The Australian General Practice Network's response to the Inquiry into the Human Services (Enhanced Service Delivery) Bill 2007

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Delivering local health solutions through general practice

Introduction and background

The Australian General Practice Network (AGPN) is the peak body representing 119 Divisions of General Practice and 8 State based organizations. Approximately 95% of GPs are members of their local Divisions as are an increasing number of practice nurses and other allied health professionals. This document represents AGPN's response to the Inquiry in to the *Human Services (Enhanced Service Delivery) Bill 2007* (the bill).

AGPN appreciates that the bill seeks to establish (in part) the legal framework for the proposed access card and that the Inquiry will be examining, among other things:

The intended scope of the card;
The intended purposes of the card;
The information to be included in the card register;
The information to be included in the card's chip;
The information to be included on the card's surface;
The range of offences aimed at prohibiting persons requiring an access card for identification purposes; and
The range of offences aimed at prohibiting other improper uses of the card.

AGPN's response to these specific points, are provided below as well as some more general comments on the Access Card.

General comments

While AGPN supports the introduction of the Access Card, a key issue is to ensure that the introduction of the Access Card delivers benefits to the GP in terms of elimination of red tape, streamlining of any regulatory reporting frameworks affecting general practice operations and, most importantly, provides clinical benefits to the patient.

The health related uses of the card are fundamental for wide acceptance by patients, GPs and practices. These card functions, when delivered, will be the catalyst for the wide spread uptake and adoption of a single Australian Government Access card for health and welfare services.

AGPN believes that a set of principles and standards for Information Management in health are required when implementing or using electronic systems in the delivery of health care services. The reach and extent of these principles have impacts on general practice and hence patients, particularly in achieving a fully integrated network – a network that at its core has the desire to reduce red tape, save time for the GP and improve patient outcomes. For this reason the AGPN is very interested in the implementation of the access card as it forms a cornerstone to GPs, practices and their patients in accessing and utilising electronic systems in health services provision. A list of core principles relevant to Divisional e-health activities, some of which are also pertinent to the introduction of the Access Card are provided at appendix 1.

Specific Comments

The intended scope of the card

The bill sets down a replacement identification card program for a number of Commonwealth funded health and welfare payments programs. AGPN supports the cards introduction for accessing health services. AGPN agrees that a single card would be of benefit to Commonwealth service provision, but also contends that that the scope and benefits must balance and enhance the owner's experience for successful implementation.

The use of the card in the every day context of health care will be centred on its use in accessing Medicare Australia rebates. Approximately 85 per cent of the Australian population visit a GP in any one year and in the 2004–05 financial year, there were about 94 million unreferred

attendances accessing Medicare items. This is an average of 4.5 GP visits per person per year.[i]

AGPN argues that the predominant use and impact of the card will be centred on patient verification for eligibility of Medicare Services and subsequent reimbursement under the Medicare arrangements. The consequences of improving immediate eligibility will have an impact on staff in general practice, as patients that now seek a rebated primary health care service will, in addition, seek to have billing and payments resolved at the practice.

AGPN is supportive of ensuring that only eligible patients are able to access the government rebate; however the quantum of any fraud and the extent of disputes/conflict that arise on eligibility grounds will now be more prevalent in the practice. This increased scrutiny is not something that practices are currently funded for or trained to cope with, particularly as GPs do not ration care on the basis of eligible/non eligible Medicare guidelines; rather they seek to improve the health outcomes of any person that requires treatment or advice. The proposed approach passes the responsibility of managing the physical processes for checking a patient's eligibility to access an Australian Government rebate to the practice without acknowledging this in the legislation.

AGPN recommends: that general practices be adequately funded for the extra time and to allow practices to provide training in the verification and billing reforms to all staff. Savings from reduced fraud and the reduction in expenditure for the provision of Medicare payment offices would more than offset this increased general practice payment.

The intended purposes of the card

AGPN appreciates that the Commonwealth has a primary interest to reduce fraud and improve administrative procedures for Government program delivery.

Improving efficiency is always commendable; however the card has the capacity to enable more than just program efficiency gains. It is a catalyst to improve the way in which patients, GPs and the practice interact. The opportunity exists to have a card, that has large and tangible benefits accruing to the Government, to also have tangible benefits to the biggest users of the card the GP, the Practice and the Patient.

Benefits of the card to the patient and GP relate to time savings, improvements in electronic billing and payments, and quality of the information that can be read by the practice in registering or managing patients as they seek treatments. Voluntary health information is critical in this regard, as is the ability to capture and transfer electronically core demographic information contained on the Commonwealth and patient areas of the chip.

AGPN notes that for checking eligibility and enabling billing and payments the card is a suitable replacement for the current Medicare Card. But it will be a lost opportunity if the card's scope is limited to simply enhanced verifications for Commonwealth payment purposes. If it is to be used by patients, GPs and their practices the intended purpose must support improved patient outcomes through improving patient data quality and must reduce duplication and save time in the practice.

The information to be included in the card register

The "register" is the centralised record system that ensures that a presented card holder is and can be verified as eligible for a payment.

AGPN understands that as a person's circumstances change, any new information must first captured on the "register" and when an Access Card is used at an agency or general practice the latest information will determine eligibility over that information that is contained on the card. At a later time "register" information will overwrite the chip information to ensure that it is current.

In the advent of the card being lost or stolen, patient information can be accessed from the "register". In the context of Medicare services, AGPN is therefore concerned that patients that forget to bring their card or have lost their card will be forced to follow up for reimbursement through Medicare offices at a later date. Therefore little benefit or change is being experienced by the patient or GP as this would be an impost/process much the same as current arrangements. It may well be even worse if Medicare Offices were not as accessible as they are now.

GPs and practice billing arrangements can be progressed if patients are aware of, or practices have recorded, their Medicare numbers in clinical and practice management systems and the patient is known to the practice. AGPN contends that this is similar to a welfare recipient that has lost their card still being able to receive a welfare payment if they were able to produce adequate identification particularly as the payment is an electronic debit into an agreed and secure bank account.

The indigenous status of a client is also recorded in the "register", but not on the chip. There are medical and administrative reasons why a GP should be aware of the indigenous status of a presenting patient and if this information is not transferred into the GPs information set it will require practices to continue to ask patient to fill in paper based registration forms as practices normally seek this information upon patient practice registration.

The process of how the register and the chip interrelate is unclear if discrepancies occur. Does the verification process generate a report

invalidating the card for the purposes of an electronic Medicare Claim? Can updates to the card from the registry be managed in the practice, and how or whom is authorised to generate a change to the registry are unclear. AGPN is of the view that this is not a role for General Practice. The card is a relationship manager between the Commonwealth and the eligible client, but in reality Australians see Medicare as part of the health services delivered in general practice and the fact remains that practices will be the greatest user of the card and therefore significant change management support will be required to implement the card.

AGPN recommends: that the indigenous flag held on the register be included on the access card chip. This information must be able to be transferred to the GP clinical information management system.

The information to be included in the card's chip

The legislation indicates that issues relating to an individual's area of the chip will be considered by the Access Card taskforce, and the Governments position on these issues will then be formulated. The AGPN is and has consistently said that the information that is on the chip should be readable by all health professionals for whom it is required. For the purposes of providing health care or facilitation of a process where the patient can access a subsidy the card becomes critical to the usage, uptake and long term acceptance for patients and practices supporting Medicare services.

Computer systems (authorised to access Commonwealth information) must be able to gather the electronic fields and use them to populate local clinical and practice management systems. By swiping the Access Card the automatic population of a local patient record with core demographics and essential medical information will immediately see the card as an important key when seeking primary health care services. If patients can swipe a card and automatically generate a practice registration form with

core details already populated, this saves time and effort for the patient and the practice administration, it also adds a degree of quality as it ensures that the data that is on the card and on the register and in the practice clinical management systems are aligned, or should be rectified.

The conflict resolution that will be required when a patient is declined as ineligible is going to be felt at the practice and AGPN contends that unless assurances adequately address training practice staff or reimbursement is made to compensate practices to ensure that they adequately informed and locally trained then the Access Card may be not as successful in its implementation as it could be.

AGPN understands that patient registration processes in general practice collects many similar fields to those maintained on the Access card chip. Apart from the standard name, address, email, sex, DOB, the three core government identification numbers: Medicare number, Veterans Affairs entitlement number and Pension/HCC number and associated expiry dates are all duplicated in the clinical records.

As mentioned before the indigenous status is also requested to be moved to the chip, and readable by GP computer systems.

AGPN notes that the National EHealth Transition Authority (NeHTA) is working towards the standardisation of data elements that will form a shared eHealth record. Any data elements that are placed on the chip must be compliant to the NeHTA established requirements. The success of EHealth will be fundamentally reliant on a coordinated and standardised approach to e-enabled technology.

AGPN recommends: Greater discussion on the processes the Commonwealth propose when a patient is declined ineligible for benefit and they believe that they are eligible.
AGPN recommends: Any data elements that are placed on the chip must

be compliant to the NeHTA established requirements.

The information to be included on the card's surface

AGPN has no comment of the information that is being proposed for the surface of the card. However thought might be given to the possibility of persons voluntarily having a symbol or token placed on the surface of the card to highlight certain health aspects that are agreed by the patient. For example organ donation status or medical alerts might be displayed on the rear of the card to ensure that in times of crisis and without the possibility to “read” the chip, patients can be assured that health professional act in their best interests.

These may simply be in the form of a removable sticker or printed onto the surface. The intent here is not to legally bind, but to indicate a preference by the card owner.

The range of offences aimed at prohibiting persons requiring an access card for identification purposes

No comment

The range of offences aimed at prohibiting other improper uses of the card.

AGPN agrees that under the new verification and billing and payment processes being designed for accessing Medicare Services, the ability of a patient to fraudulently access a subsidy has been greatly reduced. This will have an immediate impact on the misuse of Medicare Services. AGPN contends that as all practices strive to provide high quality care within the bounds of legislation and funding constraints. AGPN however, seeks clarity on what penalties will apply and to whom if a Medicare service is provided under false pretences, either knowingly OR unwittingly.

AGPN state that General Practice should never be held accountable for unwittingly contributing to a fraudulent claim on Medicare. Their job is to provide high quality primary health care services and not be pseudo Medicare offices. If a patient is prepared to seek a compensation that they are not entitled to, it is themselves that carry the risk and penalties if caught.

AGPN recommends: Greater emphasis and support is required to ensure that legal responsibilities are clarified and that practices are able to provide a service that will ensure that the Access Card becomes a true enabler of the verification and payment system.

A Future General Practice Access Card Scenario

In an ideal world patients experience an integration of health services including clinical administration and government program support arrangements. Arrangements that are on place should have the capacity to address ever increasing degrees of connectivity and complexity and care integration. The case presented below highlights a potential **future** scenario:

- Patient Y seeks a “first time” consultation with a GP.
- Practice administration staff welcome new patient Y. Patient Y swipes their Access Card upon arrival. Details are transferred automatically into the practice management system and a registration conformation sheet is printed out and handed to patient Y who confirms that the details are correct. If details are incorrect a “variance” form is printed out and given to the Doctor when the consultation occurs. Addition information is added by the patient to the hard copy printout (or PC Tablet) as requested by the practice.
- The patient’s eligibility status to access the MBS and PBS is confirmed online. DVA eligibility can also be verified along with Health Care Concessions etc. The Doctor would be advised immediately that prescribing patterns were outside the norm (the patient is on the Doctor shopping database). Depending on the age of the patient current immunisation records are checked against local clinical records. This is all undertaken in real time and local records are updated.
- Staff at the same time confirms personal information relating to patient Y as contained in the local systems if at odds with the Access Card Chip or Offsite “register” are at odds.
- Patient Y is now in the waiting room. The electronic practice management system automatically queues patient Y onto the desktop clinical management system to notify the doctor that patient Y is waiting while the doctor is currently consulting with patient X.
- Note that from now on, the patient will be able to use the internet to log onto the GP’s website and self-nominate a booking time. The patient is also able to write a short note on what their presentation is about. This has occurred as the practice can be assured that the patient exists and is traceable in the instance of a “no-show”. Identity is non-reputable.
- The Doctor exits the consulting room with patient X and invites patient Y into the consulting room.

- The doctor uses the clinical information system to record clinical notes for the patient and to activate prescriptions and pathology referrals electronically.
- The doctor prints out a note for the patient reminding them to go to a pharmacy and pathology service as required.
- The Doctor confirms the voluntary and certain Commonwealth information that has been transferred to the Clinical Management System in regards to the health critical information such as current medicines.
- If circumstances have changed the Doctor authorises a “variance” form that has been generated at the front office and now is in front of GP. Later, a practice authorised officer co-signs form with patient and this is sent either via facsimile or email to the “register” for processing. For certain details the practice staff may have to refer the patient to a human services or welfare office for confirmation or citing of relevant documents.
- Patient Y informs the doctor that they will shortly be holidaying at the coast. The doctor uses the computer application and Division maintained health service directory services to suggest several chemists that can be accessed in the coastal location but notes that, as a pathology service is unavailable in that area, the pathology visit should be made before travelling. The doctor then refers to a local pathologist within 5 km of patient Y’s residential address.
- Patient Y and their doctor discuss payment. The billing process is initiated in the consulting room by the doctor who electronically queues the bill to the front office.
- Patient Y goes to the practice administrative officer to conclude payment.
- An “Access Card” driven automatic rebate is generated (or an invoice is raised by the practice in the event that the patient is ineligible). Reimbursement is directed to the practice in the case of a bulkbilling service or the rebate is directed to patient’s account after a payment in full has been made by the patient to the practice.
- The doctor calls in patient Z.

- Before leaving for the coast, patient Y attends the pathology service as requested. The pathology service swipes the patient's Access Card. If the Card had the NeHTA unique identifier the along with verifying patient Y's identity (ID) it can retrieve the pathology request from a relevant web service. Banking details are handled again electronically after patient has paid for pathology service, unless pathology is bulkbilled then payment is automatic.
- The required pathology tests are conducted. The results are reported to patient Y's doctor(s) electronically and incorporated into the practice clinical information system. If recall or follow up is required these are generated immediately.
- A consultation booking is automatically generated for confirmation by the patient. An email from the pathology service to the patient's nominated email account states that their doctor has received the results. The pathology provider receives direct payment through a bulk-billing arrangement (over 80% of all pathology services in Australia are bulk-billed). If a patient co-payment is required, a request similar to that previously outlined above is generated.
- Patient Y travels to the coast and whilst there visits a chemist who, upon ID verification, swipes the patient's Access Card and if NeHTA unique identifier is available downloads the relevant prescription. The pharmacist fills the prescription and the patient pays the required co-payment. The pharmacist receives the associated PBS reimbursement and dispensing fee directly. Patient Y receives the prescription and a print-out of drug information including a discussion with pharmacist on what is required to meet GP prescription. Pharmacist also able to provide Patient Y an update on current PBS safety net eligibility.

AGPN looks forward to participating in the Senate Inquiry and will continue to provide the Access Card Consumer and Privacy Taskforce submissions as discussion papers are circulated. AGPN is looking forward

to presenting this submission to the Senate Committee at the Canberra public hearings 6/3/2007.

Yours sincerely

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Chief Executive Officer

Appendix 1

AGPN identifies the following core principles as fundamental to achieving a fully integrated network IM system. These principles underpin the AGPN's interest in e-health activities and form the basis upon which this submission is made.

Any initiative should:

1. Network IM activities will:

    - Act to enhance patient care and outcomes through appropriate sharing of information between different providers
    - Support integrated and continuous patient care by promoting a secure systems approach to data integration from multiple sources.
    - Enable improved health needs assessment and planning through utilisation of quality population health information at local, state and national levels.
    - Work to assist general practice business innovation and efficiency through the establishment of appropriate IM infrastructure and models

2. Divisions will work to promote a professional culture around the use of quality health data in the Network.
3. The implementation of network IM initiatives will encourage participation at both the organisational and practice level and assist Network capacity and development in the use and application of IM.
4. The introduction of new IM services will act to enhance divisional program delivery.
5. Network IM activities in data collection will afford comparative analysis across the Network, whilst collection methods will still allow for local variation.

6. The sharing of, and contribution to, information resources is equitable and relevant across the network.
7. At the practice level, divisions will work to:
    - Support secure data transfer activities with a focus on current, transferable and complete health summaries, care plans, peer review and reflective self-audit.
    - Encourage the use of appropriate clinical software, with an emphasis on good clinical practice and population health activities.
    - Support the implementation of appropriate security and privacy processes.
    - Emphasise the direct clinical benefits of appropriate IM.
    - GP access to latest accepted treatment protocols.
    - GP access to decision making (prompting) tools that integrate with their clinical software.
    - Provide the business case/change management to encourage GPs/practices to adopt new practices/meet new standards.
    - Support the transfer of information, such as discharge summaries and admission notifications, from the acute sector, in order to enhance continuity of care.

In relation to the implementation of the Access Card some of these principles apply to the introduction of the Access Card and Government implementers should be aware that the successful uptake, utilisation and sustainable use of an Access Card will require significant change management at the point where EVERY Australian will use the card. This is particularly pertinent in the context of the overarching public health programs delivered through Medicare Australia.

[i] Britt H, Miller GC, Knox S, et al. General Practice activity in Australia 2004-05. Canberra: Australian Institute of Health and Welfare, 2005. (AHIW Cat No. GEP 18.).