ACHI position paper on a national eHealth strategy.

The Australian College of Health Informatics (ACHI)

Formed in 2001, ACHI aims to enhance the Australian professional standards and capacity in health informatics as applied to research, education and training, policy and system implementation. ACHI has adopted the International Medical Informatics Association (IMIA) guidelines on health informatics education standards. ACHI is dedicated to building a community of practice in health informatics, providing national leadership in professional standards and program accreditation, fostering and developing members' skills and knowledge.

This ACHI position paper draws on the discussion on a national eHealth Plan by the ACHI membership about the current state of eHealth in Australia. Specific contributions by the following ACHI fellows are acknowledged: Paul Clarke, Enrico Coiera, Heather Grain, Terry Hannan, Evelyn Hovenga, Michael Kidd, Hugh Leslie and David More.

Definition of eHealth

eHealth is generally accepted as an umbrella term composed of 2 elements[1]:

1. health informatics (related to the collection, analysis and movement of health information and data to support health care), and

2. telehealth (related to direct e.g. videoconferencing or indirect e.g. website delivery of health information or health care to a recipient.)

eHealth encompasses products, systems and services, including tools for health authorities and professionals as well as personalised health systems for patients and citizens[2]. The scope of eHealth includes bench-top to bedside to population health activities, which present complex information management challenges to support individualised patient care.

Background

It is on the record that the Health*Connect* strategy is a "change management strategy". While laudable, there is little documented information to describe what HealthConnect is changing from and what it is changing to.

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[1] Wang X, Turner L, Scott RE. Technology solutions – saving the day? 6th Annual Can Soc of Telehealth Conference, Halifax. Nova Scotia 5-7 Oct 2003

[2] European Commission. eHealth - making healthcare better for European citizens: an action plan for a European eHealth area, 2004 (http: europa.eu.int/eur-lex/pri/en/dpi/cnc/doc/2004/com2004_0356en01.doc)

The ACHI supports the formation of NEHTA to further the standards and building blocks agenda. The NEHTA website describes 12 programs of work but has little details or explicit timelines. Nor does it make explicit the support, especially in terms of compliance to interoperability standards, among the jurisdictions. There is a perception that there is insufficient stakeholder consultation or information sharing by NEHTA. This perception is particularly strong among the vendor, clinical and health informatics stakeholders. An example is the visit in December 2005 of the SNOMED CT organisation, where the general comment seems to be that not enough people knew about it and did not have the opportunity to contribute and debate.

As part of its extension for another 2 years, the Australian Health Information Council (AHIC) has had its membership trimmed and its "implementation" subcommittees, e.g. the decision support subcommittee, ceased. The terms of reference have also been updated to reflect its new role as an advisory body, whose function may or may not be the function of a council. Perhaps a name change may be appropriate.

Basic question: who is responsible for eHealth in Australia?

ACHI has a simple, but fundamental question: *Who is responsible for, and why does there not exist, a documented clearly agreed strategy for the implementation of eHealth in Australia?*

More specifically, ACHI requires answers to a number of questions, including:

- ✓ Who in government(s) is responsible for eHealth?

- ✓ Are there any concrete plans especially those projects that have been funded

- ✓ How can ACHI engage with the "owners" and the "plans"?

In terms of the AHIC, the following questions are pertinent:

- ✓ Is AHIC being effectively silenced through repositioning what it does and how it does it? (The Australian 08 Nov 2005).

- ✓ Is NEHTA going to be enlarging its remit from building blocks and standards work to cover the whole national eHealth implementation agenda?

- ✓ If eHealth is now about change management federally, then how is a 'technocrat' organisation focussed on specific technical tasks going to change to engage with the groups that are being asked to change?

- ✓ Is a set of 'stakeholder groups' the best way of engaging with the clinical and consumer populations? The UK experience has highlighted that token engagement was a recipe for disaster, leading to significant effort to catch up with clinicians, after clear disquiet from the clinical workforce, who are going to be asked to change what they do quite significantly?

Requirements for a National eHealth plan

For a national eHealth plan to be successful, at a minimum, it needs:

1. to be cohesive, comprehensive and overarching, governing all health/eHealth.

2. to be overarching, the national plan requires the visible support and ownership from all the major stakeholders, starting at the highest level in the PM's Department and including the jurisdictions

3. to have undergone critical and public review involving broad consultation – basically to ensure it has considered and addresses all key stakeholder issues and requirements – in an open and transparent manner

4. to articulate a solid business case and performance assessment approach - linking investment with key patient quality and safety indicators

5. to provide a coordinated and standards-based ICT and clinical systems investment plan across all jurisdictions and across primary and secondary care, which has credible funding over a realistic timeframe

6. to properly address capacity building issues to ensure adequately skilled resources are available to support the implementation of a strategy which will take at least a decade to complete (if sufficiently funded and resourced)

7. to detail an implementation process which is open and transparent, accessible for public review and comment, has sufficient milestones and review points over the planned timeframe to enable appropriate and timely corrective action or fine tuning of the strategy as required following appropriate ongoing consultation involving key stakeholders, consumers and clinicians

8. to incorporate a change management and communication strategy to ensure the major benefits and performance outcomes identified in the business case can be achieved

9. a work plan with objectives and KPIs, with an evaluation research plan to monitor and measure performance outcomes achieved

As noted by Warner Slack, an American health informatics guru, "Medicine is NOT a business, our business is clinical medicine". This essential CLINICAL FOCUS must be recognised by government, professional health associations and computing bodies. Policies should be grounded on clinical services and health outcomes requirements. The focus should go beyond "incomes and litigation" to clinical and evaluation research to determine effectiveness. eHealth is about people and learning from one another and learning from the past, avoiding the "not invented here" and "invented over there" syndromes.

In addition to a clinical focus, eHealth is a (potential) vehicle to promote and achieve widespread health literacy, which will in turn promote shared decision-making and lead to healthy lifestyles and good health outcomes. This requires an optimum use of eHealth technologies by consumers and health professionals. In addition, managers, planners and policy makers must understand that technology must support health strategy not the other way round.

Some examples:

✓ HealtheLink - the flagship NSW project is due to go live in the Hunter in March 2003. This delay is partly due to some software vendors having difficulty in coming

up with a standards compliant interface and some sensitive negotiations, with both the state and federal privacy commissioners, around the "opt-out" approach being used in NSW. There are some concerns that the project may have been scaled down.

✓ In an electronic GP notification procedure being implemented in Tasmania in 2005, the clinicians are being 'told' what they will do in a project that does not appear to be clinically significant. There does not appear to be explicitly defined parameters for 'measurement' of effectiveness.

✓ An expert panel has estimated the costs of a National Health Information Network (NHIN) as "US$156 billion in capital investment over 5 years and US$48 billion in annual operating costs…"[3]. Compare this to what the US government has actually allocated, the UK government allocation to the eHealth program of £10 billion (AUD$23.5 billion) over 10 years, and the Australian government allocation of AUD$20 million over three years for an electronic health record system from 2005.

How can ACHI be engaged in the national eHealth plan?

The ACHI membership is a change agent in the health system, encouraging the appropriate use of health informatics concepts and technologies. ACHI has the expertise to advise government and the professions on eHealth matters, in particular the national direction, implementation and support for health informatics and educational and capacity building, innovation and diffusion, standards development, research, performance and quality management.

The expertise ranges from university-based health informatics R&D and education to implementation and systems analysis consultancies with health services and government. Fellows of the ACHI have been involved in a range of large scale projects such as the implementation of the Regenstrief EMR system in Africa, MediConnect, HealthConnect, National EDS Taskforce, National EHR Taskforce, Patient ID, Clinical Terminology and a range of national and international projects.

Five years after the publication of *To err is human*, "… The pace of change is likely to accelerate, particularly in implementation of electronic health records, diffusion of safe practices, team training, and full disclosure to patients following injury…"[4]. Our challenge is still the general lack of explicit processes and systems in place to promote and reward quality and safety and to manage risk at the clinical and population health levels. Factors underpinning this challenge include:

- unrealistic expectations of the profession, government and industry

- change management, including social and organisational informatics issues

- lack of information system standards and benchmarks

- fragmented political and legislative approaches and support

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[3] Kaushal R, Blumenthal D, Poon EG, et al. The costs of a National Health Information Network. Ann Inter Med 2005; 143: 165-173

[4] Leape LL, Berwick DM. Five years after *To Err is Human*. What have we learned? JAMA 2005; 293: 2384-2390.

- fragmented financial approaches and support, including an unfilled need for a clear business model with which to engage the clinical software industry.

ACHI is concerned that the lack of information freely available in the public domain is limiting critical debate and raising the perception that important eHealth initiatives are being scaled down. The AMA eHealth Forum, held from 07-08 Dec 2005, highlighted similar concerns about a lack of engagement and communication by "government". Government appears to be favouring an indirect approach, via health service fees and benefits, to fund eHealth.

National organisations like the NEHTA should make documents freely available for public comment. However, it must be recognised NEHTA is "owned" by the jurisdictions. The natural conclusion is that the NEHTA is a structure to ensure that all jurisdictions will collaborate nationally as well as ensure their compliance to national interoperability standards as well as make good and nationally relevant eHealth decisions.

It is worth repeating that HealthConnect is now being described as a "change management and implementation strategy". The first problem is we are not certain what we are changing from and what we are changing to. The second and more important problem is with what resources!

We do not wish to paint too negative a scenario. We see deficiencies in the current process, content and strategic direction in the current eHealth activities being adopted by government. The ACHI has the expertise and would like to engage with government and health and ICT professional bodies to work out a number of realistic solutions to the current eclectic mix of eHealth projects.

There is a need for a well communicated national vision, implementation plan and business case - eHealth is essential to promote safety, efficiencies and effectiveness in the Australian health care system. eHealth is also important to train and support the workforce, helping with recruitment and retention. We can achieve a sustainable, safe and effective health care system through the intelligent application of eHealth!

Given the nature of our health care system, this vision and strategy is the joint responsibility between the Commonwealth and the States/Territories but with the Australian Government providing the leadership.

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