you get an interesting case, or whatever. It is very easy for people to not stop and think, 'Gee, this is something new; the ball game has changed.' New rules are needed here because these people are even more recognisable; you can see their faces. It brings a whole lot of concerns.

CHAIRMAN—I see that the Consumers Health Forum is an NGO. How are you funded? Do you have any public funding, government funding, or is it all private sector funding?

Ms Moore—We get a grant from the government under the community sector support scheme, and we charge our members a membership fee.

CHAIRMAN—What percentage of your overall costs would the government fund?

Ms Moore—It is a large percentage. I think you have to understand that the sector we represent is very poorly resourced.

CHAIRMAN—I was not being critical; I was just trying to ask what percentage of your costings would be government funded.

Ms Moore—It is about 80 to 90 per cent.

CHAIRMAN—Who are your members?

Ms Bastian—The members are a lot of community and consumer groups that have an interest in health. So there will be a lot of very specific self-help groups and patient oriented type groups, like multiple sclerosis societies and so forth, through to the kinds of broad community groups, like Council on the Ageing and so on.

Mr FORREST—Are any of those rural based?

Ms Bastian—A lot of the national organisations obviously have better rural bases than others. There is also a national rural health consumers organisation that is represented on our general committee.

CHAIRMAN—You are currently undertaking a project which is exploring consumer views concerning the use of personal health information for research and other purposes. Perhaps you could tell us about that project, including those organisations you

have surveyed and consulted, and summarise the views which have emerged. If there have been any reports published to date or prior to the presentation of the results of our inquiry, we would appreciate your passing them on to the secretary.

Ms Moore—That project is very much in progress at the moment, so no reports have been published, but we would hope to do that in July. The process we have undertaken is a two-stage process. The first stage was to consult with the consumer sector—to go out to CHF's member organisations, first of all, to ascertain their views on a broad range of questions, and then to hold a workshop around some of the results of that survey.

The second stage was to say, 'Well, this is how far we've got, this is what consumers are saying; we now need to test the feasibility of what consumers want with the broader health care sector.' So at the moment we are undergoing a consultation with a range of stakeholders in the health care sector.

CHAIRMAN—A lot of Telemedicine trials take place around the country. We have inspected some, and we believe a lot of them are very valuable. Has your forum had any input into any of these?

Ms Bastian—That has been one of the things we have been concerned about and, while we were looking at this, we have been trying to get in touch with it. We are finding that there has not been a real lot of consumer and community involvement. When you start to get in touch with people in different communities, a lot of them will say, 'We know that's happening and we know so-and-so was involved.' But we have not had anything in any kind of formal way through really talking with members of the community and trying to involve them. That has been a concern for us.

CHAIRMAN—Previous hearings have said that perhaps this technology should be driven by the clinicians rather than by the technicians. You are obviously suggesting it should be driven by the consumers rather than those two other groups.

Ms Bastian—I do not know. Certainly a range of different things have to be considered here involving consumers, and having a very primary concern about what the effects are ultimately is important. Some of those issues will be shared by consumers and clinicians, and so on. But yes, we really do think that ultimately it is the consumers who will be paying the price for this and experiencing whatever the good and bad effects are to a very great degree, just as much as the health services are.

Mr FORREST—I am trying to get an understanding of where you are coming from. Where are you based? Are you here in Canberra?

Ms Bastian—Me, personally?

Mr FORREST—The organisation, I suppose.

Ms Bastian—The organisation is a Canberra based organisation with members from around the country. Then we have a board, which we call the general committee. That is elected.

CHAIRMAN—Are you both based here?

Ms Bastian—The secretariat, the office, is based in Canberra, and the general committee that governs the organisation is voted in from around the country. We have people on the general committee at the moment from every state and territory, except the Northern Territory—and I personally come from South Australia.

Mr FORREST—This just helps to give me an understanding. I hear a lot of city based people trying to tell rural based people what is good for them.

Ms Bastian—Yes.

CHAIRMAN—Mr Forrest really means most of Victoria, and rural Victoria in particular.

Mr FORREST—There is a real interest coming from consumers in getting access to this, to improve their access to health care. I just want to get this clear. A quick reading of your submission indicates that, although you are not embracing it in a positive way, you are not going to be obstructionist about it and you want to try to make it work. Is that the intention of your forum?

Ms Bastian—I think there are a couple of things. We certainly do not intend to say, ‘Look, we want to stop this happening,’ and, ‘All of this is some terrible, terrible thing.’ But on the other hand, we are also saying, ‘Look, there has to be some caution here,’ because everything that is new is not necessarily always better. We need to find out whether in practice these things work out as well as people at the moment are feeling that they might.

We have had experience already with quite a few electronic technologies, that people made all kinds of promises about, that consumers then embraced and said, ‘Gee, if it can do that, that’s wonderful; we’d really like that.’ Then, when they were evaluated in practice—and this is a lot of different kinds of electronic screening processes, and so on—that increasing exposure to more and more tests, and so on, actually had adverse effects on people and led to overdiagnosis and much more hospitalisation.

On the one hand, you could take the issue of rural. I take the issue of the organisation I come from, maternity alliance. We get situations where people say, ‘Look, we’ll be able to do this test down a phone wire and you won’t have to go into the city for

as many tests, and so on.’ When those things actually started to happen in practice, people found that yes, that was true, but they would start to pick up so many things on some of these tests that everybody would end up getting sent down to the city, or wherever, almost as often as before, and a lot of the promises did not get delivered on.

So it is a matter of finding out what this actually means in practice and what it is that we lose when there are a lot of issues about capital needs—needs for capital equipment, and so on, in hospitals. A lot of people are seeing their hospitals deteriorating and saying, ‘Well, maybe the most important thing we need is not necessarily a big video conferencing facility when there are all of these other needs.’

So there is that concern about, ‘Yes, but what about these different urgent needs in our community.’ In some communities people feel very strongly, ‘This is really important; why don’t we have access?’ In others, people are saying, ‘Well, hang on, we still haven’t got these other things that we want more urgently.’ So I guess it is a matter of caution and saying that we have to look and count the cost as we go.

Mr FORREST—If it is of any assurance to you, this committee has been all over Australia and we have come across that cautionary note, but we have seen some pretty good examples of where the technology has been used to improve the service—psychiatric service and support in remote areas, and renal programs which save so much travelling, and that is where most of the trauma is for the patient. We have collected a wealth of evidence and you are welcome to get copies of the *Hansard*.

Ms Bastian—That would be great, yes.

Mr FORREST—Let us focus on where the positives are and be mindful of the concerns that are there, because we all have them. But never forget that there are a lot of people in rural Australia who see some great advantage in this. It is a long way to travel seven hours to a base hospital in a capital city.

Ms Bastian—Yes, especially when you are sick.

Mr FORREST—Even if you can save one or two of those trips, it is better for the patient.

Ms Bastian—I suppose we are saying that certainly can be true, but it is not necessarily always true. A lot of the things that in the early stages we think will work out really well, when people go back a few years later and check they find, ‘Well, these were the side effects, these were the things that happened and these were the things that came along with this not envisaged by us in the beginning.’ So we are just saying, ‘Be careful.’

Ms Moore—I think the important thing to emphasise here is that we are not saying don’t do it; we are saying do it with caution, and evaluate it as you are doing it. In your

evaluation, take into account what consumers are saying about their experiences of using it—not just the doctors.

Mrs ELIZABETH GRACE—Basically picking up that line, everything that is done that is new very rarely lives up to expectations. But is that not part of the learning; is that not part of getting the system right; is that not part of producing a system that is going to service the community in the way we want it to? We discard what is not working, but we pick up the good parts of it and put it into the next system. I think, from necessity, it has to be expensive because it is experimental, unfortunately—that is part of the problem.

But going back to the privacy issue—and I brought this up before—what we have seen in our travels is that the technological access of files is far more strict than the accessing of paper files because of the audit trails that are left. Every time someone accesses that file, a name, a number and a time are placed on the record. Even if you are transferring for teaching purposes, and things like that, you have a record of where that has gone. If something happens, you have more accountability for what has happened.

They are the advantages that we have seen as a committee in moving around the community. When it comes to rural and remote access, both John and I have had experience in this area. There can be the saving of those hours and those times on something that is quite simple. One of the cases was from Dubbo; it was a child with an enlarged heart. The immediate reaction was to get the child to Westmead new children's hospital. However, on the telecommunications system they found that it was not actually an enlarged heart; it was something that was quite normal with a new baby; and neither the child nor the mother had to be transported.

We have to weigh up those sorts of things against other things, when it comes to that type of thing. Have you undertaken any surveys along these lines of what people are doing? Is it part of your work to do that type of thing?

Ms Bastian—As we said with the example of the project that we are doing around how people feel about access to information for research purposes and so on, we need to go out and have our members say, 'This is an issue that we want addressed,' and then go and seek project funding, and so on, to undertake a project. We have not done one specifically on this point. We have been working on this other issue about access to information for research purposes, and that is the only specific thing.

Mrs ELIZABETH GRACE—May I suggest that you perhaps extend, or look at, that as a possible project and have a look at some of these areas like Port Augusta, and Maryborough in Queensland, and some of the Western Australian people and the work they are doing in relation to getting information back to their head teaching hospitals in the capital cities.

Ms Bastian—Yes. For us, certainly that issue of having more consumer involvement and community involvement in some of these initiatives is really important, and not enough of it is happening. There still remains that thing about saying, ‘Okay, don’t stand in the way of progress.’ But we have to innovate carefully, and we cannot decide which are the things we should stop and which are the things we should keep with, if they are not really well evaluated.

Mrs ELIZABETH GRACE—That is why I say that it is an ongoing evaluation, it is an ongoing experiment. I think it will continue to be now that we have reached this technological age, because each year they are producing something that is even more advanced and more wonderful than it was the year before. There are things we have to monitor all the time now; it is constant monitoring now.

Ms ELLIS—I want to ask a couple of questions. The first is just for general information for me. You are the Consumers Health Forum of Australia. Are you the major, the only or one of a group of national consumer spokesgroups? What is your status? Are you the only national consumer spokesgroup?

Ms Bastian—There are different kinds of groups in different specific areas, but we are a coalition, a kind of a peak umbrella body of other groups.

Ms ELLIS—And you are the one in health?

Ms Bastian—Specifically, only about health, yes.

Ms ELLIS—I am trying to make certain that where there is an overarching general consumer group in the health area in Australia you are it.

Ms Bastian—Nationally.

Ms ELLIS—Nationally, right. On that basis, do you have members of your committee or of your group who are of non-English speaking background, ethnic groups and so on? We are worried about rural representation, but I am also concerned about these people. Do you have membership from those sorts of groups or contact with them?

Ms Bastian—Yes, again several people in different groups do and again there are different strengths and weakness and so on. We have an election process to our general committee and this time around we did not end up with somebody who was specifically of non-English speaking background so we are in the process of coopting somebody.

Ms ELLIS—But indirectly they are there as well anyway?

Ms Bastian—They are there indirectly as well, but we do not consider that enough. We are saying that is a lack in our election process and we are addressing that.

Ms ELLIS—In relation to Telemedicine generally, my observation on this committee is that there has been an overwhelming impression of frustration—no matter whom we speak to—about the lack of coordination. There are pilot projects all over the place being done by every Tom, Dick and Harry—or Mary, Alice and Bertha—and nobody really has a finger on all of that in one place. Would you share that frustration?

Ms Bastian—That was exactly our experience and why one of the first things I said was that there was a lot of confusion out there. When we started to go to people in all these different areas, they would say, ‘Yes, we know something is happening, but we do not really understand what, why and so on.’

Ms ELLIS—Could that have a lot to do with the fact that your consultative role appears to have been missing in terms of Telemedicine pilot projects? That would obviously, in my understanding, have somehow contributed to a lack so far of an integral role by your group.

Ms Bastian—At every level there has been a bit of a dearth of consumer group and community group involvement, except sometimes in a fundraising capacity or whatever. It just has not happened. I think this is one of those areas where things have leapt ahead quite quickly and now people are trying to catch up with what is happening. That has certainly been happening to consumers.

Ms ELLIS—Can I also mention for your benefit as well as for mine another major frustration I have with this whole Telemedicine question. I absolutely agree with what Mr Forrest and others have been saying in terms of the inevitability and the gains that can be made by this technology, but I am also sharing the caution that you are expressing inasmuch as I do not want to see this whole area move ahead driven by the industry that provides it or driven by the medical profession that performs it without in the latter sense an absolute commitment by the driving forces that consumers—in other words, the people who are going to be at the other end of this system—are somehow involved as well.

It seems to me insane if we allow the industry to do it, because we will never catch up with it and we will never quite know what we are buying. It has to be an end product want on behalf of government and community and then we strive to get there. I am little bit appalled to think that, through the lack of coordination of pilot projects around this country, we are seeing a lack of consumer consultation—and I am not laying that at your doorstep at all. I think maybe we should add to this committee’s observation of the need for national coordination a desperate call for an involvement of health consumers in that whole process. Would you agree?

CHAIRMAN—Could I just add something. What role do you see for government in this coordination process?

Ms Bastian—I will answer the first question first. I would agree with that

absolutely. One of the issues about what the different drivers and so on in this kind of scenario are and the kinds of concerns that are coming up for our membership is the things that go along in the slipstream. It is not just a case of, 'Here is the technology. This person can talk to this person.' That is something that people really welcome. Certainly in rural areas people have a long history and involvement with those kinds of things already. Everything from School of the Air to radio contact and different networking really does build communities and people are used to them.

It is a lot of the other things that come along in the slipstream that are of concern. There may be somebody marketing a machine who says, 'Now we have a machine that can diagnose this across the lines. Now we have a machine that can do this.' There is obviously a huge interest for people to encourage the adoption of even more technologies that these primary technologies then make possible. That becomes the area of concern and people say, 'What is going to drive this?' Is it desire to do everything that you can do and people making a lot of money or is it deciding what is best for people that drives things?

Ms ELLIS—How do you see the government's role in this coordination that I am talking about?

Ms Bastian—Given that so much of this is actually publicly funded and a lot of the pilot projects have a strong level of community involvement and government involvement already, I guess I do not entirely know what the precise mechanism should be.

Ms Moore—I guess we would like to see the federal government take a strong role in trying to coordinate what is happening at both the federal and state level and make sure that there is proper evaluation and proper standards for the use of this technology—and basically making sure that taxpayers' funds are spent well.

Ms ELLIS—Can I add to that by saying that I am sure that you would agree that in any proposed administrative overarching or coordination that this committee is going to have to call for, in my view, the consumer role simply must be an integral part; otherwise I wonder why we are doing the whole thing.

Ms Bastian—Absolutely, because of issues like accountability and not losing sight of the human faces here. Not every single thing is necessarily as good as it looks in the first place. But it is also to lessen some of those effects. The community should understand what is happening. The more people are involved and the more understanding and so forth that seeps back to people the better. People will then not necessarily panic at the rate of change. There are a variety of different reasons as to why more community involvement in this process would be valuable we would think.

Ms ELLIS—Could I finish off my questions by suggesting that it would be useful if the committee could receive from the forum a very brief background as to who belongs

to the forum, how you are constituted and how you operate in that sense. It would be very useful for us, when we come to considering the pivotal point of arrangement for any coordination, to see exactly who is on your board, what your structure is and what sort of consumer level input you have from a variety of groups.

Ms Bastian—Yes, of course.

CHAIRMAN—That would be appreciated. If you could pass it on to the secretary he will be able to circulate it to all of us.

Mrs WEST—From the results of surveys and information from the consumer bodies do you actually make a report to government? Do you make an annual report?

Ms Moore—We make both an annual report on our overall activities and we do individual reports on particular projects. They are available publicly.

CHAIRMAN—Is that to the department or to the minister?

Ms Moore—To the department, but we normally send a copy to the minister.

Ms Bastian—We are an incorporated association and it is not a report to government. It is the usual annual report type process, but with each individual project, as Kate says, we have a—

Ms Moore—But we are required also to report regularly to the community sector support scheme which funds us. That is more of an administrative report.

Mr FORREST—Is the funding from the Commonwealth on a project to project basis or an annual allocation basis ?

Ms Bastian—Both, but we get more in project funding than we do in administration funding. For example, in terms of the research issue we said, ‘Our members are saying these are concerns and somebody needs to go around the country and talk to consumers about this.’ We went and said, ‘We see this need,’ and we argued why and sought funding for it.

Mr FORREST—What would a national survey of your consumers’ attitudes to this technology cost? What are we looking at?

Ms Bastian—It would depend on how you did it, because clearly it being such a strongly rural based area would have to be taken into account. I guess it would depend on how we decided it should be done. It would definitely have to be South Australia and a couple of other places.

Ms Moore—Yes, it would depend on the methodology. It would probably need some formal consultations to be done with our members in the rural areas.

Ms Bastian—Dare I say it, I think we have to do it face to face.

CHAIRMAN—If there are no further questions, I would like to thank both of you for appearing before the committee this morning. I would like to welcome Ms Moore back to Parliament House, where I understand she spent some considerable amount of time a number of years ago.

[11.58 a.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

LAFHEY, Mrs Jennifer Anne, Electronic Data Interchange Coordinator/Project Manager, National Consultative Group for Private Healthcare Electronic Data Interchange, Suite 1, 25 Napier Close, Deakin, Australian Capital Territory 2600

McDONALD, Mr Peter Robert, Senior Research Officer, National Consultative Group for Private Healthcare Electronic Data Interchange, 4 Campion Street, Deakin, Australian Capital Territory 2600

QUILLIAM, Mr Stephen Kay, Manager, Information Technology Services, National Consultative Group for Private Healthcare Electronic Data Interchange and the Australian Private Hospitals Association, Suite 1, 25 Napier Close, Deakin, Australian Capital Territory 2600

WILLIAMS, Mr Chris, Chairman, National Consultative Group for Private Healthcare Electronic Data Interchange, Suite 1, 25 Napier Close, Deakin, Australian Capital Territory 2600

CHAIRMAN—Thank you very much for appearing before the committee this morning. We have received and read the submissions. Would one of you like to make a brief opening statement of less than a minute?

Mr Williams—Since our initial submission, some updates have occurred. The document accompanying the submission *Guide to private health care EDI* has been updated following the recent release of version two of our messages. The updated document is now *Guide to EDI implementation in Australian hospitals and health insurance funds*. This guide is available over the Internet and upon request to the EDI coordinator and includes more updated references to issues such as data transmission and encryption. We would like to table a copy of this document for the committee's reference.

CHAIRMAN—Thank you. We will receive that.

Mr Williams—Version two changes incorporated standardisation with existing health care industry messages in current use; namely, the EDI messages designed and used by the Health Insurance Commission for bulk-billed Medicare claim assessing and statement provision, commonly known as Medclaims; lodgment of immunisation records; maintenance of medical claims under the changes to the legislation; and maintenance of the private health insurance incentives scheme, which will come into effect from 1 July 1997.

The National Consultative Group for Private Healthcare EDI has a vested interest in complying with national and international standards—standards development is a

complex issue and even more so at an international level. The national consultative group believes that meeting the business needs of the industry is the highest priority.

Steve Quilliam from the Australian Private Hospitals Association, who is with our group, has asked me to briefly mention those issues raised by the Australian Private Hospitals Association. These relate to: the ownership of data where central data repositories are stored; the avoidance of monopoly situations over software, coding classifications, communication networks and protocols to control escalating costs; the security of data during transmission; the requirement for adequate disaster recovery techniques; and the physical security of data held at numerous sites.

The national consultative group reinforces the view that all care should be taken to ensure data security and privacy. It is the view of the Australian Private Hospitals Association and the national consultative group that, given the security provided by encryption techniques, Internet can be used for EDI transmission rather than the more secure but more expensive value added network services provided by the big telecommunication companies. There is a possibility that legislation restricting electronic commerce as we wish to practice it will defeat the purpose of electronic commerce—that is, improving operational efficiency and saving money for the organisations involved.

CHAIRMAN—Is that legislation around at the moment or being seriously mooted?

Mr Williams—Our impression is that that is a possibility, yes. If electronic commerce involving sensitive information is confined by legislation to expensive transmission alternatives then the implementation may not necessarily be worth the effort. I would like to introduce Peter McDonald who is the senior research officer from the Australian Health Insurance Association.

Mr McDonald—I want to make a comment about health insurance and Telemedicine while we are here today principally as the EDI group. It was put to me that you would be interested in the insurance stance on Telemedicine. The short answer is that there is no real health insurance industry stance with regard to Telemedicine. We simply have not been confronted with it in terms of benefits or arrangements.

The way health insurance benefits are structured, we pay for medical services, medical practitioners and hospital services and technology. The approach to medical services is largely driven by the way the MBS is structured. I imagine there would be a precedent there if the business of Telemedicine raised complications as to how you pay benefits for consultations off-site and that sort of thing. It would be partly driven by how we currently deal with medical practitioners. If you view Telemedicine simply as a new means of technology enabling delivery of health care, it is the same issue that we have in dealing with private hospitals and other providers. If we can see the benefits and we can negotiate about the advantages of a new technology, health funds are willing to consider it and pay fair benefits.

CHAIRMAN—It would seem that there are no item numbers in the medical benefits schedule at the moment. Unless we are going to make some provision as a nation to pay for this facility, medical practitioners are simply not going to set it up and use it.

Mr McDonald—I guess that is what I am saying. We are bound to only pay what is on the MBS for medical services. It has not been raised for us either.

CHAIRMAN—How should the schedule be changed in your view and how would you approach it?

Mr McDonald—I think as far as health insurers go we would still be guided by the way the MBS schedule is driven at present where it should be put to government and reviewed and shown to be effective and cost effective.

CHAIRMAN—Both submissions showed a keen interest in the subject of privacy. We have had evidence that the new technologies give better opportunities for privacy than the old paper based records. I can see from the looks on your faces that you have heard about some hair-raising experiences patients have had where they have discovered their medical records in rather peculiar places. Do you think that the use of encryption is going to increase costs considerably?

Mrs Laffey—Most of the encryption packages that are available are freeware so they will not increase the costs to industry. The encryption package that our group is recommending is document preparation software designed by Telstra for the Health Insurance Commission. We have a vested interest in taking an industry approach to encryption. We understand that that will not be an expense to industry either.

CHAIRMAN—What security systems generally are around out there in the community, including those being used in the pilot trials?

Mrs Laffey—The pilot trials that are currently running are using an X-400 service, a value added network which is more secure than say an Internet option. Another trial that is going ahead is using the Internet but they are using a lower level encryption service. A hospital, for example, is using that to log onto a health insurance fund's database to query whether a hospital admission is a member of that fund. They are using a lower level encryption service for that, but there is not particularly sensitive information in that query.

CHAIRMAN—Is any of this technology being developed in Australia?

Mr Williams—Yes, the DPS software that Jenny referred to was developed in consultation with the Health Insurance Commission and Telstra.

Mrs ELIZABETH GRACE—Your group had an input into that development so it is natural that you would recommend that or find it more preferable, but are there other

programs readily available that would do a similar job?

Mr Williams—I am not as aware of other products as I am of this particular product. As Jenny said, there is a range of encryption methods that organisations could start to use to send messages across the Internet and so forth. They invariably come out of North America and invariably there is some limitation on the actual amount of information that is allowed to be encrypted, based on what can be taken outside the United States of America. The other thing is that there are companies around that have encryption software available, and it is the use of the RSA technique that is incorporated that refers to the original authors. I understand that there are a number of companies around that sell that particular type of software—not at great expense.

Mrs ELIZABETH GRACE—The thing that would be most important with all of this is: do these interact with one another? Can one translate another one's encryption?

Mrs Laffey—No. This is why we are currently recommending a national approach to encryption.

Mrs ELIZABETH GRACE—That is something we as a government should be looking at—setting out the guidelines so that we can have these systems all talking to one another, which is not happening if we have different ones being used.

Mr Williams—Yes. If the answer to your question was yes then that would also imply that the encryption can actually be broken.

Mrs ELIZABETH GRACE—Yes. That was the next thing I was going to say: how secure is this if we go to that capacity?

Mr Williams—One may be able to receive the message but the message would not mean anything. It is perhaps possible to receive and to listen in to other people's messages but you would not understand what they were saying until you were part of that encryption technique. Most of them involve the use of keys—sequences of characters and numbers and other things—to allow people to decrypt, if you like, their message. They often refer to public and private keys where the public key is known to a number of parties and the private key is not.

Mrs Laffey—On the subject of the DPS, while our group does recommend its use, we do recognise some limitations with that software. The main one is that it is less readily available than some of the others, but by the same token it has been developed locally and it has local product support in conjunction with defence signals directorate input into that encryption process.

Mrs ELIZABETH GRACE—So it is fairly important that as a government we move reasonably rapidly in this area to make sure that when things become more

accessible this becomes more uniform without high expense in having to cross over or intermarry different programs.

Mrs Laffey—One of our group's concerns about the DPS also is the fact that it is designed to encrypt files and we are considering electronic commerce in the real time sense as well. While the DPS could be used for that, you would still need additional encryption for a real time scenario.

Mrs ELIZABETH GRACE—In point 3 on page 1 of your submission you said that potential problems will arise with the ownership of data, where the central data repository resides, and how authorisation for access of data is administered. Would you like to elaborate a little bit more on this, because I think this is another area that we are going to have to look at as a government.

Mr Quilliam—I raised that point. What is tending to happen now is that there are certainly centralised databases of patients' medical records starting to become evident around the country. The problem that we foresee is where the data is coming from disparate sources—as to who, in fact, owns that data once it reaches a centralised repository. We see perhaps some problems associated with that. But not only that, we see problems with how that data is, in turn, returned to various providers of medical services so that the information is being returned to other service providers. Our question is not only about ownership, but about how secure that data is when it is now residing in a new service provider's residence or their place of work. We do not have any answers to that at this stage, but we foresee them certainly as potential problems that need to be resolved.

Mrs WEST—Further to that, on the second page of the submission from the association there are two points that raise the question of disaster recovery and the physical security of data following transmission. But the second point raises the question of disaster recovery techniques. Could you tell the committee what is meant by that point and what precautions you are taking to prevent any problems that may arise?

Mr Quilliam—We have highlighted that because of all the data that is held, particularly in central repositories. There certainly do need to be adequate disaster recovery techniques in place, otherwise that data will no longer—

Mr FORREST—What is 'a disaster'?

Mr Quilliam—An equipment failure. It is going to be stored on a hard drive of some description or some other media in a computer based situation and should that equipment fail then there is a protocol to follow if that occurs so the data is readily available still to service providers.

Mr FORREST—That is easily answered. I have got a huge database in my office which is backed up every day. It is just a question of backing it up.

Mr Quilliam—What we are saying is that there must be provision for adequate recovery of data, particularly if it is going to be accessed not just by one area but by multiple areas from a central database; so the down time has got to be minimal as well.

Mr FORREST—I get really frustrated with the evidence that this committee is collecting. People create issues; this is not really a serious issue.

Mr Quilliam—Is it not?

Mr FORREST—People are just trying to grasp onto something to get in the way of the roll-out of something that is going to be good for the people that I represent.

Mr Quilliam—This is a very important aspect.

Mr FORREST—We currently have a system where a breach of privacy can occur as easily as that. I saw it in evidence last week in a medical practice. I was put in a room with three files on a desk in front of me. If I had been inclined, and a curious person, I could have discovered the medical problems of three people in a small community. Are we serious here? We have an opportunity to tighten up on some of these privacy issues with this technology and the risks that we are hearing about are far worse than those that currently exist. Why is there not an uproar about this paper based system we have now?

Mr Quilliam—The problem I alluded to is a normal problem in computer based situations where there have to be adequate recovery techniques following equipment failure as opposed to privacy.

Mr FORREST—Your submission talks about those issues of privacy. Why is there not all this great concern about this huge amount of paper that can be so easily read by anybody? Because of new technology, suddenly everyone is concerned that the whole world is going to read it.

Mr Williams—If I can speak about some of my experiences. I am currently the director of information services at St Vincents Private Hospital. Part of our patient record is computerised. We have a situation where any of our doctors—or even people pretending to be doctors—or clinicians assisting in the patient's care could walk in and try to access the patient's paper based records and where a doctor can take those records, particularly after the patient has left, out of the building to another hospital or to add to his or her documentation to them. We have all these problems.

I do not know why there is not an uproar with regard to the paper based records. There seems to be more of an uproar with regard to when we move to computerising some of those records to ensure—

Mr FORREST—Exactly, you try to make it safer.

Mr Williams—That is right. So we have to employ other techniques. For example, when we first set up the system, who has access to that particular patient's record on the computer? Only the doctors who are looking after that patient, but we cannot have that because at any time any doctor could be called upon to assist. They could be walking past the corridor and be called upon to look after that person if there is some particular problem with that patient. So we have to make all of our computerised records available to all of our clinicians and doctors accredited to the hospital.

We monitor access to the patient's records so we can report to the main doctor attending the patient. We report on who is accessing it. In actual fact we are providing better security, I would suggest, than our paper based systems.

If I can take the examples further. We are also currently providing pathology results not only for patients in the hospital but also for patients who have been consulted by doctors in our clinic next door. Because we are physically co-located, we can provide from the pathology supplier pathology results. It just happens to turn out that we are providing pathology results on-line to these clinicians where those people may never be patients of, in this case, the private hospital.

I am, if you like, perhaps the de facto custodian of that information. The doctors want me to keep that information for quite a period of time on my computer systems. I have security systems in place so only those doctors in this case can access that patient's results. But I do have a responsibility. I think what the submission was trying to address there is that there have to be guidelines and—I suppose, since I am coming from a hospital perspective—in the accreditation process of hospitals some type of review or examination to see that these processes actually exist.

If we do away with the paper, it is quite easy to lose all of that data. If we have a fire in our medical records department, we have got the same problem, but you have more problems with computers than you do with fire in buildings in actual fact.

Mr FORREST—All you would need there is a backup provision and the tape locked up. There are some protocols about how that is done, surely?

Mr Williams—That is true. In our scenario we are dealing with much smaller down times. We have equipment in networks and much more sophisticated systems to provide that information much more quickly if a disaster occurs. The principle is basically the same.

Mr ALLAN MORRIS—You refer in your submission to HL7 accounting aspects. We were under the impression that HL7 was operational and was being used fairly widely, but your submission seems to imply that that is not the case.

Mr Williams—I am not aware that HL7 as the North American standard or the

adaption to Australian conditions—that is, the recent standard released by the minister—is in common use within health facilities today. Some organisations may be using HL7—the North American version—to communicate between patient admission and discharge systems and, say, pathology, but they would be only a small number I would suggest. While the Australian standard has been released, it will take some time for software vendors and others responsible for software to incorporate that standard into their systems.

Mr ALLAN MORRIS—Perhaps we will have to check back on the *Hansard*, but I had the impression from a number of people who gave evidence and from people I have spoken to privately in pathology practices and so on that HL7 was very widely used. The second question I wanted to ask you is to do with analog and digital and encryption. If you go real time, as some of you were talking about, in some of your billing and, perhaps, the transmission of pictures and so on and it is encrypted then the question of analog and digital transmissions could cause some serious problems.

Mr Quilliam—I think it is true to say that. Digital line facilities would certainly be the preferred source. Analog would simply be too slow in those circumstances, but not too slow, probably, for the message structures that we are talking about here.

Mr ALLAN MORRIS—The encryption technology would have to be different, wouldn't it?

Mrs Laffey—No, the digital package we are recommending is independent of the method of transmission and the line used because all it does is convert a file into an ASCII format and send it. It does not matter how it is sent.

Mr ALLAN MORRIS—If that is the case then it would be very easy to crack that code, wouldn't it? That would be a very simplistic encryption that would be simple to crack if people wanted to.

Mrs Laffey—The 40-bit secure sockets layer encryption package that is readily used, but not by our group, takes 250 workstations linked together and 5½ hours to crack. We are talking about a more complex encryption than that. We are talking about a 56-bit private key algorithm and 512-bit public key algorithm. It would probably take a significant amount of computer resources and time to crack it, no matter what transmission method is used.

Mr ALLAN MORRIS—This is what I am concerned about: we currently have a digital analog system in the country—across our exchanges and so on. If we were designing it for best advantage you would design it for digital, which would probably be much more effective with much less computing power involved. If we have to cope with analog in the bush, in particular, we will have to have a two-tiered or two-class system. I am curious as to where you see the impediments.

Mrs Laffey—We do not see any particular impediments other than that digital is more secure anyway. But we are not actually closing off any hospital or health fund options as to what line they could use for our EDI transmissions. We do not suggest that they need to use digital, even though it is a little more secure, because we believe that the encryption is sufficient even on an analog line. As Steve said earlier, it is possible that the transmission times might not be sufficient.

Mr FORREST—Mr Morris used to write computer programs; he can actually read ASCII files himself. You said this software was freeware; that means anyone can have it. Once the encryption is done that does not mean that if I have the same package I can unencrypt it—I have to go and find this complicated formula. How does that work? People are concerned about that. If you can encrypt it you can unencrypt it if you have the same package, but that is misunderstood.

Mrs Laffey—You can only decrypt it if you have the public key of whoever sent it to you. It actually involves the use of two keys. You have to have the public key of your counterpart who has sent the message and your own private key. But we believe that there is more of an issue of who will be using those keys and who has access to the keys other than the encryption and the ability to decrypt it as the message is transmitted. We believe that the access at either end of the transmission is probably more of an issue. It is the same issue for paper based records; there is no difference.

Mr ALLAN MORRIS—I think you are simplifying it. Anybody who has access to the key methodology, in other words the kind of regime you use to set your keys, could cut back the decryption time quite substantially. All it requires is an ex-employee of one of the organisations, who knows the regimes that are used, to run a sample of those regimes. They would be able to decrypt it in an analog system much more easily than in a digital system. That was what I was concerned about.

Mrs Laffey—That is possible but they would have to know the private keys and no-one ought to know the private keys involved—or secret keys as the Health Insurance Commission—

Mr ALLAN MORRIS—If they know the basis on which people set up their keys, whether it is alphanumeric or whether it is five or six characters—there is a range of ways to set what those private and public keys are—and if they have worked within the system and know what regimes are used in organisations then the capacity to decode those is very high. It is not a random thing of taking all the possible combinations; you actually narrow it down quite substantially. That is why I was trying to suggest that digital would be better. On the other hand, if we use that we may lock out some remote or regional areas that do not have digital systems. I do not think as a community we are facing that question, because you are saying, ‘We can encrypt it anyhow, therefore we do not need to.’ I am saying, ‘I don’t think that is quite the case.’

Mr Williams—My comments go back to what Jenny said with regard to the

regimes. The intention is to not use any key regimes.

Mr ALLAN MORRIS—But you will, because you are human beings.

Mr Williams—But it still takes that type of computer power and effort to be able to pull it apart.

Mr ALLAN MORRIS—No, what I am saying is that it is not working totally from random across the maximum range of possible public and private keys. If you know that a particular hospital will use a regime which is four characters long and will be half alphabetical then you actually reduce that back to one-tenth or one-twentieth of what it would take in a totally random situation. With digital you are much safer and it is easier and more secure and in a way we should be talking as a society more about the inequality of areas that do not have access to digital technology because that will, in the years ahead, become a real handicap. If we bring it in now designed for analog then it will not be long before pressure pushes us onto digital and then we are going to start locking out people who do not have access to digital technology. That was my concern.

Mrs Laffey—That is true and it may not necessarily be a remote region issue. It is a cost issue because digital is more expensive. That may mean that a private hospital in an area which has access to a digital network is also disadvantaged in that way.

Mrs VALE—I am interested in your pilot project sites. What are these sites trialling? Just answer briefly because I note that there are several. What is the impetus for the establishment of these sites?

Mrs Laffey—The impetus has been from individual health insurance funds and private hospitals who believe that there are benefits involved in transmitting claims via EDI. We have tried to provide an impetus as well, but it is really down to a particular organisation to do a cost-benefit analysis based on their individual needs. Of the pilots that are currently running, St Andrew's Private Hospital in Adelaide is the most advanced and they are sending EDI claims via a value added network service of Telstra to National Mutual Health Insurance. National Mutual Health Insurance has been the most proactive fund. It really is down to whether a fund is willing to commit itself. They are also beginning to suggest that EDI based transactions will become part of a contractual arrangement between private hospitals and National Mutual Health Insurance. They are currently sending claims and they are finding that there is a lower error rate, a better turnaround for payment—so the hospital is benefiting from that—reduced paperwork and various other benefits involved.

Mrs VALE—Are these sites able to exchange information or are they just specifically for data storage and access within the particular hospital or private health fund?

Mrs Laffey—They are able to exchange information. St Andrew's Private Hospital is sending claims information to National Mutual. National Mutual is currently writing a message assembly program to send a statement of benefits in return via the same process, which will enable easier reconciliation for that hospital. Ashford Community Hospital is currently sending EDI claims and paper based claims so they are in what we call a parallel processing phase where they are testing the accuracy and integrity of the data that they are sending via EDI by doing both at once. They will be implementing it in the near future.

St Vincent's Private Hospital in Sydney is currently sending test data on a floppy disk to two health funds in Sydney, MBF and HCF. Western Sydney Health Service on behalf of Westmead is, for the private patients, sending test data to HCF as well. There are a number of others who are beginning to become involved in pilot testing, but their ability to do so is dependent on whether software has been written to send an EDI based transaction. That is up to the individual software vendors within the particular hospitals and health funds to do that, because they know the system very well and they know how to extract the data elements necessary to send an EDI claim better than anybody else. Some of the major software vendors in hospitals are starting to write code to send EDI claims so we are looking to have quite a number of pilot sites up and running over the next year or so.

Mrs VALE—How long is it since the pilot sites were established? How long have they been in progress?

Mr Williams—St Andrew's has been going for at least 10 to 12 months. Really what we are trying to deal with is the amount of paper that flows between the hospitals and funds, and in other avenues from the funds to the Health Insurance Commission and so forth. The amount of paper and the processing that goes on is really at the heart of what we perceive as the benefits and savings to both sides of the equation.

CHAIRMAN—Thank you for appearing before the committee this morning.

Luncheon adjournment

[1.07 p.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

BAILIE, Dr Ross Stewart, Fellow, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory

DOUGLAS, Professor Robert Matheson, Director, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory

KELMAN, Dr Christopher William, PhD student, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory

MOUNT, Mr Christopher Donald, PhD student, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory

SMITH, Dr Leonard R., Consultant Epidemiologist, National Centre for Epidemiology and Population Health, Australian National University, Canberra, Australian Capital Territory

CHAIRMAN—Thank you very much, gentlemen, for appearing today. We have read your submission and we found it very interesting. I notice that it has been prepared by some academics and some future academics—PhD scholars—and that these people all have wide experience in medical practice as well as in administration. It is pleasing to see both arms, the bureaucrats and the clinicians, rolled up into the same bodies. Would you be able to briefly summarise a couple of the highlights of your submission? Do not regurgitate it, as some witnesses have endeavoured to do, but just give us a brief outline so we can focus our questioning.

Prof. Douglas—Certainly. I agree that part of the problem is the fragmentation of expertise. We wanted to make four major points to you. The first is the significant problem that there is no guiding policy or framework for health information through electronic means in Australia at the present time. That is both a serious loss and a potential loss of a major opportunity.

We believe there is a need for an advisory body that incorporates representation from consumers, from health-care providers, from academics, from industry and from government that will focus on the future and be able to respond to the changing ability of the system. We think that, unless that happens, we are going to miss the golden opportunity that exists at the moment of being able to exploit the current state of the art computer technology and the fact that, to some extent, we are operating in a relatively green field in Australia at the present time with respect to making it work better for us.

That is our first point: we need a better framework.

Our second point is that we think that we need to intentionally build Australia's health information system from the population and the community and the individual rather than from institutions. There is a serious problem starting to emerge that, if the system is built from hospitals down, it will have the wrong flavour to it and will not serve the needs of the community. We are happy to talk further on that.

The third thing is that we believe there needs to be a system—and it is now possible to have a system—where the individual Australian is in charge of their own personal health record, and we think that is where it should be. The health record should be if not in the patient's wallet then at least in the control of the patient. They should be the person who unlocks access to it for the rest of the system rather than the rest of the system defending their access to it, which is where we are at the moment.

The fourth point we want to highlight is the need for the information system to be adapted to the needs of the population as a whole so that we can use it to make better decisions and not to waste so many health dollars, and that really does mean considering the issue of record linkage. Those are really the four issues we would be happy to talk about, although we would be happy to try to answer any other questions you may have.

CHAIRMAN—I think the lack of a guiding policy is a point that has come home to us in the evidence that we have received. We seem to have pilots going everywhere; some going nowhere. Many are doing good work but information is not being shared and then a pilot is being recreated across a state border. If I said to you, Professor, you are now the minister for health and family services, what would you do to bring about such a guiding policy?

Prof. Douglas—I would create a standing committee somewhere in the system, maybe in the National Health and Medical Research Council or maybe in association with National Health Information Agreements, but it has to be a system that is not driven by one group. There does need to be multi-representation.

CHAIRMAN—Clinicians, bureaucrats and consumers—

Prof. Douglas—Clinicians, bureaucrats, patients and the computer industry—and that is just not happening. As you say, we have little things happening all over the country but there is no intentional effort. I think this inquiry is unquestionably the place to begin to develop a decent national effort—

CHAIRMAN—The minister clearly has a concern about it; otherwise he would not have referred this to us. The submission notes on page 6 that the centre currently has two PhD students, the gentlemen at the table:

. . . working on Health Information Management. The first candidate is exploring the potential uses of existing data sources for monitoring health outcomes and health service utilisation.

Perhaps those two students could detail for the committee options for storage of data and information.

Mr Mount—I think possibly this is a question for myself. I would highlight that the use of the existing systems for health management is the work that Chris Kelman is focusing on, so that is making best use of what we currently have on the ground now. My work, which is the diagrams at the back of the submission, is focused rather more on the future, what we could be doing, and making the best of the health information that is out there. An underlying thesis is that the aggregation of the fragmented record can provide improvements to the health of the individual simply through bringing it all together so that every individual health care provider is going to make a better decision. There are also benefits that may well accrue purely through the empowerment of the individual.

Looking at the systems outlined on the diagrams here, you may have a national system whereby you connect all the health care providers. They send off all the information that they collect to a central point or more likely to a collection of distributed data warehouses. When you walk into the consultation room, the doctor sends out a request to the national processing centre and says, 'Send me everything you have on Chris Mount'; down it comes and away you go. With that central system, while meeting the needs of the individual you can then draw from that information for population level analysis and administration research.

The second option we demonstrate is actually much more individually focused whereby it is the consumer who gathers up the fragments out there and holds them in their wallet or in some other mechanism.

CHAIRMAN—On a smart card?

Mr Mount—Smart card is the most likely candidate at this time although there are capacity questions there. I am looking more at the process and possibilities and separating a bit from the technology to some extent. By giving that power to the individual to collect their record in one place and then choose who they issue it to, allow access to it, you circumvent a lot of issues of privacy and confidentiality that are, in many ways, driving the discussion today when they are a peripheral issue. The real issue is: let us make everyone healthier.

CHAIRMAN—That would presuppose a certain level of, I will not say, intelligence in the community that everyone would be able to manage their own records in their wallet or in some other way. Is that a realistic assumption that all sectors in the community would have a capacity to do that?

Mr Mount—I think to say that every single one of the approximately 18 million of us out there could do it is probably not right. There is a very high level of desire in the population to have more control and access to their information. The third option is the

one we are primarily suggesting. One of the major concerns in using a smart card type system is what happens when the card is lost? You have lost that aggregated record and that would be detrimental to the individual.

CHAIRMAN—Unless there is a master file somewhere.

Mr Mount—That is right. The proposal is to have a separate national backup facility which, in many respects, looks and sounds a bit like option one but is actually a very isolated structure security wise because it does not have to make real time connection with the consulting room. It can actually be physically separated and require tape transfer so there is no actual electronic network connection to this place. So you have a high level of security, but all that information is collected at one point or in a series of warehouses and you can then replace those cards as and when a consumer desires it. Additionally, in building on that facility you can, through appropriate controls, issue information for the population level management of health so that you are providing information for administrative purposes, for research purposes and for the application of population level health action.

CHAIRMAN—Ethical considerations and privacy considerations have been expressed to us as matters of concern. I do not know whether you have read the evidence of previous hearings, but I think the collective view on the committee, not absolutely, is that privacy concerns can be overstated bearing in mind the lack of protection of privacy existing in paper based records. Mr Forrest asked a series of questions on that this morning. I imagine from what you are saying that you see this as simply being a problem that has to be fixed and you believe, through your submission, that it can be easily fixed?

Prof. Douglas—I do not know that it is going to be easily fixed. It is a second order question. I think it is fair to say that we have somewhat of a disaster in Health Information Management at the moment and that confidentiality is not all that special in the present system.

CHAIRMAN—People do not worry about it because it has always been that way.

Mr FORREST—There is no uproar about it.

Prof. Douglas—My own sense is that the Australian community, while it is easily stirred up about the issue of privacy, nevertheless is really a very sensible community and recognises the need for medical information to be accessible to make better decisions for them. Electronically, you have better chance of making something rational.

CHAIRMAN—Following on from that point, could you discuss how you have assessed degrees of security with the various options?

Mr Mount—I think you are referring here to the table in the submission. In the

table, it is probably fair to say we really looked at relative levels of security. In simple terms, the absolute level of security achieved depends on how many resources and much money you are prepared to throw at the question and also the development of good human protocols—you have to manage the human factor. Technology is fine to get that right, but it is the people who use it who are the other half of the equation in terms of security.

In a sense, this table is looking at relativities between the three options proposed rather than an absolute figure. To that extent, we have also divided it into two components. There is a risk to the system. If you could get into the system and you suddenly have access to 18 million records out there that is a risk to the whole community. That is a different level of risk to the risk to the particular individual. If a particular individual's records are got into that is 100 per cent penetration for that particular person, but in a global sense it may not be as important as preventing someone getting access to the whole nation's health records.

In that sense, we divided the table into those two components. We feel that, in system terms, for option one, where you have lifetime interconnection between the central facility and consulting rooms and require a fairly rapid security process, there are opportunities: if you sneak into a hospital and get on a terminal you could plug in and work your way round and get all that information. There is potential for a reasonably high level of risk for system wide problems. Also if you can get into the system you can get into individuals' records as well. The system wide risk with the other two options is much lower and, in terms of the individual, it depends on the resources you apply to the security question.

CHAIRMAN—The submission indicates that the Medicare number provides an identifier that could facilitate useful aggregation of the currently fragmented health record. Most families would have one Medicare card. How would you see this would or would not create confusion?

Dr Smith—There are two aspects to that. The Medicare card itself has a single number, but obviously family members on that card are separately identified. Behind that card sits a computer system at the Health Insurance Commission on which each of the family members has a unique number. As a national resource for identifying individuals in the Australian population, we would be thinking more about the database held by the Health Insurance Commission than the actual card. The card could be modified if needed to show individual numbers.

Mr FORREST—I was hoping that you might have a strategy in place by which the thesis the students finally come up with can be communicated. It seems to me—and I think you partly answered my question—that there is an overreaction to this privacy. When there are breaches of privacy occurring innocently, maybe even deliberately, day to day with the current system, we have with this an opportunity to provide a much secure retention of health records on top of all of the benefits that can flow from the whole issue

of Telemedicine. We are in an exercise where we need to communicate a lot of this to GPs, consumers and everybody. There is a lack of understanding. They just see this big electronic monster instead of focusing on what can be real benefits. Can you draw that together? I am particularly interested in how you might go on beyond the conclusions of the PhD projects you have.

Prof. Douglas—I think we have embarked on these two PhD projects recognising that they do offer policy ways forward if the work that Dr Kelman and Mr Mount do produces something that looks rational. I think the way they are going to conduct those projects is different. Dr Kelman is wanting to embark on this whole issue of record linkage and use available data that is already accessible through health insurance companies and through Medicare to better assess the outcomes of various devices that are used out there in the community such as artificial hips and lens implants and so on. We are not monitoring that kind of thing very well at all at the moment. My own feeling is that his case study is a project that is advancing very nicely and it will raise a lot of these issues about record linkage.

CHAIRMAN—It must be reassuring to hear that, Dr Kelman.

Dr Kelman—I will add a bit to that when Professor Douglas has finished.

Prof. Douglas—Mr Mount's project is starting further back. It is really asking: how do we start with the consumer and work towards the national database and improve the quality of care for the consumer, guarantee the confidentiality of care for the consumer and, at the end of the day, end up with a better health information system that enables Minister Wooldridge to make better decisions? My guess is that there will be pilot studies that Mr Mount will embark on. We see your inquiry as important because we see the possibility of you giving visibility to some of the issues that are still somewhat clouded in suspicion out in the community, enabling us to go ahead and get funding and trial resources to test some of the approaches that Mr Mount is talking about. Perhaps Dr Kelman will want to talk a bit more about the record linkage.

Dr Kelman—It is reassuring to hear myself described as a pragmatist, because I am not actually happy with the current system. The driving force for my project was to say that we have national databases; we record huge amounts of data about patients, about their health service utilisation—even about their outcomes. We are not using it. I am saying that there are various impediments to us using that information easily at the moment, but my project was designed to prove what we could do with that information, even now. My project is designed to support some changes in the way this data is collected and integrated, which will support your project, of course.

The current status quo is not adequate. We have got major problems with identification of individuals in these records, for instance. Data which describes all hospital admissions across the country is not identified. So if you want to follow a patient

through the system it is very hard to do that, because the individual data is removed from the name of the patient by the states before submission to the Institute of Health and Welfare. So we have got some work to do.

CHAIRMAN—For privacy reasons?

Dr Kelman—Yes, and because of the ownership the states like to keep over their expenditure and their health care.

CHAIRMAN—We haven't heard that accusation before.

Dr Kelman—So we have got some major political problems to sort out.

Mr FORREST—There is another area where I would like your input. I have discovered that there is an enormous amount of broad health information on the Internet. I have mentioned at other locations where we have held this inquiry that I had a constituent who needed to know about a new genetic disease called glycogen storage deficiency. I had never heard of it. I clicked on to the Internet, went searching around for a while and I found heaps of information, particularly from Europe. Within about half an hour I had an e-mail message from a doctor in Edinburgh who was doing some great research on Pompei's disease, which happens to be the particular strain my constituent has. Since then she has been able to be on a regular snail mail net. I found that a very useful exercise. She thought she was the only person in Australia who had this disease.

I have also been looking for immunisation information relating to different countries. There is just so much information there. But it seems to me that it is not coordinated; my assumption is that it is not coordinated. There is not any monitoring done of this, any tests of its veracity or whether it is accurate or proper information. I can see that an individual might rush off and take some actions that may or may not be appropriate without a doctor's advice. Is that an issue and should there be some work done to coordinate that better?

Prof. Douglas—Dr Smith is our World Wide Web expert.

Dr Smith—What you say is absolutely correct. The Internet and the World Wide Web are a wonderful resource. There is an enormous amount of information available out there. The problem is that there is no way of certifying its quality. A number of initiatives are under way to try to address that. I suppose at this stage, when the individual is trying to satisfy themselves, apart from commonsense tests of who it is they are talking to on the net, the only way in which we can be sure of the quality of the stuff is to look at the source. For instance, the National Institute of Health in the US is providing a wealth of information on a whole variety of aspects of disease, both from the professional's point of view and the patient's point of view.

If you were to give advice to people about where they should look and how they should filter out the rubbish from the excellent information, in the first instance you would have to say, 'Start with authoritative sources, like NIH in particular.' Other methods are being used as well. There is a project to develop what is essentially an encyclopaedia of the web, where, rather than individuals themselves deciding to put information out, they are commissioned to do it in the same way as an author might be commissioned to write a chapter in an encyclopaedia. Slowly mechanisms are being developed to add that stamp of authority to the information. At the moment, a person coming in cold has no way of telling whether they are being given the latest information or absolute rubbish.

I come back to your point about how we might promote the better use of information. It seems to me that, from our perspective as scientists who are nevertheless quite close to the policy process, thinking converges on the use of trials. In ordinary clinical medicine and in all areas of technology, if we have ideas that we think could be beneficial, we think about how you would test them out. In this particular area where there is a strong public and political interest in it as well, to try it out is itself a part of the process of promoting it and demonstrating that the fears that people have are not necessarily going to be realised.

In Australia we do have some excellent examples of the way in which integration of existing information can produce enormous yields in terms of monitoring of public health, in terms of monitoring of the use of health services and their costs and improving them. The state of Western Australia is by far the best example. Over several decades they have been getting their act together, linking together all of the records over which the state has control. So at the moment, if a researcher who has authority to access the information wants to know anything about clinical history or health service contact history of an individual in WA, to the extent that they got those services from the state you can get that information. It is all linked together through an existing patient master index.

What is missing is the capacity to link that to Commonwealth data—the Medicare data and the PBS data. So if you ask me what way we would see forward in this I would say that somewhere there need to be trials of total linkage of state and federal data. To some extent that is being done at the moment through the trials of coordinated care in particular age groups that the Commonwealth has promoted over the last few years. One could sit down and I think map out a strategy of testing the feasibility of the various steps that need to be taken towards a system of total linkage of the data on individuals. That would involve both testing the technical feasibility of it and also testing the politics of it to make sure that people were satisfied that it did not bring with it any dangers or threats. That is how I would approach it.

Mrs ELIZABETH GRACE—We have had some comments when we have been going around listening to submissions that a very small percentage of GPs use computers for clinical purposes and that we may be some way away from them doing it as a general use practice. I noticed that you said in your submission that there were important changes

in the Health Information Management in the computerisation of general practice. Would you like to expand on that a little bit?

Prof. Douglas—I will invite Dr Bailie to speak. He is very much involved in the ACT coordinated care trial and is looking at the issues relating to general practice involvement and is partially supervising Mr Mount's work with respect to its involvement in the general practice area.

Dr Bailie—I think the fact that very few GPs' general practices are computerised and even fewer of them actually have a computer on their desk is very true. It is one of the hindrances to really getting a well-established national electronic database together, but I do not think that should be overplayed. It has been achieved very successfully in other countries. New Zealand has much higher rates of computerisation in general practice. In the UK I think almost every general practitioner would have access to a computer. There is a very well-organised and efficient system of entry of information in general practice in the UK, and there is a feedback mechanism.

We have not given any thought directly to time frames of how soon computerisation can be achieved in Australia, but the AMA and the RACGP are working at the moment on a strategy for Information Technology in general practice. I think the obvious strategies are to provide incentives—some of which will be positive and some negative. Obviously financial funding for practices is an important issue, but I think the other side of that is to make some demands on general practices to submit information in an electronic format which would be entered into the system.

Mrs ELIZABETH GRACE—It has been mooted that possibly electronic payment could be one way to provide an incentive which would turn Medicare claims around much quicker through a general practice.

Dr Bailie—Yes. Obviously if those turnarounds were quicker there would be a positive incentive as well.

Prof. Douglas—I will come back to my first point that I made at the beginning of the presentation: it has to be done as part of an intentional process. What I think is a very serious concern at the moment is that everybody is doing their own thing. The general practice branch in the health department is trying to do something, the AMA is trying to do something, the college of GPs is trying to do something. There is not a serious national coordination taking place. I think that we need to get that right—as I see it, that is the most important outcome of your deliberation—and we need to put something on the national agenda that does enable this dialogue to occur and advice to take place. Then we need to put big resources into making it happen. I think the big resources will pay off both in terms of the cost to the health system and in the possibilities of export industry.

Mr FORREST—You suggest that should be the National Health and Medical

Research Council. Is there any reason why you picked that group out?

Prof. Douglas—Yes, because it has a tradition of bringing all of the players together. Its council does bring various stakeholders together. It is a forum in which the states and the Commonwealth, the consumer representatives, industry, academics and government employees can actually thrash it out and be forced to come up with some kind of advisory documents. It seems to me that only when you have all of those players involved, and you have something from the NHMRC that has put its seal of approval on it, does it have the kind of force that enables it to be implemented in our federated system.

Mr FORREST—Are the consumers adequately represented in that council?

Prof. Douglas—Yes, though I am sure they would say ‘not adequately’. They may say they are not adequately represented, but I was on the council when the first representatives started to come on board. I think their contribution has been immensely important. I think that meeting point between those players is part of what has to go on if we are going to get to a decent national informatics strategy. I would very strongly urge against it being sequestered in bureaucratic hands.

CHAIRMAN—Thank you very much for appearing before the committee today. We greatly appreciate your contribution. I must say that I personally would like to have the opportunity of having a look at your theses when they are ultimately submitted. I suspect that they will not be finalised before our inquiry is, but certainly both of you seem to be doing a lot of very good work. Thank you very much.

[1.40 p.m.]

CHAIRMAN—I ask the secretariat to invite the witness to swear an oath or make an affirmation.

CERCHEZ, Dr George, Director, Division of General Practice Northern Tasmania Inc., 37 Elphin Road, Launceston, Tasmania 7250

CHAIRMAN—Welcome.

Dr Cerchez—Thank you. I am here today not representing, as the title says, the Division of General Practice Northern Tasmania, but I am here in my role as a board member of a non-profit company called GP Divisions Services. This company was established by the Divisions of General Practice as the result of advice from a consultancy initiated by a General Practice Branch. Because the submission was made over 12 months ago, the situation of our original submission has changed quite substantially. I have prepared a follow-on document which, if I am allowed, could be circulated for your consideration.

CHAIRMAN—If you could give it to the secretary, we will receive it as evidence and it will be circulated and be considered.

Dr Cerchez—Thank you, I have done that. I will make a brief statement. GP Divisions Services, as I said, is a non-profit company whose primary objective is to facilitate the interaction of divisions with commercial organisations. It is bound by a memorandum of articles which covers its rules of membership. Elections are held and directors are appointed. Directors represent each state, and they are developing strategies to improve services for general practitioners and divisions.

An important part of the GP Divisions Services philosophy is to remain entirely non-medico political and develop ethical partnerships. We have decided to encourage computerisation in general practice. Therefore, we have adopted as one of our main activities the development of a nationwide network of computer servers to provide a secure and inexpensive e-mail service for divisions, and through them, to general practices.

CHAIRMAN—At this point could you just outline and elaborate on that proposal? Is the proposal on behalf of just the company or the Division of General Practice Northern Tasmania or on behalf of all divisions of general practice Australia-wide? Where did the initiative come from? Did the proposal receive any federal or state funding? In answering that, you might tell us whether the non-profit company receives any federal or state funding.

Dr Cerchez—You will have to repeat some of those questions as we go. Firstly, the northern Tasmania division was one of the 10 demonstration divisions in the first year in 1992. They set up a lot of the framework for divisions, along with other divisions like

Hunter Urban and some of the more advanced divisions. Early on in the process we were given the charter of developing an electronic communications system for divisions of general practice, and we have been running that from northern Tasmania for the last three years.

CHAIRMAN—For or from?

Dr Cerchez—From. Which goes to show that you can run electronic networks from anywhere in Australia. In the northern division of Tasmania we have the hub, if you like, of the e-mail system for divisions. It is recognised that Tasmania does not run Australia, so we felt it necessary to get some partners for this. We have now secured a node in Victoria, which has been funded at by a contribution by the Victorian government, and a node in South Australia with a contribution from that state government. So two state governments have now invested over \$300,000 to establish computer servers.

Our aim is to build servers in New South Wales and the other states as well and link them, making divisions important in the transfer of information. If you refer to my document, you will see a figure—the pages are not numbered and I apologise for that but it is the only figure in the document—that shows that GP divisions are at the centre of information flows. No doubt the committee has heard various submissions about hospital networks. The problem with these networks, as you have heard from the previous submission, is that often the GP's data—which is the most plentiful and, if you like, the up to date—is left out of these situations. So we are proposing that data be held by a GP division, not a central information source, be held on patients. But patients go to general practitioners—85 per cent of people in any one year attend their GP—so the division could become the ethical and secure data source for that patient. It is local, it is linked by local call access and the philosophy behind the concept is given in that diagram. Are there some other questions?

CHAIRMAN—What funding, if any, did you receive? Was it state or federal funding?

Dr Cerchez—The state funding I have outlined to date. There is no federal funding in the company. The company has been formed by contributions by 62 divisions of general practice so far out of the 112. It is on a very limited capital basis that we are proceeding with this. That is causing some of the slowness of its penetration.

CHAIRMAN—Can you clarify for us if you are now seeking full federal funding, which you estimate at between \$1.2 million and \$2.2 million? No doubt Mr Forrest would be interested to know the degree of coverage you hope to achieve in rural areas. Could you outline briefly how you costed the project, and how you define the rural area coverage, which doubled the estimated costs of the project? Does the rural coverage that you have factored in cover the whole of rural and regional Australia?

Dr Cerchez—That costing, as I say, was done a year ago and it was done with technology a year ago. At that time, we were asked by a committee of General Practice

Branch of DSG, the division steering group, to prepare that submission. They asked us to prepare a submission to develop an e-mail system for all divisions of general practice around Australia, which we did in combination with MATCOM—a South Australian company, Microsoft, Digital and ourselves. The costing was worked out but a lot of things have happened since then. With Telstra's Big Pond and dial-connect services, which have come into play in the last 12 months, that cost is very greatly reduced. Federal funding was not forthcoming for a number of reasons of which we are not certain. DSG recommended that this proposal go ahead.

CHAIRMAN—DSG being?

Dr Cerchez—Division Steering Group—an advisory group to General Practice Branch. But for reasons which we are not sure, it was a seven-week approval process and in the eighth week the proposal was rejected.

CHAIRMAN—The committee will write and endeavour to find out why. We cannot guarantee we will, but we will certainly ask.

Dr Cerchez—There is a number of interesting scenarios but the plan requested was perhaps too big.

CHAIRMAN—Getting on to the rural areas, what percentage of rural and regional Australia do you propose to cover?

Dr Cerchez—Divisions of General Practice cover all rural areas and, again, locating computer service in the division covers the entire rural population. We have submissions before the Department of Communications and the Arts about putting a server in, for example, Whyalla. And, yes, our aim is one of equity of access for rural divisions. Rural GPs can phone in to their division with a 13 number or a 008 number—thereby reducing the phone costs—and access data which is held in their division.

CHAIRMAN—Mr Forrest, do you have any further questions relating to rural and regional areas?

Mr FORREST—I go on the east side of the great divide, too. Is this proposal using some form of Intranet or is it still on the World Wide Web—

Dr Cerchez—The proposal we have put forward is using Intranet technology. The advice we keep getting is that the Internet is cheaper and easier, yet our committee has concerns about the security; I have heard a lot of discussion here about security of the Internet. When I talk about security, there are two issues. One is reliability of message transmission. There is still no reliability of message transmission on the Internet. Security may be an overemphasised concern but it is a very much perceived concern by consumers, as you have pointed out.

I think there is a lot of concern about data going on the Internet—via Bombay, via

Singapore, via America—and maybe ending up in the GP's surgery. That could potentially happen if you put a message out on the Internet. So we are proposing the establishment of an Intranet—which is much more secure—with very broadband links to the Internet when required.

Mrs ELIZABETH GRACE—I would like to follow up with you the comment I made before about GPs being slow to pick up the technology. Not a very large percentage are using computers for clinical purposes but quite a lot, I think, are using them for record purposes. Could you outline for us the extent to which the strategy that you have costed will be utilised by your members?

Dr Cerchez—Unlike the previous presenter, I would say that there are enormous barriers to the penetration of computers in general practice and I have outlined these in my second submission. They are cost barriers, security concerns, limitations of time to investigate it, relevance to the local area and general practice, poor computer literacy and the absence of a national government incentive are very critical. The present system of remuneration, as we heard this morning, does not encourage any investment in Information Technology. Indeed, the rationing of time and absence of a need prevents even the investigation of the idea.

I am in an eight-partner group in Launceston and I have got on my desk a computer in which I have invested \$4,000. My partners, who do not have computers and are not computer literate, are just as efficient and earn just as high an income—perhaps higher because more of my time is occupied in these sorts of activities—as I do. There is no incentive for them to computerise. As for issues such as accuracy and cost savings for the government, most GPs will tell you that their prescriptions are accurate and there are no drug interactions. But since I have been using my computer, I have been amazed at the drug interactions which I was previously engaged in prescribing. The computer has a much better memory than I have. My partners do not know that because they have not had time to pursue it.

Our strategy, because it is a not for profit strategy and all the income from it will be turned back to divisions and general practitioners, will be available at a much lower cost than the commercial Internet provider. If I want to go to an Internet provider, I have to pay between \$5 and \$8 an hour to have Internet access. Why should I do that if there is no perceived benefit and I am being paid exactly the same as my partner next door?

What we are aiming to do—and in it is a strategy—is to provide Internet access to doctors for free and provide support and levels of computerisation through divisions—not hardware; we are hoping that the government may get involved in providing incentives. We are hoping to organise the internet data in such ways—we heard this morning that there is a myriad of data—as to provide an organised site because time is an issue so that general practitioners do not have to waste myriads of hours going through and learning the whole process.

So divisions can get involved in training, they can get involved in organisation of data, they can get involved in storage of data and they can get involved in cost-recovery. There is great economic value to this data. I will give you an example. There is a software company that has surveyed its GP members as to whether they have any objection to their prescribing data being on-sold to the pharmaceutical industry so that they may better assess what prescriptions are being written and what products are being sold.

Seventy-five per cent of GPs involved in that survey had no problem at all with the on-sale of that data. They had not thought through the issues well enough because that data alone is estimated to be worth, conservatively, \$20 million. There are no controls in place when you talk about security. We are concerned about patient security, confidentiality, as well as being used for divisions.

We do not believe that \$20 million should reside in the computer industry. We would like to see that turned back in on divisions and being used to help divisions of general practice once it had gone through a proper vetting process because there are no controls on the de-identification of that data. The government has no controls on how that data is used or what uses it is put to. At the moment, that computer company can collect that data and sell it to a pharmaceutical industry. GP Divisions Services sees that as a major problem.

Divisions have consumers on their management committees or consumers intimately involved, and they are non-profit organisations. So they would seem a logical group to be involved in these scenarios.

Mrs ELIZABETH GRACE—It would be one way of financing your divisions without having to draw from your members.

Dr Cerchez—Exactly, the aim of GP Divisions Services is to point divisions eventually into the areas of self-funding because, like all government programs, some of us realise that they will not be publicly funded forever.

Mr FORREST—Your submission suggests that that project is funded for three years, but what happens after that?

Dr Cerchez—Income generation by collection and sale of data and transfer of pathology information and information from regional hospitals, public and private providers. Imagine charging 1c for transmitting every pathology result which is tested in this country today. It would be a lot cheaper than paying couriers to take it out and so the pathology companies are interested.

If you can charge 1c for every pathology test, you have got an ongoing stream of income. It needs a push and it needs a little injection of capital. Fortunately, the state governments are coming to the party on that, but it is not going to be enough. Once it is

has got a certain momentum, it will be income generating through data, through subscriptions, through access to pathology and x-ray services. It will be an inherently useful system.

Mr FORREST—There is obviously a larger up-front capital cost, but operating costs would not be anywhere near \$1.2 million to \$2 million over three years.

Dr Cerchez—That was the up-front establishment costs of putting the computer service there. I might point out that we were asked to do that submission. Our original idea was to set up a couple of pilots—that horrible word. It was our aim to put one or two servers in in various states. This is happening now. So the \$1.2 million was a request to our division to say, ‘If you want to computerise all divisions and do what you are saying you want to do, what will it cost?’ That was the cost.

Our present mode of operating is to do it in a number of stages. The cost of the technology for that has gone down dramatically, as has the cost of the dial-in capacity through the Big Pond and Optus. We have just been asked to tender again for the division’s e-mail service. Instead of being run by divisions as a project, the general practice branch has decided to go to tender. We are one of the tenderers, and we have worked with Optus on this one. Today I delivered a joint tender with Optus to run the next division’s e-mail service.

Mrs VALE—I would like to ask you some questions on health insurance. At the present time, the Medicare Benefits Schedule does not accommodate consultations by Telemedicine. Does the division have a view as to how the Medicare schedule should be amended to ensure professional remuneration?

Dr Cerchez—This is an issue for GPs all the time. Again, I think back to my own practice. Often pressure of work means that you cannot see all the people who want to see you because of the low number of GPs in a small provincial town. A lot of my time is spent giving advice on the phone, so it is a fairly comparable situation. I would see that, like lawyers and accountants—and most other professionals—to save time, especially in the rural areas where access to a GP in person is difficult, there will have to come to be some sort of remuneration for telephone consultation or advice. I know that every time I ring my lawyer it costs me \$9.20, yet I can be interrupted many times during the day and I am not allowed to charge. If there is a fee for that, obviously it would be quite easy to hook onto that some sort of electronic transfer of information and thereby facilitate the consultation.

Again, in outlying clinics nurses could hook a patient up to an ECG, transmit the ECG to the doctor in the remote centre, and the doctor can look at that. A private doctor could charge for that consultation. At the moment that is not possible because he has to have a patient physically in front of him. I would say there would be an enormous cost benefit by allowing some latitude in the current remuneration for general practice. That is

one of the issues that I have pointed out in the second paper.

Mrs VALE—Thank you. On the role of government, it has been put to the committee that a national plan is essential in order to draw all the players together and therefore achieve a more strategic approach in the development of health Information Technology. The committee would like to hear your views about the possible development of a national strategic approach with the various stakeholders.

Dr Cerchez—I firmly support that. The problem is, as has been pointed out, that there are so many different things happening in different directions: GP Branch is often not aware of what the hospital section is doing, which is not aware of what the Pharmaceutical section is doing. My concern with centralised databases is the difficulty of accessing them, the time cost of accessing them if you are on-line to them, and obviously there are some perceived confidentiality issues relating to those central databases. That is why we are proposing a more local approach, if you like: centrally backed up but locally held databases. We would support it in a very large way.

The divisions support the AMA and the college strategic plan on information management, and they are working to help implement it, but at the moment what is greatly lacking is that coordination. If you want to get in touch with 85 per cent of the population in any one year, it is essential for you to have a few GPs on such a coordination body.

Mr FORREST—As a practitioner and someone who has got some literacy in computers, what is your overview of where we are going with this technology? We have heard so much evidence one way or the other. There are worries and concerns about privacy and all that, and there are so many different pilot projects. My view is that it is time to bite the bullet and get on and implement it—it is time to get a national strategy and get on with it. Will your profession come up with that?

Dr Cerchez—It is exactly what GP Divisions Services has done, and we have been criticised for it by the academics. We have been told, ‘Okay, don’t do it this way. Do it that way. Do a pilot. Do a plan.’ We actually said, ‘No, we’re going to go ahead and do it. We’re going to get something up and running. We’re going to see if it works and we’re going to make it national.’ We are actually going to put something in place and test it. That is the way of GPs, I am afraid. They are pragmatists; they are not academics. They try something and see how it goes. So the approach is coming from a purely GP point of view.

As far as the issue of getting my colleagues on board is concerned, the incentives are going to have to come from government. As I say, at the moment they can earn a very healthy living without getting involved. Naturally, I do not think there should be punitive incentives; I think they should be positive incentives. The general practitioner, as you know, is a very independent, stubborn personality. He reacts to punitive measures in a

very independent, stubborn way and walks away from them. If you think about your own GP you will understand that. I think they would have to be positive incentives. I think, yes, they are going to have to come from government and they are going to have to come very soon. Of the professions medicine and general practice must be the ones that are lagging enormously in the move towards computerisation. Computerisation is something which a lot of my colleagues and I see as being essential. But often you are just too busy seeing the patients and getting the work done to investigate the problem.

Mr FORREST—The national health and medical council, or whatever the acronym is, should be a coordinating policy body, but are GPs adequately represented in that organisation?

Dr Cerchez—I am not sure. I would imagine they are very poorly represented. I could not answer that one from my own knowledge, but I would be surprised if there were a GP on that body—there may well be.

CHAIRMAN—Doctor, thank you very much for appearing before the committee. Thank you for that additional submission, which we will receive and circulate to all our members. We appreciate your input.

Dr Cerchez—Thank you.

[14.07]

CHAIRMAN—I ask the secretariat to invite the witness to swear an oath or make an affirmation.

NEILSEN, Mr Stephen William, Director, Information Management Advisor Section, Department of Veterans' Affairs, PO Box 21, Woden, Australian Capital Territory

CHAIRMAN—Welcome. Could you briefly summarise the key points you would like to draw to our attention?

Mr Neilsen—Certainly. DVA is no longer a provider of health care services and has adopted the roles of service purchaser, facilitator, funder, monitoring agency et cetera, on behalf of the veteran community. It has recognised that management information is an essential part of this new environment and, in order to provide the necessary information to effectively manage this change, the department has initiated a project. The project will provide a means of collecting data from a range of existing systems and relating the data to each other. For example, collecting details of drugs taken by a veteran so that an appropriate combination of drugs can be identified with the aim of improving the health outcome for the veteran. The project will also provide a set of query and reporting tools for easily searching, extracting and summarising information flexibly in whatever form the manager wants it and immediately the manager needs it.

Tools and technology—generally known as data warehousing, can provide the necessary management information. To date, the project has produced a comprehensive analysis of the business needs of managers in the health program of the Department of Veterans Affairs. It has also produced a data model which is based on the Australian Institute of Health and Welfare data model. The DVA model is compatible with the national model, although it differs in some respects. For example, there is little need for paediatrics or obstetrics elements. It tends to focus on the relationship between the veteran, the medical provider and the services used.

Potential outcomes of the project are: reductions in both administrative and program expenditure; creation of an environment where planning for future services is easier and more comprehensive; providing additional tools and assistance for the department's fraud and overservicing detection activities; checking that services being provided to veterans are appropriate; and the provision of timely advice to minister and government on issues and policy matters. By itself, the project will not achieve these outcomes. It is enabling technology which will allow managers to access data which will be collected and stored centrally.

CHAIRMAN—What about some aspects of the security considerations that you have taken into account?

Mr Neilsen—The department's database is covered by the Privacy Act and, as such, all our existing databases are already covered by that act. This database will be no

different.

CHAIRMAN—Will it have built-in security or is it envisaged that encryption keys or passwords will be given to designated staff?

Mr Neilsen—At the moment, only existing staff can access certain elements of existing data. The same security requirements will apply to this. Only the staff who need to access the data will be given access to it.

CHAIRMAN—Will the various databases being developed or trialled conform to any national standards so that information could be transmitted to or shared at another point within the Australian health system if considered appropriate for the health needs of the veteran or widow?

Mr Neilsen—Yes, as I said before, we have built our data model to conform with the national institute of health and welfare data model, with the specific aim in mind that, if we need to, we can share the data. Our major concern there is that we would have to depersonalise the data before we shared it with other agencies so it would become a summary or statistical sharing of data.

Mrs ELIZABETH GRACE—I have heard that some of the work you have done already has uncovered some huge anomalies of people taking medicine that is not necessarily correct medicine and that interacts incorrectly with other medicine and things like that. It is going to be an obvious cost saving if these things can be recognised. Have you got any other anecdotal evidence at this early stage as to what benefits are starting to show through and what cost benefits are starting to show through?

Mr Neilsen—Admittedly, the evidence we have is anecdotal too. It is our line mangers who said, 'If we had access to this information, then we could do these tasks, for instance, finding inappropriate combinations of medical needs.' With the total expenditure of \$1.6 billion, even a minor reduction of one per cent will deliver savings to the Commonwealth of \$16 million. Administrative savings are possible through redeployment of staff, who currently do what we call post-payment monitoring, and through analysis of existing data.

The press has recently reported instances of fraud and overservicing detected at the Health Insurance Commission. Our proposed project will provide the same tools and technology to receive similar results. While recovery of money may prove difficult, there is a possibility that provider behaviour may be modified by the possibility of exposure. There are potential savings.

Mrs VALE—I was interested in the pilot trials. It appears in the department's submission that a number of pilot trials are being undertaken for the management of data and information relating to the veterans and war widows. On page 2 of your submission you say that the health management information system is to be operational by late 1996. In attachment A, you say that a phased implementation plan had been developed and one

phase will be implemented early in 1997.

A trial of health care plans and of regular home visits is being conducted over a two-year period and another trial is mentioned on pages 2 and 3 of the submission, namely the preventative care trial to be conducted over a period of about four years. Could you give us a brief overview of these trials and discuss what each project is meant to achieve?

Mr Neilsen—Unfortunately I cannot. They are not my area of expertise. My area of expertise is the management information system outlined in attachment A of our submission. I am not directly involved in those. Naturally enough, the people who are doing those trials are keenly looking forward to the implementation of our management information system so that they can evaluate the outcomes of the trials.

At the moment though, the project is not up and running. We were a little optimistic in setting our implementation dates. Part of the problem has been that our IT infrastructure has been outsourced to ISSC and the process of getting that new environment set up has meant that all staff in the IT area have been devoted to that job. Staff for this project are very few and far between, so it is still very much in the planning stages.

Mrs VALE—Thank you.

Mr FORREST—It sounds great. You are doing this with veterans. What is the plan to share this information once it can be decided that some good has come of it? Are you able to do that?

Mr Neilsen—As I said before, our major concern is privacy. The veterans' medical records are sacrosanct. However, what we would do is depersonalise the data so it can be used by other agencies if considered appropriate. Bear in mind we only have the capacity to collect information on services for which we pay. For veterans entitled to full medical treatment from the department we will have most information available on the database. Some data will be missing because the veterans are able to pay for medical treatment themselves or in some cases they are bulk-billed.

By collecting this billing data we will have a comprehensive national database on a selected group of ageing Australians. We see that as a possible national resource that would be available to other agencies.

Mr FORREST—A lot of the arguments we get involved in with our veterans concern trying to relate their latter medical problems with their war experience. We need some way to compare a man who has not been in the war that has prostate cancer with someone who has. These sorts of things cause tremendous arguments in terms of the disability provisions through their pension. We do not have a comparison. We cannot compare an individual who has been through that experience with someone who has not.

What we need is a database to try to make these comparisons when all the privacy provisions can be made. Is that ultimately where you can see this information being useful?

Mr Neilsen—There is some potential down the track for that sort of information. Bear in mind at the moment we are limited to collecting billing data. For instance, if a veteran goes to a general practitioner, the information that comes back to the department is that veteran Smith visited Dr Jones on this date and was charged for a short consultation. In fact there is no diagnostic information in that information that we collect. However, if a veteran goes to a hospital under the Casemix proposals we get diagnostic information back about the hospitalisation of the veteran. Depending on the quality of the data that is picked up by that diagnostic related group, then we would be in a much better position to start influencing medical outcomes for veterans. You would need a comparable set of data on the other side of the coin, the non-veteran medical data, and I am not sure if that is going to be available. Once again, it is outside the scope of my expertise at the moment.

Mr FORREST—If that is the only information you are collecting through these projects, what use is that? Is it going to make the delivery of the service better?

Mr Neilsen—We hope that we can provide three different sorts of information, what we call veteran profiles for either individuals or groups where we examine the natural history or the impact of intervention of health care on a veteran. We would also be looking at health service utilisation and effectiveness of those health services, both in a historical sense and for planning processes.

We would like to do the same thing with providers, be they GPs or hospitals; examine what they have done, how they have done it, when they did it and what the future will hold. We would also like to examine the usage of services on a national or regional basis—demographic and geographic analysis in areas of interest either on veterans or on providers or on the services or combinations of all. Of course, financial analysis of fraud and over-servicing will be enhanced.

We would want to be monitoring the performance of the department against its own strategies, providing performance indicators for health departmental activities, and ensure that our operational activities are directed at improving veteran health outcomes. There are lots of benefits but whether we can determine from the data we collect that veteran Jones's prostate cancer was directly related to an incident in the war is unknown.

CHAIRMAN—Is there anything else you would like to tell the committee?

Mr Neilsen—No, thank you.

CHAIRMAN—Thank you very much for appearing before us this afternoon.

[2.20 p.m.]

CHAIRMAN—I ask the secretariat to invite the witness to swear an oath or make an affirmation.

VINING, Dr Ross Frank, Deputy Director, Institute of Clinical Pathology and Medical Research, Westmead Hospital, Westmead, New South Wales

CHAIRMAN—Welcome. Do you have any comments to make on the capacity in which you appear?

Dr Vining—I am the Deputy Director of the Institute of Clinical Pathology and Medical Research and I also bring to this inquiry the knowledge I have gained in acting as consultant to both the New South Wales and Commonwealth governments on reform of pathology.

CHAIRMAN—Thank you for what you have already submitted. Would you like to highlight just a couple of aspects of it to assist us in subsequent questioning?

Dr Vining—Certainly. I will keep it very brief. To my mind, Information Technology and the analytical technologies that are associated with pathology are the absolute key to getting value out of the health system in future. I do not think we can look at the information systems and telepathology in the absence of all the other analytical technologies and transport technologies that drive pathology. We do need to look at those.

I find one of the biggest frustrations in trying to drive further efficiencies through our system is the fact that electronic ordering of pathology is disallowed. If I had to highlight one thing that is needed to enable further efficiencies, it is electronic ordering and that is presently not allowed under the Medicare rules.

CHAIRMAN—Is it likely to be?

Dr Vining—It is not allowed. There have been a couple of trials of it, I believe, but I have not been involved with them. At present it is discouraged and, I think, largely disallowed.

CHAIRMAN—Why?

Dr Vining—My understanding is that the Health Insurance Commission legislation covering Medicare will not allow electronic ordering of pathology.

CHAIRMAN—I am well aware of that. What was the rationale behind that legislation in your view as a practitioner?

Dr Vining—I was not involved in pathology when that ruling first came out. I understand it was put in there to stop excessive ordering.

CHAIRMAN—The submission outlines a number of telepathology pilot projects, including one that is being funded by the government of New South Wales. Would you like to give us an update on those pilot projects?

Dr Vining—Yes.

CHAIRMAN—It seems to us, from our hearings to date, that we have lots of pilots everywhere. Most of them are doing great work. There seems to be very little interconnection between one pilot and the next and very little sharing of information resulting from pilot programs. Would you outline what you are doing? Are you going to share what you find out with others?

Dr Vining—I would be delighted to do so. We have been involved for more than a year in a telepathology link between Westmead Hospital and Armidale Hospital. We had also intended to link ourselves to hospitals in the south-west of New South Wales, specifically Wagga and Albury. We have had considerable equipment problems, which have delayed the whole project, so I cannot report to you as much as I would like to be able to. Interestingly though, we have had a lot of cooperation between our own efforts and another linkage. There was to be a linkage between Hunter area and Tamworth Hospital. They also have had some equipment problems, mainly at the Hunter end. Our problems were at the Armidale end, so their Tamworth end has linked with our Westmead end. There has been considerable cooperation there.

CHAIRMAN—We have inspected Telemedicine projects and we have not been told of problems that people were having with equipment. In fact, we keep getting told that the cost of equipment is plummeting and a range of equipment is available for choice. Why would you have problems when others do not?

Dr Vining—Maybe we just got some bad equipment. There have been a lot of problems with maintenance on the equipment. Part of the problem with trying to maintain these things in rural areas is that when there is a fault they have to be shipped to Sydney—a number of issues like that. They are not significant hardware issues, but they have delayed our project.

CHAIRMAN—What is Cerner PathNet?

Dr Vining—The Cerner Corporation is a company in the United States that supplies software for the health system. Their original software was a program called 'Pathnet', which is a laboratory information system for pathology laboratories. Cerner PathNet is a suite of programs for running a pathology laboratory.

CHAIRMAN—So it is no longer a trial, it is actually up and running?

Dr Vining—Cerner PathNet is one of the biggest software suppliers to the pathology industry in the world. In New South Wales it is the biggest single software program running hospitals in New South Wales.

In our own case, we implemented an early version of PathNet back in 1993 in Westmead Hospital. That has been upgraded to a later version. We have then implemented the same system in Mount Druitt, Auburn, Blacktown and St. Joseph's hospitals, all linked together and running off the same hardware, the same database. Furthermore, we have piggy-backed onto the back of that hardware and we have the same software in Armidale, Glen Innes and Inverell hospitals. It has been an extremely cost-effective solution to our problems.

Doctors can now walk into any of those hospitals and if they have clearance they can look up the results of any patient in the system. It enables us to run all of our equipment from all of our laboratories off the one hardware platform. If we have outages of equipment we can just move specimens to the next laboratory. All of the results are always available in all of the hospitals.

Mrs ELIZABETH GRACE—This whole program seems extremely interesting. However, in your submission you say:

The New South Wales Department of Health IT Strategy originally intended Cerner PathNet to be the preferred laboratory information system (LIS).

You then go on to say that it now seems that the exercise has proved too costly and that rural pathology services are currently facing increasing pressure to reduce their funding. You also suggest in the submission that there are growing demands in the rural pathology services that are looking for better Information Technology and looking for forming alliances with referral services. Could you elaborate on this?

Dr Vining—The supply of pathology services into rural areas all over Australia has always been problematic. It has proven over the last decade exceedingly difficult to get pathologists to go and work west of the Great Dividing Range in New South Wales. The Dubbo area, for instance, advertised for more than a year before they could get a pathologist to go and work in Dubbo. Supplying medical services into these towns has been very difficult, as I am sure you are aware, and not only just for pathology.

The economics of supplying pathology services into rural towns is very difficult. About 80 per cent of all pathology in a typical New South Wales country town will originate in doctors rooms, not in the hospital. Yet, if we are to have the hospital to be capable of responding to acute medical needs, the hospital has to have a certain minimum number of pathology services available.

The costs of maintaining a state of readiness to supply those pathology services is

an absolute minimum of several hundred thousand dollars a year. Whether you do any pathology or not, there is a certain fixed cost of maintaining a state of readiness. If it is to be economic, you really need to get a substantial amount of pathology from the country town going through the hospital laboratory, otherwise the laboratory is not very efficiently used.

What we have been trying to do is to leverage the IT we have developed in western Sydney, out into country areas because at fairly minimal cost we can run those country laboratories off our existing IT package. Also, using telepathology and teleconferencing, we can link the staff in those country laboratories into our laboratory at Westmead, supply them with training, and supply expert consultative support to the doctors in the town from our expert pathologists at Westmead. That is what we have been trying to do.

Mrs ELIZABETH GRACE—That partly answers my next question, because I was going to ask how you can electronically organise the transmission of pathology. You have to have a sample of some sort before you can do the analysis. I can understand that once the analysis is done it can be downloaded into a machine and transmitted back to the GP or the hospital very quickly. I see huge advantages with that for rural and remote Australia, because of delays of days sometimes to get results and if you are having a heart attack that can be quite frightening. If the pathology units are prepared to be set up in various towns with a courier service from smaller centres, then in that way you would be technologically linked to the main centres. You would not necessarily have to have all the equipment in that laboratory.

Dr Vining—No, but you need to have a certain amount because, as you point out, urgent cases need to be dealt with. You cannot ship the specimen down to Sydney. There is a certain core of pathology readiness that is needed in any significant centre in rural areas. So we need a certain volume of equipment. We need to have staff there who are trained and meet the appropriate national guidelines for training and qualifications and currency in the things they are doing. We need to maintain staff and minimal equipment.

Mrs ELIZABETH GRACE—Does that become a private laboratory at a community-based hospital, does that become a private laboratory in offices in the town or is it government provided equipment? Just where does that come from?

Dr Vining—At the moment there are only a minimal number of private laboratories in rural New South Wales. The majority of the laboratories in the country areas are hospital based and owned by the New South Wales government. In addition to that though, increasingly private pathology companies are opening collecting rooms in country towns. They will collect the ambulatory pathology, fly that back to Sydney, do it in their Sydney laboratories and then transfer the result electronically down to their rooms for delivery to the doctor the next day. There are some private laboratories in some country towns, but a vast majority of the on-site pathology in rural Australia—but particularly in New South Wales where I have had my focus—is done in the hospital

laboratories.

Mrs ELIZABETH GRACE—Is this satisfactory or do you think it should be open to private practitioners to open laboratories in the country areas?

Dr Vining—One of the big difficulties is that the total volume of pathology in a typical New South Wales country town of somewhere between 10,000 to 30,000 people is such that there really is only enough pathology to keep one fairly small lab busy. If you set up two laboratories, you have two sets of fixed costs. So what has tended to happen in some country towns, is that people have said, ‘Wouldn’t it be wonderful to have some competition here?’ A private laboratory has opened up in town and the work is then split between the hospital laboratory and the private laboratory.

But the costs of the hospital laboratory do not go down, because they are already fairly close to the minimum size that you can have and still supply the acute care services to the hospital. So the opening of the private collection rooms has meant that the Medicare money is no longer coming into the hospital, but the costs of running a lab stay pretty much the same. There is only a minimal decrease in cost when you remove the ambulatory work to the private lab. So in fact that has put additional cost onto the health area that is responsible for that hospital.

Yes, I think there should be competition for the pathology in country towns. But I think it should be done in such a way that the hospital laboratory or the private laboratory is given a five-year contract or a certain period of contract to supply pathology services to that region. At the end of that period, it should be open to another body. But there should only be one provider at any time. By having two there at once, that just drives health costs up without any increase in quality.

Mrs ELIZABETH GRACE—So what is in the country hospitals could be—to use a modern expression—outsourced by tendering to private practitioners or something along those lines, do you think? I do not know whether it is unique to New South Wales, but it seems to be more predominant in New South Wales.

Dr Vining—Yes. The best of the private laboratories in Australia are very good. One of the difficulties of outsourcing something like pathology is that, if all you want is a result on a piece of paper, then it is fairly easy to cost that. But if you want consultative support, if you want infection control guidance in the hospital and you want to develop the clinical links between the clinicians in that hospital and the specialist pathologist, it is harder to cost that. It can be done, but experience in other countries and elsewhere in Australia suggests that it is not quite as simple as just saying that there is a private pathology industry and therefore we can outsource all hospital pathology.

Mrs ELIZABETH GRACE—Pathology seems to be one of those units that is increasing in costs, and the pathologists themselves seem to be absorbing more of the

costs to make it affordable. Is there an answer to this problem?

Dr Vining—Pathology is the best source of objective information on the health status of your community. It gives you hard data and, if you have it sourced electronically, it gives you hard data in a form that is readily analysable. So if you want to understand what is happening to the health status of your community, a pathology information system is your best source of information. As we move to more outcomes based medicine, looking at pathology results will be the best indicator of whether we are getting value for money.

When you say that pathology costs are increasing, I suspect that we should be spending more on pathology than we are now, but not doing what we are doing now, not just cranking through more basic pathology. We could probably get the basic pathology we are getting now more cheaply, but there are a lot of other new pathology tests that are becoming available that are not paid for under the medical benefits schedule. There is a vast new range of tests—some are available now and others are on the horizon—which can revolutionise our whole approach to health care. At the moment we are not really being allowed to implement a lot of those. I think that by judicious use of these new tests we could actually drive health care costs down elsewhere.

There are lots of examples in hospitals. With regard to some of the tests being done now, you might question whether we should be doing, for example, serial CKMB measurements. That is a test that can give some indication of whether a person is having a myocardial infarction. So, if a patient presents at casualty with chest pain, what do you do? If it is only indigestion, you want to send him or her home. If the person is really having a myocardial infarction, you need to take appropriate medical action and admit that person to hospital. If you make the wrong decision, it is not good for the patient if you discharge him or her. But, equally, if that person is not having an MI and you admit him or her to hospital, you are driving costs up. By doing additional pathology tests, sure, you put up the cost to pathology, but you may just have saved several thousand dollars by avoiding putting that patient into intensive care when it was not needed.

Often, looking at pathology tests becomes fairly simplistic with people saying, 'Pathology is just a cost on the health care system. We should drive that cost down.' Yes, we certainly should drive it down to get the minimum price for every test we do, but it may actually be in our community's interest to spend more money doing more tests, to avoid other health care costs.

Mrs VALE—You talk about costs on the Cerner PathNet. Has that process been evaluated for its cost benefits?

Dr Vining—One of the big benefits that was projected from this system was electronic ordering because by having the doctors order on an electronic screen, it is much easier to give them guidance in what tests they should be ordering. It is much easier to

have an expert system which can guide them and say, 'Why are you ordering this combination of tests? Would it not be better to use a different combination of tests?' We are not allowed to go to electronic ordering, so much of the benefit we had hoped to gain is not available via Cerner PathNet, or any other system. A lot of the eventual benefits from information systems will come from electronic ordering and then having electronic reporting and expert systems that can advise the reporting and advise on what the results mean.

But, having said that, yes, we have derived immense benefits from using PathNet. Our PathNet implementation has enabled all of the labs in western Sydney to be merged together. We now have single policies and procedures across five hospitals. We rotate staff among those hospitals. We have achieved a 10 per cent reduction in the staff in the pathology laboratories by having all these common systems. In addition to that, our turnaround times for delivering results into the wards have been driven down enormously. The hospital has saved money in the medical records department because the primary record of pathology is now electronic, so they do not have to file thousands of reports all the time. The system has driven immense benefits through our hospital but there are more benefits to come once we have got electronic ordering.

CHAIRMAN—Would you like to see us in our report recommend electronic ordering?

Dr Vining—Yes. I think it has to be entered into very carefully and very cautiously. If it is not watched carefully there is the potential for it to drive basic ordering up. I guess it is like all powerful tools. It can be used in a way that will decrease our costs and improve outcomes, or it could be used in other ways, but I think to just blanket ban it is not in our interests.

CHAIRMAN—Concerns about privacy have often been expressed. How do you suggest these matters should be handled to provide appropriate safeguards, bearing in mind that privacy does not always exist for patients under the current paper based systems?

Dr Vining—I think it is one of those interesting issues that privacy has always been a problem. Under the paper based system we tried to ensure privacy but paper drifting around all over the hospital was probably harder to control than the electronic form it is in now. There was probably an expectation that there would be leakage in a paper system. Our expectation in electronic systems is that they will be perfect. They cannot be perfect. The PathNet system does provide for a lot of grouping of results with doctors having passwords so they can be locked in and out of information. The problem we increasingly face, though, is in trying to network across a group of hospitals, in trying to bring the appropriate specialist expertise of one doctor to bear on a particular case—we need to keep opening the system up. What we are tending to find is that the problems of providing immediate high-quality care require us to have fairly open systems, whereas the need for privacy means that it is more difficult to achieve the clinical outcomes we want

for patients.

Mrs ELIZABETH GRACE—You said earlier that you had had equipment problems and put them down to, perhaps, just equipment that had gremlins in it. What type of equipment are you using? Are you using stuff that is generally available on the market or is it specialist type?

Dr Vining—The problems we have had were just with standard microcomputers. To bring the telepathology project together you need three components. There is the software, there is a microcomputer and there are various elements of specific imaging hardware. The reason we set up a trial like this was to sort out exactly the sorts of problems we have encountered. We were using equipment from different manufacturers. Their specifications said that it would all work; we were assured it would all work. When we put it together it did not work and then there was much toing and froing.

I think they are the standard teething problems you get whenever you are on the cutting edge of implementing new technology. The technology will work. The quality of the images that we have been getting has surprised our pathologists. Some of them were sceptical at the beginning that the quality would be sufficient for them to give an opinion. All of the initial indications are that they are very impressed with the quality and their expectation is that they will be able to give a diagnostic opinion based on the image that is being passed down these ISDN lines into our equipment.

Mrs ELIZABETH GRACE—You have learnt from the mistakes, you have learnt from the problems, and it will be something that can be put into the marketplace as a viable option?

Dr Vining—There is no doubt in my mind that the technology is now capable of giving us diagnostic quality images, from what our pathologists have told me. Once we have these teething problems sorted out—and we then need to go through appropriate trials—I expect that this equipment will be in use and we will be making diagnoses over this equipment.

Mrs ELIZABETH GRACE—It has been put to the committee on one occasion that when new equipment does not work, or a program does not work, we have in Australia—and they did generalise there—a particular tendency to throw it out and put it in the wheelie bin and start again, rather than learn from what we have been using and implement that in the corrected form. That is why I am pleased to hear you are prepared to keep going with what you are doing; you have not thrown it all out and thrown your hands up in disgust.

Dr Vining—No. My involvement in this project goes back a couple of years to when I was asked to stand on a New South Wales government committee to select equipment. They wanted us to design a specification for the equipment that the state

would use. A couple of other people and I said, 'This is not a smart way to go. When you are on the cutting edge of technology, you know that things are not going to work to specifications. If we try to design a specification and then you source millions and millions of dollars worth of equipment and put it in, it is going to be a costly mistake.'

We also said, 'It is much better to start a series of trials. Let us get our hands dirty with this equipment for a couple of years and then, two years down the track, you will have a lot of people throughout the state who have some very valuable experience with the way the equipment works, with the equipment-human interface and with the problems of using this equipment over the communications lines throughout the state.' That is exactly what is happening. We are getting our hands dirty; we are having some problems; we are having some successes; but it is looking very promising.

Mrs ELIZABETH GRACE—I am pleased to hear that.

Mrs VALE—Dr Vining, I would like to ask you a question on health insurance. It has been put to the committee that the introduction of telecommunication technology into the health system will affect the Medicare Benefits Scheme and the whole question of professional indemnity. Will the medical benefits scheme require amendment to reflect the use of telepathology?

Dr Vining—I am not a legal expert, but it is an issue that I have grappled with. Who is the patient consulting? Let us say that a patient goes into Inverell Hospital, where a specimen is collected and transferred to Armidale Hospital. The pathologist there looks at it, thinks he knows what it is but he calls a pathologist, on his telepathology equipment, at Westmead Hospital for a second opinion. The pathologist at Westmead Hospital thinks that this is a very interesting case and dials another pathologist at RPA, and the three of them have a consultation. Who bills and, if the decision is incorrect, who is liable? I cannot answer those questions, but the technology is now making this sort of approach possible. This sort of approach gives us the potential for much better quality answers, but it also gives us some complex legal questions to answer.

Mrs VALE—Would you like to make any comment about how you see the role of government in this kind of technology?

Dr Vining—The role of government is to pass the appropriate legislative changes to enable us to use this equipment in a logical and reasonable way.

CHAIRMAN—Thank you very much, Dr Vining, for appearing before the committee this afternoon. We greatly appreciate it. We will send you a draft of your evidence for checking.

[2.48 p.m.]

CHAIRMAN—I ask the secretariat to invite the witnesses to swear an oath or make an affirmation.

GRAHAM, Mr Lindsay David, Deputy Chief Executive Officer and Convenor, Informatics Committee, Australian Association of Pathology Practices, PO Box 158, Deakin, Australian Capital Territory 2600

LEGG, Dr Michael John, Vice-President and Chairman, Informatics Committee, Australian Association of Pathology Practices, PO Box 158, Deakin, Australian Capital Territory 2600

CHAIRMAN—Welcome, gentlemen. I note for the record that Mr David Kindon is unable to be present. The committee has received your submission. Would you like to summarise a couple of aspects of it to focus our subsequent exchange of thoughts?

Dr Legg—There are three main points that we wanted to convey: firstly, we believe that informatics could improve both the quality of pathology and the cost of the provision of the service; secondly, we believe that there is a requirement for the coordination of the projects happening in Australia at the moment; and, thirdly, there was a concern on our part that the cost for the infrastructure to enable transfer of information be shared by those who benefit from the infrastructure.

CHAIRMAN—We have had evidence before that at least one pathology provider was offering incentives, through the provision of computers, to medical practices to use their services. Do you know anything about that?

Dr Legg—I have heard something of it.

CHAIRMAN—How widespread is the practice and, in your view, is it illegal?

Dr Legg—We certainly do not believe that it is proper. I do not have an opinion on whether it is illegal or not, that has not been tested at this stage. We have provided to the committee our stance in respect of the provision of equipment.

CHAIRMAN—How widespread is that procedure?

Dr Legg—I do not think it is that widespread. Lindsay might like to say more.

Mr Graham—I do not think it could be said that it is widespread, but it certainly happens and it has been of concern to the AAPP. As Michael said, there are differences in terms of the legal interpretation as to whether it is legal or not. We have generally believed that it is illegal in terms of the Health Insurance Act.

CHAIRMAN—Has the name of any particular pathology provider been bandied

around in the media as being guilty of this?

Dr Legg—It has certainly been bandied around in the media, yes. Macquarie Pathology has been bandied around in the media.

CHAIRMAN—Thank you. We have heard that before, I just wanted to see whether there would be confirmation forthcoming. You use the term informatics; others use the terms Telemedicine or Telehealth. What do you understand Telemedicine to mean?

Dr Legg—Telemedicine, to me, is a component of informatics, and it generally relates to near-to-patient application of technology, to my way of thinking. In terms of pathology, it relates, by and large, to anatomical pathology and being able to look at images from a distance. In radiology it means looking at X-rays, MRI and those kinds of things. In psychiatry, it is having videoconferences and conducting consultations. It tends to be at the consulting level. Informatics is much broader than that: it is about how you handle information and the analysis and use of the information thereafter.

CHAIRMAN—How would you like to see the medical benefits schedule altered to facilitate the use of Telemedicine and to encourage its use?

Dr Legg—I am not sure that there is any particular requirement for alteration to the schedule per se. I would support Dr Vining's evidence in terms of electronic ordering with appropriate evidence of the person responsible making the ordering as being appropriate. I am not sure that that is part of the schedule. If you are asking how fees and the description of services would change, I am not sure that there is any particular requirement for that. I feel reasonably confident that the system that we have for changing those things would accommodate the kinds of things which would come in due course.

CHAIRMAN—I was interested to hear you refer to the lack of coordination with pilot projects relating to Telemedicine, and how there does not seem to be any coordinating body—I think you said that. We had evidence earlier today along the same lines, and I will put a similar question to you as I have put to previous witnesses. If you were the Minister for Health and Family Services and you were receiving this kind of evidence, how would you approach the problem that has been outlined? How would you set up some kind of steering committee or group to do the coordination which, at the present time, appears to be so sadly lacking?

Dr Legg—As we wrote in our submission, we would see that as being a committee of AHMAC. The concern that we might have about such a recommendation is that the committees of AHMAC seem to move more slowly than needs be in this area. I really do not have a good answer. I know where the kinds of people that you would want involved get together, and that is at IT/14 of Standards Australia. There you have representatives of government, consumer organisations and private practice—they are exactly the right people. I am a member of that committee and we have discussed the coordination issue and, certainly, there is agreement at that committee level that coordination should take place. I suspect that it should be an independent committee advising the minister.

CHAIRMAN—Who would comprise the membership and, apart from the coordination role, what else should it do?

Dr Legg—That is a very good question and probably the question that I would ask of that committee when we brought them together. As to who should be there, I think there should be careful study of the group attending IT/14. I think their representation would be appropriate.

CHAIRMAN—And you would support the involvement of consumer groups?

Dr Legg—Certainly.

Mrs VALE—I would like to ask some questions on ethics and privacy. Your submission observes that, whilst privacy must be respected, privacy considerations should be balanced by those relating to cost and complexity. How could you achieve a balance between cost and complexity, as you put it? Is there a tension between cost and privacy, as you said?

Dr Legg—There is certainly a tension between privacy and the delivery of the service. It is not just cost. As Dr Vining pointed out, it can get in the way of providing proper medical treatment. I think the principles, as espoused in the Australian standard AS 4400, are proper principles to aim for. As we do that, we need to find systems that minimise the cost of implementing those systems. I think that can be done and also I think that most of the colleagues that I communicate with would support that. I guess we would have some anxiety that there are almost 40,000 external communications from a large private pathology practice. You do not want to be putting too many barriers in the way of that happening.

Mrs VALE—To what extent do you think that telecommunication technology poses serious privacy issues that do not exist under paper based management of data information? Some of the evidence that we have heard during the committee's hearings have been that paper based information is often open to privacy leaks, if you like, just by the general process, the operation of day-to-day work.

Dr Legg—I think that is right. Rather than making privacy a greater issue, I think it is a lesser issue with electronic transmission. You have many more controls.

Mr FORREST—I was amazed to read in your submission about the number of transactions that occur, four billion a year. That translates back to 10 million a day, roughly. What is a transaction? Obviously, for one pathology test, there may be a number of transactions. It seems to me that that would be impossible to handle.

Dr Legg—Those transactions are internal transactions within the laboratory. The kind that you are talking about are the external transactions and I think that is a smaller

number.

Mr FORREST—Do you have any idea as to how much of that is currently conducted electronically?

Dr Legg—Yes, we have a reasonable idea. I can give you the evidence for a New South Wales practice with which I am associated. It currently has 300 medical practitioners all receiving their reports electronically now. There are other ways of providing a request in an encoded form, without using electronic means. The two dimensional bar coding technology that is available now allows you to encode up to two A4 sheets of paper and can be read with a bar code. So there are other alternatives to electronic ordering. But certainly a lot of value can be got out of improving ordering because the current system for ordering with handwritten requests certainly causes many errors.

Mr FORREST—That would be handwritten and by facsimile, would it?

Dr Legg—It can be. But their request generally comes with the patient. In the practice that I was previously associated with, 60 per cent of the collections were made by the pathology practice. The doctor would hand the request over to the patient, the patient would visit a collection centre at a pathology laboratory and hand over the request at that time. Those that come from doctors' surgeries, the request and the specimen come together. That is the current system.

Mr FORREST—Just in the interests of saving our forests, with that many transactions on pieces of paper, the mind boggles.

Dr Legg—It does indeed. I sat in on a meeting at the University of Wollongong where one of the great proponents of EDI, an Australian who had been in America for a number of years, sat down and on the back of an envelope did a calculation. He believes that there are 5,000 million pieces of paper generated in the business of medicine in Australia and that is before we start treating any patients. That is just bills and prescriptions and those kinds of things.

Mr FORREST—So there is another advantage of an electronic base, is there?

Dr Legg—I am a keen proponent of it, yes. I think President Clinton made a very fine quote when he said, 'All this paper and stuff, we must be able to save some money here!'

Mr FORREST—I am sure that is the case around the parliament as well. The committee has heard time and time again of the need for a nationally coordinated strategy on all this. Let us say you are king for the day, Dr Legg—you are the minister for health. What would you do?

Dr Legg—I think I would set up a committee, not under the auspices of the department—I do not know what capacity he has to do that—and I would ask them to first find out what is going on. I presume that the responses to this inquiry would help in that. I sat in a meeting with about 20 people in the AMA and the College of General Practitioners—the people that you would expect to know what was going on in Australia. We wrote on the whiteboard about 35 projects that were going on in Australia, nobody in the room knew of all of them and many of them overlapped. I think it is blatantly clear that that needs to be done. I do not think I understand the system well enough to know how to do it. As I said before, it also needs state government coordination. As I understand it AHMAC, or a committee of AHMAC, would be the appropriate body. But all of those to whom I suggest that, who have had some association with AHMAC, think that that would be its death knell.

Mr FORREST—Why? Because it is not representative enough of all the players?

Dr Legg—No. I think it is just slow and cumbersome.

Mrs ELIZABETH GRACE—We had the medical council here this morning and we put it to them that doctors should be registered nationally and not by state. We also put it to them that there should be a more uniform way of legislating for some of our health regulations so that they are basically the same across the continent. The two areas mentioned were mental health and the poisons register, and how they are handled in various parts of Australia. To lay people like us that all seems terribly logical so there has to be something wrong with it!

Dr Legg—No.

Mrs ELIZABETH GRACE—We were definitely given what I considered a brush-off. Neither suggestion was well received and we were informed that it would take between 15 and 20 years to get some sort of uniformity into any of this, be it registration or acts of parliament or whatever. From what we have heard, and I think the other members of the committee would back me up here, I think that is where we have to start. If we do not have uniformity of understanding of medical terms, acts of parliament, and registration of medical practitioners, Telemedicine is going to end up an awful minefield of not just logistics but litigation and people going out and doing all sorts of dastardly deeds. It is going to go across states and there is no way we can stop it from doing that. It is going to go international. Do you have any comment on that?

Dr Legg—Only that I think you are right. Just to pick up the legislation story: one of the things that the APP has done is to look at the legislation that impacts on pathology practices.

Mrs ELIZABETH GRACE—Yes. I would have thought that was another area.

Dr Legg—It is just huge. It is almost impossible for us to know the laws that we are meant to be meeting. By and large, we do what we think is proper and hope that the laws match.

Mrs ELIZABETH GRACE—Is there any need for it to be different in each state? Is there any logical explanation for it?

Dr Legg—I do not think so.

Mrs ELIZABETH GRACE—No. Another thing is that at the moment laboratories appear to be state based. Would it be sensible for one laboratory, say it was based in Brisbane, to carry equipment that is very expensive—millions of dollars worth—and become the national base for getting some sort of pathology result to a particular unit of analysis that needs to be done. Is that a possibility through this technology?

Dr Legg—That is already happening and more and more pathology is becoming national based and not state based. The two largest pathology practices in Australia cross state boundaries. In fact, the four largest cross state boundaries now.

Mrs ELIZABETH GRACE—So you have run into this problem straightaway of different legislation in different states?

Dr Legg—Absolutely. Coming back to Informatics, one of the concerns I have is that there are a number of flows of information. The state based cancer registries and the other registries are a major problem because they each want something different and none of them tend to be related to anything which is internationally accepted in terms of standards. I am also the chairman of the pathology messaging group of Standards Australia and one of the things that we tried to start as a project was to get those people to talk to one another so that we could move towards standard messaging for the registries, and I met the same response as you did. I think that would be a wonderful thing to be supported.

Mrs ELIZABETH GRACE—I would like to follow on something Dr Vining said on electronic ordering. He indicated that electronic ordering was considered to be a very expensive exercise and this was one reason that it was not being looked at very seriously by the Health Commission at the moment. Just from what Mr Forrest said before about saving trees, and thinking about it from the accuracy point of view and the fact that you can backtrack very quickly with electronic ordering, I would think that, rather than overservicing and using it unnecessarily, it would stop overservicing. There would be an immediate record to say that Mrs Brown had those tests two days before and these are the results. Again, am I putting too simplistic a translation on that type of thing?

Dr Legg—No, I think you have got it exactly right, again. I think Dr Vining was saying there was a concern that, because it is easier to order, there would be more of it

done. I do not believe there is any evidence of that. There was a concern some years ago now that tick boxes on request forms meant that doctors ordered more pathology and so legislation was made so that it had to be in the doctors own handwriting. I do not think there is any evidence that that changed ordering patterns, other than it made it more difficult for the laboratories to know what the doctor wanted.

Mrs ELIZABETH GRACE—I understand from the little contact that I have had with electronic ordering, and electronic results coming down the line, that there is a lot less possibility of inaccuracies and of the wrong person getting the wrong results—for example, Mrs Jones's results ending up in Mr Jones's file or Mrs E Jones's results end up in Mrs A Jones's or something like that.

Dr Legg—That is actually a major issue and I am sure others have said this; we have no universal identifier for health care and that is a problem. The biggest difficulty we have is knowing that this episode relates to a patient we have had before because of the quality of the information that comes about their demographics.

Mrs ELIZABETH GRACE—And should there be one?

Dr Legg—I would support one, yes, providing that you could make Australia concerned for its privacy.

Mrs ELIZABETH GRACE—And you do not think the Medicare number does that?

Dr Legg—It certainly does not, no.

Mr Graham—The Medicare number is family related rather than individual.

CHAIRMAN—We had another witness today who had a question in relation to the Medicare number and he said that you have a number on the card but behind that you have individual patient identifiers on the Health Insurance Commission computer. So he did not see a problem with using the Medicare number because the real number is not the number on the card but the number given to each family member on the Health Insurance Commission computer.

Dr Legg—But we do not have access to that.

Mr Graham—Exactly. The HIC does has an individual identifier but it is not available in the doctor's surgery.

Dr Legg—But we do not have access to that.

Dr Graham—The HIC does have an identifier, but it is not available in the

doctor's surgery.

Dr Legg—Judging by the quality of the information that we have had, I suspect that the matching is not great.

Mr FORREST—Does your division of general practice go beyond the boundaries of the Canberra city—not that there is much beyond that in the ACT—

CHAIRMAN—This is the Australian Association of Pathology Practices.

Mr FORREST—I beg your pardon—information overload. The perennial problem for many rural areas is the absence of the infrastructure to access this technology in the first place. Have you struck any of that in your—

Dr Legg—No, unlike Dr Vining, I believe that rural Australia is quite well served by private pathology. There are many laboratories in the larger country towns. There is good evidence that private pathology can provide services to both public and private hospitals. That is certainly happening in Victoria. The quality of the services improved rather than declined in many circumstances.

CHAIRMAN—So you would not be attracted to the idea of five-year contracts, as suggested by Dr Vining?

Dr Legg—I would be quite attracted to it provided that we bid on the same grounds. I do think that there is a place for public pathology, and would not argue otherwise.

CHAIRMAN—I can see Dr Vining smiling at the back of the room.

Dr Legg—I cannot and, perhaps, I should not.

CHAIRMAN—Thank you very much, gentlemen, for appearing before the committee this afternoon. We greatly appreciate it.

[3.14 p.m.]

CHAIRMAN—I ask the secretariat to invite the witness to swear an oath or make an affirmation.

RICHARDS, Dr Brian Howard, Executive Director, Australian Capital Territory Division of General Practice Inc., PO Box 31, Deakin West, Australian Capital Territory

CHAIRMAN—Welcome. We have your submission. Would you like to highlight a couple of aspects of it to which we ought to particularly take note?

Dr Richards—I guess, reading between the lines, it is the frustration that peeps through about how we commence work, we start progressing and then basically the funding dries up and there is policy paralysis which restrains us.

The last raft of Information Technology projects that the ACT Division of General Practice submitted to the Commonwealth Department of Health and Family Services was in 1995. They went through the usual assessment and approval process and got as far as the minister's delegate to be authorised. The question was asked by the delegate, of the branch, 'How do these projects fit within the department's Information Management Strategy for general practice?'. There was an embarrassed silence. When it was realised that the department did not have an Information Management Strategy for general practice, he said, 'I am not approving any more information management projects for divisions of general practice until the department has a policy on this. That was two years ago.

CHAIRMAN—That would be irritating, to say the least?

Dr Richards—Yes!

CHAIRMAN—The submission observes that one of the aims of your information management project is:

To pilot and evaluate technical solutions to information management needs.

If you have completed any pilot trials, could you discuss the nature of these with the committee and any evaluation you have undertaken? Also, could you inform the committee about the evaluation model you have chosen and whether the same model would be used in respect of other projects?

Dr Richards—It is a condition of grant of all projects under the divisions and projects grants program of the Commonwealth Department of Health and Family Services that they be subject to an evaluation process. Obviously, the type of evaluation differs according to the subject matter under examination. In the case of the Information

Technology projects, much of the evaluation consists of the technical achievement of what was set out to be achieved and, obviously, the degree to which they are taken up by the general practitioners. The first raft of projects that we put forward were cultural and attitudinal change and feasibility studies. It is at the point of moving forward to formal, more widespread piloting that we have currently stalled.

CHAIRMAN—You do not think that we are piloted out, that it is time to go forward?

Dr Richards—Yes, I do think so.

CHAIRMAN—Why do you think we are continuing to pilot?

Dr Richards—Basically, to satisfy the concerns of the other stakeholders in the processes.

CHAIRMAN—The stakeholders being?

Dr Richards—The major concerns that have been put forward are around confidentiality and consent. The concerns have been put forward mainly by other custodians of clinical information to which we wish to have access.

CHAIRMAN—We have had evidence that there does not seem to be a coordinating body for pilots or for Telemedicine nationally. What is your observation on that and what should be done about it?

Dr Richards—There seems to be a plethora of committees and organisations who claim to have that mandate in various areas. Even in the area of general practice Information Technology we have got within the department's consultative committees an Information Management Strategy group, which is a group of predominantly academic general practitioners or people loosely called 'boffins'.

CHAIRMAN—People who have never seen a patient?

Dr Richards—There is a preponderance of people who may not have direct clinical contact.

That strategy group has not actually had a budget to play with; they are just there to provide sage advice. The divisions and projects grants program is under the control of the divisions strategy group which is attempting to set guidelines and provide funding. There has been a battle between the divisions strategy group and the Information Management Strategy group as to how that should go. They have actually set up now a joint subcommittee called the divisions information management subcommittee, the DIM committee—

CHAIRMAN—We all know of a few dim committees!

Dr Richards—Yes. That is just a microcosm of what is happening and it is frustrating. The RACGP, the Royal Australian College of General Practitioners, and the Australian Medical Association have attempted to get some rationality into it and have convened several meetings and undertaken a strategic planning process to try to bring all the stakeholders together.

CHAIRMAN—Only a small number of practitioners use computers for clinical applications in their practices—under 15 per cent, we are told. A larger number use computers for administrative purposes. What should be done to encourage the use by practitioners of computers? In the submission you say that, because computers are tax deductible, GPs will purchase and use them when they can perceive direct benefits for the care of their patients. That is a very laudatory statement, but a more realistic statement would be they will make purchases when they see greater benefits for themselves, in the sense that people are prepared to spend money to make money. What should be done by the government to facilitate increased usage at both clinical and administrative levels?

Dr Richards—On the first point, in the ACT division of general practice, we undertook a survey recently of our members to ascertain the extent of computerisation. We had about a 50 per cent response rate to the survey. Of those who responded, around 80 per cent have computers in their practices but, as you say, largely for administrative purposes—

CHAIRMAN—But one would imagine the motivated people would have responded.

Dr Richards—It is possible. Of the respondents, 38 per cent had computers on their desks in their consulting rooms and were using them primarily for prescribing, medical report writing, certificates and so on. It was a much higher percentage than we had anticipated.

CHAIRMAN—That is a high percentage of the 50 per cent who responded.

Dr Richards—Yes.

CHAIRMAN—You might find that, of the 50 per cent who did not respond, only five per cent had computers on their desks.

Dr Richards—We might find that.

CHAIRMAN—The results might be skewed by the fact that interested and motivated people may have responded.

Dr Richards—This is the peril of many surveys. We do not have the power of coercion in engaging response.

CHAIRMAN—What should the government do? Obviously hardware and software purchases are both tax deductible now. There have been some suggestions that the government should do more. One suggestion made that I am personally attracted to is that the Medicare rebate proportion of the medical bill ought to be able to be bulk-billed. Even if there is a co-payment, the balance of the bill must be paid by the patient personally. This would save the Health Insurance Commission money. Perhaps a carrot and stick arrangement could be used. You might get paid more quickly if you do it that way.

Dr Richards—My understanding is that was a budget announcement last week.

CHAIRMAN—My understanding wasn't exactly that, but—

Dr Richards—Maybe I misinterpreted the budget papers, but that wasn't how I read it.

CHAIRMAN—You could have. I looked at that reasonably closely, but I will look at it again.

Dr Richards—I agree with you. That would be a significant step forward. To me the role of government primarily in this system, and particularly the role of the Department of Health and Family Services, is to lay down a broad framework to ensure that there is consistency in whatever approaches are going on around the country. There is a conflict of opinion with, for example, the Information Management Strategy group—the IMSG, a General Practice Strategy group—of the view that governments should put computers on everybody's desks and, when there are enough computers around on GPs desks as expensive paperweights, then the private software industry will suddenly see there is a market there and write lots of material for them.

My converse view, and the view of many others, is that when there is sufficient clinical-relevant software that will be useful to us, we will go out and buy computers. There is a lot of work being done on software development, but it is not compatible. It is like the old narrow gauge and broad gauge railway systems—

CHAIRMAN—Exactly.

Dr Richards—And we need to develop agreed parameters around modularity and interconnectedness of agreed minimum data sets.

CHAIRMAN—I used to run a law office. It reminds me how, when we were given the opportunity to computerise, there were a lot of programs out there. Not being very computer literate at that time, there was confusion. I would imagine that the general

practitioners in the medical area must look at all of these competing software programs and wonder which one is right for their practice. At the end of the day some people might throw their hands up in the air and say, 'It is all too hard. We will wait until this murky situation clarifies itself.'

Dr Richards—I am fortunate or unfortunate enough to work in a practice with another general practitioner, who is my partner, who is very keen on computers in medicine. When we moved our premises to a new building about four years ago, we were faced with having an antiquated paper based medical records system from which you cannot really extract data in terms of quality assurance and monitoring performance; it is just a paper-based system. We looked at moving either to a more formalised paper based system such as that recommended by the college of GPs or computerising the practice and moving ahead. The capital cost was about the same of converting to a different paper based system or installing the necessary computer equipment. We installed all the computer equipment and then set about looking for what software we were going to use. We have still not found any that suits our needs four years later. The \$20,000-odd we invested in computer equipment four years ago is now becoming obsolete and this week we have had agreement from our bank to lease another \$21,000 worth of computer equipment to upgrade. We are, in fact, starting to be a beta test site for a new clinical management software.

We are one of those practices that have been using computers for accounts and for administration for many years. We have been using computers on our desks for reports, certificates and prescribing for a number of years but we still have not made the step into a clinical record and ordering system because we are not satisfied that they are user friendly enough and they are not set up the way we practise medicine.

CHAIRMAN—I would suspect there would be a lot of other people in your position.

Dr Richards—Yes.

CHAIRMAN—My understanding of that budget decision, as I think about it, was that the claim is able to be made from the doctor's surgery but that the refund or rebate is to be sent back to the patient directly. I personally am more attracted to the scenario outlined before.

Mrs ELIZABETH GRACE—I want to have a bit of a talk about standards because the submission mentioned the development and distribution of the health service directory and a proposed project to pilot software, which is something along the lines we have just been talking about. The project also included both management and administrative systems. I assume from that we are talking about medical records and office administration; could you explain to the committee if this proposed pilot project, using the international classification of primary care, was done in consultation with the family

medicine research unit at Sydney university?

Dr Richards—Yes. It has been done in consultation with the family medicine research unit. There were actually two separate projects we were undertaking at that time: the first is the health services directory, which is a nice, user-friendly, fuzzy interface that allows GPs to search community support groups and allied health professional specialists by various interests and localities. We had version 1.0 of that out several years ago and have been repeatedly denied further funding to develop that beyond that initial stage.

The Commonwealth health department let a consultancy to a company because a number of divisions of general practice had done different sorts of health services directories and they went around and looked at them all. They decided that ours was, in fact, the best of all of them and that company has wanted to take our product and develop it further despite the fact that we saw it as our intellectual input and something that we wanted to develop further. That has led to a stalemate where we have declined to pass on source codes to the private company because, basically, they would be profiting from our research.

That has left us with quite a nasty taste in our mouth about putting a lot of effort into things which have potential commercial value and then the department gives them to consultants to play with.

The other project is one being developed by Dr Ed Quay who is a GP in Kambah in the ACT. He is a very innovative GP with a very keen interest in computers, who has been using in his practice now for several years a very comprehensive software system. When he gets a patient in for a consultation, he can click a mouse button and it starts timing the consultation so he can actually tell exactly how long and record how long he has spent with every patient. That is obviously useful for billing purposes but also useful for audit purposes. But whenever he writes a prescription or makes a referral or orders pathology or other imaging, he has, built into his software, the Medicare Benefits Schedule and pharmaceutical benefits schedule and can calculate the Medicare costs of every intervention that he does. So he knows at the end of each consultation not only exactly how much he is going to get for his consultation fee, but how much are his costs for Medicare, pathology and prescribing. He has been analysing the data from within his practice about different ways of treating people with hypertension and infections and looking at the cost effectiveness of various interventions. We were looking at taking his system and piloting it a bit more broadly to see if it was something that was more acceptable in general practice. But again that is one of our projects that has hit the policy wall.

Mrs ELIZABETH GRACE—And is that depth of data necessary?

Dr Richards—It would be extremely useful for policy makers. The problem with the Medicare database is that it is not related to any specific disease. What Dr Quay's

program does is, when he is taking the history into the computer, it actually uses ICPC coding on key words. It actually codes the reason for the tests against a particular diagnosis. This is the only way we can actually link expenditures to specific diseases and say how much hypertension costs to treat, how much hyperlipidemia costs to treat and how much middle ear infections cost to treat. Medicare cannot tell you that; all they have is big buckets of numbers.

Mrs ELIZABETH GRACE—And so their costings are more arbitrary?

Dr Richards—They are more global. They can just say, ‘We have spent so much on pathology and so much on antibiotics.’ They do not actually know what exactly they are treating and there is no direct linkage. It is also extremely useful as a professional tool for self-audit and interpractice audit for comparison. We can say, ‘When I treat someone with hypertension, it costs so many dollars per year. When you treat hypertension, it costs you half that. What are you doing differently?’ We can probably learn a lot about cost effectiveness and cost utility in general practice.

Mrs ELIZABETH GRACE—That program that you were talking about is one that he has written himself?

Dr Richards—Yes. He has worked extensively with Dr Teng Liaw who is at the University of Melbourne. They have liaised a lot. The link with the Family Medicine Research Unit in Sydney is a compulsory link. The Family Medicine Research Unit has been given the Australian copyright of ICPC which was developed by WONCA, the World Organisation of National Colleges and Associations of General Practice and Family Medicine. No-one can use that in Australia without paying them money, basically.

Mrs ELIZABETH GRACE—We had gentlemen from Tasmania talking about the way the general college of practitioners is trying to interlink everybody and all the colleges of general practitioners. One of his comments was that they had some data that was asked to be given over. He said it was worth quite a lot of money and, had they been paid for that information, it would have funded the organisation and any of the new innovative work that they want to do. This is something like you were saying before about people wanting to take your information and turn it to a profit without giving you the benefit of having done the work.

Dr Richards—I assume that that is the Northern Tasmania Division of General Practice at Launceston.

Mrs ELIZABETH GRACE—Yes.

Dr Richards—We have had a number of similar experiences.

Mrs ELIZABETH GRACE—He was qualifying something similar to what you

have just been saying.

Mrs VALE—I would like to ask a question on ethics and privacy. On page four of your submission you indicate that:

The ACT Division of General Practice has applied for funding to trial the use of "smart cards" as patient-held devices to authorise health carers to access data held in central or regional repositories
...

Could you elaborate on your proposal and discuss why you chose the patient-held smart cards as a method of accessing medical histories?

Dr Richards—This proposal arose out of several previous projects coming up against barriers and looking for solutions. It might be useful just to point out what the current situation is without any computers. You might come in to see me in my surgery and this is perhaps the first time I have seen you or you may be a regular patient. You say that you went into the accident and emergency department last week and had a test, or you had a test ordered by another doctor at another pathology company. I could pick up the phone and say, 'It's Dr Richards here. I've got Mrs Vale with me. Could you please give me her latest liver function test?' They just tell you over the phone.

There is no consent process. There is no confidentiality or privacy issue. It is just straight over the phone and that is universal in Australia at the moment. We try and make the system more efficient by getting direct dialling computer links and suddenly we are being assailed. Because it is a computer, it is a major privacy issue, whereas currently there is no such problem.

Mrs VALE—That is what we have been finding.

Dr Richards—Our first project back in 1994 was just getting GPs to use computers, modems and hook into the hospital pathology computer. They were able to go looking for their patient results to save the phone call and the phone answerer on the other end.

CHAIRMAN—They could get anyone else's results on the way through.

Dr Richards—They could, but there would be audit trails. That initial idea was obviously hit on the head because of the confidentiality thing. But at the moment, I could ring up and say, 'What's Mr Slipper's serum potassium?' and they would tell me. It is not any different really. We agreed then to do it via a dial back modem rack. We actually bought the equipment, the server and the dial back modem rack. The GP logs into the computer and says, 'I'm Dr Richards. I want to see Mr Slipper's serum rhubarb.' The computer says, 'Okay. We're going to hang up now and we will dial you back.' It is programmed only to dial back to your dedicated number.

Mrs VALE—A check.

Dr Richards—It is a security thing. The data being transmitted is encoded. Therefore anyone else hacking in cannot get it unless they have got the software to decode the transcription. The difficulty was that the software systems that we were trying to interface with were being changed over and it was a matter of adapting the information to a certain point.

At the same time, the accident and emergency department at the local hospital was putting in a whole new computerised system which was meant to be up and running a year ago. I believe the latest starting date is 10 June. We thought that there are a number of computer systems, medical records, pathology and radiology records which we could start linking into. We developed this proposal to get this remote access via the dial back modem rack.

From the piloting studies in general practice it was found that the technology was too slow. By the time you turn on your computer, get it up, dial in, get it to disconnect and then get it to ring back, it is quicker to pick up the phone and get it the old way. So we have been developing a store and forward method. It is an e-mail system where the stuff is put in your pigeonhole on the server and you can just log in once a day and download all the information that has been put in, such as all the discharge summaries, x-ray reports and whatever. You can just download them that way. You cannot then interrogate other things.

To get around the issue of after hours or someone seeing a different doctor from the one that they had originally authorised to get a copy of the result, we felt we needed to give the patient the right to determine who that was. We are proposing smart cards—getting around to the answer to your question—not to store the information on the smart card, but as a key that the patient needs to swipe through the terminal at the GP's practice that gives the GP the right to go to that patient's mailbox and download that patient's details. That is only valid when the patient is there in the surgery and gives that GP direct access.

It is an electronic consenting form that is held by the patient. It needs the patient to swipe it and it also needs the GP's own ID. So the GP needs permission to get into the system and they need to be given permission by the patient, if the patient has not already given a consent at the time when the test was done. For example, if you are a regular patient of mine and you are admitted to hospital for a procedure, on admission you say, 'And I consent for information to be sent to Dr Richards.' If you had to see me and you were not my normal patient but I was on after hours, or you were visiting Canberra and were sick, if you had your smart card that could provide me with that access without me having to then repeat the tests. That is what it is all about.

Mrs VALE—Is the smart card a preferred option of your other colleagues?

Dr Richards—Smart cards have obviously got an odour about them following the Australia card debate. The smart card proposal and the project we submitted two years ago to the department to trial and develop the smart card process was as a result of the feasibility studies arising from those other projects. It is to be used in the sense that it is not a portable medical record, but it gives right of access to where information is stored in other systems and there was support.

Mr FORREST—I think there is a whole fuss over nothing with all of this. If I come in to see you and you are a bit unsure about the diagnosis and you want to discuss my case with one of your partners in your practice, you will say to them, 'I've got this really difficult case.' You are not going to ring me up and say, 'Can I discuss your case with one of my partners?' You would do that in my own interests. In turn I trust them with the information you convey to them. That happens now. There is not a great public uproar about it. I think the whole issue of privacy and all the evidence we have been hearing for the last eight or nine months is a red herring.

Dr Richards—It is an issue that we come up against repeatedly as a barrier. For example, the hospital would not even allow us to set up a system where they were prepared to fax results to GPs, because they said there was a hospital policy never to fax clinical information because faxes can go astray and they can go to someone else. That has been a major privacy issue.

Within our division we have actually had to go through a major process to get declarations from GPs that, firstly, their fax is secure—that is, that the fax is not sitting out in the middle of the waiting area or that it is not the fax that they are borrowing from the real estate agent next door so they just go and pick up the bits of paper from time to time—and that the fax paper is going to come out where only the GP and their staff will see it. We have had to get signed undertakings from GPs that their faxes are secure, and then program fax machines, have test transmissions and have GPs ring up to say, 'Yes, I got that fax; that is my fax number', before the hospital agreed to a system where even basic information could be faxed.

CHAIRMAN—That is modern technology.

Dr Richards—It is very frustrating.

Mrs ELIZABETH GRACE—On computer records, though, that we have seen, there is an audit trail. Every time someone goes into that file it tells you the time, who it was, how long they were in there—

Dr Richards—The argument is that that is after the event and that you find out after security has been breached.

Mrs ELIZABETH GRACE—Even so, there is a case in Queensland at the

moment, and it is nothing to do with medicine, but the police went into a file. They have been able to pinpoint both policemen and exactly the day and time that they did this. An inquiry has now come up because they were able to find this out. So you are exposing yourself to that type of prosecution if you do that type of thing.

Dr Richards—Yes, I am well aware of that.

Mrs ELIZABETH GRACE—We have heard evidence that you can go into a doctor's surgery and see paper records that have been whited out, been rubbed out, had notes not put on them—

Dr Richards—Torn out or lost.

Mrs ELIZABETH GRACE—Yes, exactly. There have been x-rays taken to show students special things and they are never returned to the file and things like that.

Dr Richards—I personally agree with Mr Forrest. I would consider that doctors as professionals would behave professionally but we are having difficulty persuading administrators of this.

Mrs ELIZABETH GRACE—Yes.

Mr FORREST—I am okay for the exchange of, say, broad information, but if I am HIV positive I do not want anyone else to know—or if I have haemorrhoids or some other unsavoury social disease. That is the thing that seems to be a little sticking point. They want to know who is going to know this information. I could accept that, but we either put some faith in the medical profession or we do not. We know they exchange information now. That information, if you rang the hospital, they would probably give you over the phone because they know it is you they are talking to.

Dr Richards—There is an exception for HIV. Everything else they will tell me over the phone. I had a case a couple of years ago when a patient of mine was raped the day before she was due to leave with her family for an overseas posting. She went to the hospital and had the usual blood tests, and the family were desperate to find out the results of the tests before they left to go overseas. I could not extract the HIV result from the hospital, even though they had it, in time to tell the family. In fact, they actually had to ring me when they arrived there. I told them over the phone. The test was going to be negative but it was a baseline test and had to be repeated in three months time. Still, because it was HIV, it was a special case—and that is the only special case. I could find out about your haemorrhoids—no problem.

Mrs ELIZABETH GRACE—Do you think the medical benefits schedule should be amended to take into account this technology in the delivery of health care?

Dr Richards—I am not sure I understand.

Mrs ELIZABETH GRACE—With the electronic consultation, in your case perhaps you conjure up a specialist from somewhere, but who is going to get paid and how? Should we be looking at the medical benefits schedule to get those sorts of things under control?

Dr Richards—Putting on a different hat for the moment, I am deputy chairman of the ACT Medical Board and, I think, as the previous witnesses were saying, the concerns are more around registration and discipline issues. If a service is provided in a different state and it is provided incompetently, how is action taken against that practitioner? If a doctor in Sydney treats a patient in Canberra and there is an adverse outcome and a complaint, is the New South Wales Medical Board going to take action against that doctor? They would say the service was provided to a patient in Canberra so it is not in their jurisdiction. We would say we cannot touch the doctor because they are registered in Sydney and they are not even registered here.

CHAIRMAN—I think the question related more to the fact that if you were a remote general practitioner and had some kind of video link-up, and you were in your surgery with a patient and you needed to send some computer images to, say, a major teaching hospital or to a city specialist, at the present time there is no provision in the medical benefits schedule for that kind of consultation. A lot of the evidence we have been receiving is that, while doctors are very altruistic individuals, unless there is a provision for payment doctors are not going to be prepared to buy this sort of equipment. The question is: do you think there ought to be a change to the medical benefits schedule to encourage the use of Telemedicine in this particular area?

Dr Richards—Clearly an item number on the medical benefits schedule for a thing such as a Telemedicine consultation would need to be put in after a cost-benefit analysis, and obviously a lot of the evidence today has been outside my expertise. If there is evidence of cost effectiveness, that it saves the health system freighting the patient up to the capital city, then that is reasonable. The difficulty is the different buckets of money from which these things come. Sending the patient to capital cities is state government expense; the Medicare Benefits Schedule is a Commonwealth government expense.

CHAIRMAN—I think so often we tend not to look at the overall cost; we just tend to look at the cost to individual agencies or aspects of government.

Dr Richards—That is what the COAG reforms are meant to be about.

CHAIRMAN—That is not really appropriate.

Dr Richards—They will probably hit AHMAC.

CHAIRMAN—Absolutely.

Mr FORREST—The committee has always appreciated the evidence we receive from actual practitioners who are on the ground at the coalface, and more particularly those that have actually had to operate in remote areas. We have had a couple of those.

In reading your submission and summary remarks I hear a little cynicism about the process. Do you have colleagues that you know in remote areas that may have a different view from you where the benefit in terms of the patient can be demonstrated much more tangibly, even if it saves one seven-hour trip by car paid for by the family themselves to the big capital city for one test or one examination? From a rural perspective there are intangible benefits like that that are hard to measure. What is your view in terms of your GP colleagues who are in that position, because they have a slightly different view from you, I think?

Dr Richards—Yes, they would. I think they actually agree with you. If I think it would benefit me, it would benefit them far more because, at the end of the day, I could always drive the five minutes to the Canberra Hospital and go into the pathology department or look at the x-ray myself, whereas they do not have that luxury.

CHAIRMAN—Thank you very much, Dr Richards, for appearing before us this afternoon.

Resolved (on motion by Mrs Vale, seconded by Mrs Grace):

That the further submission from the Northern Tasmanian Division of General Practice be accepted as evidence.

Resolved (on motion by Mr Forrest, seconded by Mrs Vale):

That, pursuant to the power conferred by section 2(2) of the Parliamentary Papers Act 1908, this committee authorises publication of the evidence given before it at public hearing this day.

Committee adjourned at 3.48 p.m.