



# SPEECH NOTES

Minister for Health and Ageing  
Leader of the House of Representatives

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### **ADDRESS TO THE MELBOURNE INSTITUTE ECONOMIC AND SOCIAL OUTLOOK CONFERENCE - PURSUING OPPORTUNITY AND PROSPERITY**

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Since 1996, health spending as a percentage of the federal Government's budget has increased from 14 to 18 per cent. Federal health spending has increased from 3.7 to 4.3 per cent of GDP (while state health spending has increased from just 2 to 2.1 per cent). Even so, health is one of those areas where funds are always inadequate, some needy groups are always missing out, responsibilities are always blurred, and crises are always lurking just round the corner even though it's internationally recognised and widely conceded locally that Australia has one of the world's best and fairest health systems. Amidst all these day-to-day pressures, policy makers' challenge is to improve the system not just patch it up.

One of the more disturbing reports a new Health Minister discovers is the 1994 Quality in Health Care study suggesting that there are some 18,000 preventable deaths in Australian hospitals every year. At face value, this finding (based on extrapolation of after-the-event analysis of case notes) suggests that hospitals can be dangerous places to be sick. What it does certainly highlight is the range of things that can go wrong and their potential to contribute to catastrophic outcomes for patients.

One of the most significant causes of preventable death is inappropriate treatment based on ignorance of patients' previous medical history. Analysis of the 1994 study suggests that 9 per cent of preventable deaths result from communications problems and 11 per cent result from poor record keeping. In other words, accurate information about patients' medication, allergies, previous treatments, past illnesses and health characteristics could be a decisive factor in saving up to 3600 lives every year.

For nearly every Australian, this information is currently on record somewhere. The challenge is making it immediately available to treating doctors and other medical staff.

It's impossible to take a history from an unconscious patient. If ambulance officers or emergency department doctors could use patients' Medicare cards (or some other widely available "smart card") to access their medical records and health information, much unnecessary testing and counter-productive treatment could be avoided. The result should be

significant cost savings, substantially better health care, and hundreds of people alive who would otherwise be dead.

Currently, patient information is available on the files of each treating doctor and hospital; in the records generated by the Medical Benefits Schedule and Pharmaceutical Benefits Scheme held by the Health Insurance Commission; in other records such as the Australian Childhood Immunisation Register and the Australian Organ Donor Register also held by the Health Insurance Commission; and in the data of private health insurers. Despite some doctors' nostalgia for hand-written index cards, this information is increasingly stored electronically and potentially available on line. The challenge is connecting systems and linking information in ways which enhance patients' control over their own health records and facilitate the best possible medical treatment.

Since the mid-90s, the Australian Government has been encouraging doctors to computerise their surgeries through practice incentive payments and the creation of a peak body to oversee the use of IT in general practice. An estimated 80 per cent of GPs now use IT to generate prescriptions. A large and growing percentage have electronic patient records and referral systems. Nearly all medical practices have computer generated billing systems including links with the Health Insurance Commission to facilitate bulk-billing. About 120 surgeries now have access to HIC Online which not only enables doctors to claim the rebate for bulk-billed patients but allows other patients to claim their rebate without the need to visit Medicare offices or post in forms.

The *MediConnect* initiative, currently on trial in Launceston and Ballarat, is an electronic medication record integrating information held by doctors, pharmacies and hospitals. It's designed to improve communication between treating health professionals and to monitor and prevent possible over-medication or misuse of prescription drugs.

The states have also been using IT to improve hospital services and generate savings. In South Australia, for instance, the Oacis (or Open Architecture Clinical Information System) initiative enables a patient's hospital data (pathology, radiology, pharmacy, and theatre and ward case notes) to be accessed instantaneously anywhere across the South Australian public health system. The South Australian Health Department says that this pioneering initiative means better clinical decision-making (through better access to information), greater patient satisfaction (through reduced need for information collection), and lower costs (through fewer duplicated tests).

Existing initiatives such as HIC Online, MediConnect and Oacis are potential building blocks for the HealthConnect project taking shape as a cooperative venture between federal and state governments. This began in July 2000 when federal and state health ministers agreed to build a national system of electronic health records. Since 2001, federal and state officials have been creating the IT infrastructure to support HealthConnect, drafting protocols for its operation and considering necessary privacy, consent, identification and governance standards.

HealthConnect aims to integrate patient records from hospitals, doctors' surgeries, nursing homes, medical laboratories and pharmacies. It also aims to give patients access to their own files and, if they wish, to add or delete personal information available to health care providers. HealthConnect trials are currently underway or planned for Hobart, Katherine, Townsville, south Brisbane and western Sydney.

In Tasmania, for instance, the Royal Hobart Hospital, 23 local medical practices and 750 people with diabetes are part of a trial to make diagnostic testing and patient histories available on line. In the Northern Territory, more than 1000 highly mobile Aboriginal people have agreed to participate in a trial to make their health records (including diagnoses, treatments, medications, clinical observations and recommended tests) available to all the significant health services in the Katherine area.

Despite better access to the information held *within* particular systems, not-very-compatible IT arrangements and the traditional "information is power" reluctance to give anything away, mean there has been little progress towards information sharing *between* different systems. In July, federal and state health ministers endorsed a new health information governance structure to facilitate quicker achievement of a national system of health and medical records. The Australian Health Information Council will try to foster partnerships between health care and IT providers and the National Health Information Group will try to ensure that governmental systems encourage information sharing between people with relevant information and those with authorised access to it.

A decade ago, more than a billion pounds was invested in integrated, on-line record-keeping in the UK National Health System with very disappointing results. Although technology has improved, the public sector's ability to frustrate outsiders and concern about possible misuse of confidential information remain stumbling blocks. Despite official enthusiasm for information sharing, the Health Insurance Commission apparently took five years to make de-identified medication records available to West Australian epidemiologists.

Inevitably, the ghost of the Australia Card hovers over this process even though its object is to help patients rather than bureaucrats. NSW, Victoria and the ACT have specific and inconsistent health privacy legislation. Under current federal law, the HIC cannot hold MBS and PBS information in a common database, cannot hold electronic data for more than five years and cannot data match between the two main systems. If patients request MBS and PBS data, they receive two documents full of technical codes and academic terminology which make them largely unintelligible to consumers.

There are limitations to the information held on HIC databases. MBS information includes the date and nature of a consultation and the doctor's charge and rebate (but not case notes or patient histories). PBS information includes the date, place and type of subsidised prescription and its cost (but not similar information about unsubsidised prescriptions).

Even so, an operational *HealthConnect* system could provide people with information about their personal access to the MBS and PBS safety nets, immunisation records, and dates (and possibly results) of precautionary health checks and tests. There's the potential to give people more involvement in their own health management, more capacity to make informed decisions about their health care and more ability to check and correct their own records.

Access to any such system could be controlled by passwords in much the same way as online banking and credit systems. In addition, there would have to be electronic versions of the existing strict controls on when and for what purpose and with whose consent health professionals could access patients' records.

In a 2001 HIC survey, 74 per cent of respondents supported (and 22 per cent opposed) personal access to health data. Peoples' fears of Big Brother should never be under-estimated – as politicians accustomed to living in a goldfish bowl and policy makers mesmerised by potential information efficiencies and systems synergies often do. Still, there appears to be one completely effective way to defuse privacy concerns: namely to give everyone an absolute right to remove information from his or her individual *HealthConnect* file.

One way to avoid the swamp of committees associated with government-led IT integration might be to define the project, set timelines and go to the market with the private sector submitting bids to make an integrated system work. One way to allay fear about snoops and busy-bodies prying into secrets might be to have people opt-in, perhaps even buy the service, as a more sophisticated version of the information bracelets diabetics and others used to wear to enable better emergency treatment.

An integrated health record system could reduce privacy anxiety by giving people immediate access to their personal health information. At present, people have no ready access to different medical authorities' stores of information about drug use, mental health or communicable diseases – information that, in the wrong hands, might conceivably be used against them. This way, people worried about potentially damaging information would have more capacity to act as their own vigilantes patrolling their files and taking action against the material they don't like. People with more confidence in their fellow human beings could allow the system to generate and share the information that just might save them from a medical disaster. Either way, it would be entirely a question of personal choice.

Although patient benefit is the main justification for an integrated health record system, there should be substantial savings available for re-investment in the wider health system. In 2000, the National Electronic Health Record Taskforce speculated that reductions in unnecessary hospitalisation and duplicated testing could generate savings of \$300 million a year. A British trial of electronic medical record keeping in hospitals has calculated staff time savings in the order of four to eight per cent. A US study of the benefits of electronic record keeping in primary care has estimated a five-year saving per practice of about \$150,000.

The main obstacles to the creation of an operational integrated health record system are: technical problems (which are rapidly diminishing); doctors' sense of ownership over files (even though the information really belongs to their patients); and patients' worry about potential misuse of information (which should be dispelled by giving each patient total access and the ability to delete information from any composite file). It's almost inevitable that, at any one time, governments will have higher political priorities than systems integration and access. Still, there could be few surer signs of systemic paralysis than the inability to achieve such an obvious improvement within five years.