

Submission to National Health and Hospitals Commission

From

Dr David G. More

8th May, 2009

Background:

The NHHRC issued a press release entitled "NHHRC Backs Person-controlled Electronic Health Records" on 30 April, 2009.

This may be accessed here:

<http://www.nhhrc.org.au/internet/nhhrc/publishing.nsf/Content/mediaRelease300409>

In summary the report made 7 recommendations which were summarised as follows:

"The Commission has made seven recommendations to make person-controlled electronic health records a reality. These include:

- By 2012, every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person;
- The Commonwealth Government must legislate to ensure the privacy of a person's electronic health data, while enabling secure access to the data by the person's authorised health providers;
- The Commonwealth Government must introduce unique personal identifiers for health care by 1 July 2010;
- The Commonwealth Government must develop and implement an appropriate national social marketing strategy to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach; and
- The Commonwealth Government must mandate that the payment of public and private benefits for all health and aged care services be dependent upon the provision of data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record."

Qualifications to Provide Comment:

I am a consultant in the e-Health domain and have been so for over 20 years. I have provided professional advice for both public and private sector organisations including DoHA, NEHTA, SA Health, NSW Health (where I acted as CIO for a period), IBM, Ramsay Healthcare etc.

My qualifications include medical and science degrees, a PhD in Medicine, 2 clinical fellowships in Anaesthesia and Intensive Care and a Fellowship of the Australian College of Health Informatics.

Key Comments:

I have the four major criticisms of the document as it was released.

First the evidence base on which is supports the deployment of the Person-Controlled Electronic Health Record (PEHR) has been assembled in what can only be termed a fraudulent and deceptive fashion. For reasons best known to the authors of the paper evidence for the use , by healthcare

providers, of electronic health records (EHRs) has been appropriated and it is claimed this evidence supports the adoption of PEHRs which is simply does not.

To date I am not aware of any major studies validating the value of PEHRs (or PHRs as the rest of the world describes these records).

Indeed a major review published as late as December 2008 stated the following.

“We spend nearly \$2 trillion annually in healthcare in the US with a high cost per person and an unacceptable variability in the quality of care. It is clear that PHRs have the potential, if designed appropriately and adopted widely, to reduce costs and simultaneously improve quality and safety of care. This potential has led to enormous public enthusiasm for PHRs and large investment. However, the existing knowledge base that underpins this work is surprisingly limited and most of the fundamental issues remain unresolved. For PHRs to realize their future potential, additional research is essential, but it is unlikely to be performed unless substantial additional financial support is committed to PHR research and evaluation, especially from federal and commercial sources. If these additional investments are not made, much time and money may be wasted and the potential value of PHRs will remain unrealized.”

See the following for the full article.

<http://www.jamia.org/cgi/content/full/15/6/729>

Similar sentiments are expressed here in a slightly earlier paper when discussing benefits:

“Benefits of Personal Health Records

For consumers, PHRs have a wide variety of potential benefits. One of the most important PHR benefits is greater patient access to a wide array of credible health information, data, and knowledge. Patients can leverage that access to improve their health and manage their diseases. Such information can be highly customized to make PHRs more useful. Patients with chronic illnesses will be able to track their diseases in conjunction with their providers, promoting earlier interventions when they encounter a deviation or problem. Collaborative disease tracking has the potential to lower communication barriers between patients and caregivers. Improved communication will make it easier for patients and caregivers to ask questions, to set up appointments, to request refills and referrals, and to report problems. For example, communication barriers are responsible for many adverse drug events in the outpatient setting.¹¹ In addition, PHRs should make it easier for caregivers (proxies for the patients) to care for patients, which is difficult today. A critical benefit of PHRs is that they provide an ongoing connection between patient and physician, which changes encounters from episodic to continuous, thus substantially shortening the time to address problems that may arise.

To date, there is limited evidence supporting these hypothetical benefits; however, many consumers have high satisfaction levels with existing early versions of PHRs.^{3,7,12,13} In particular, consumers place value on easy access to test results and better communication with clinicians.

The PHR can benefit clinicians in many ways. First, patients entering data into their health records can elect to submit the data into their clinicians' EHRs. Having more data helps clinicians to make better decisions. The PHR may also become a conduit for improved sharing of medical records. Patients who are more engaged in their health are more active participants in the therapeutic alliance, for example, when patients with chronic conditions collaboratively manage their illnesses with clinicians to reduce pain, improve functional outcomes, and improve medication adherence. Finally, asynchronous, PHR-mediated electronic communication between patients and members of their health care teams can free clinicians from the limitations of telephone and face-to-face communication or improve the efficiency of such personal contacts. Notably, all the advantages of PHRs for providers depend on the PHR being integrated with the provider's EHR.

Potential benefits of PHRs to payers and purchasers of health care include lower chronic disease management costs, lower medication costs, and lower wellness program costs, although none of these has been well studied. The greatest area of benefit relates to the chronic disease management, where costs are typically high.¹⁴

Full paper here:

<http://www.jamia.org/cgi/content/full/13/2/121>

Note there is “limited evidence supporting these hypothetical benefits”.

On the other hand there are many studies identifying the benefits of provider used EHRs. This evidence can be best accessed at the Health IT page of the US Agency for Health Care Research and Quality. See here:

<http://healthit.ahrq.gov/portal/server.pt?open=512&objID=650&PageID=0&parentname=ObjMgr&parentid=106&mode=2&dumy=t>

There seems little point in rehearsing this information again in this short submission

My second criticism is that by having the NHHRC publish this apparent plan – the fuller scope and much more fully thought out National E-Health Strategy developed by Deloitte for AHMAC – is very likely to be sidelined and not supported for implementation. The NHHRC document does not address a legion of issues regarding the development of e-Health in Australia and its support of Health Reform and this is a deeply concerning. At best the NHHRC document should be seen as being adjunctive to the work undertaken by Deloitte and Booz and Co on behalf of the NHHRC.

My third criticism is that even if the recommendations found on pages two and three of the PEHR document were to be implemented, and this seems to be highly unlikely, the document totally fails to address provider costs and compliance as well as overarching national e-Health governance. The benefits for the cost, sustainability and quality and health care in Australia would be dramatically less than that which may be achieved by implementation of the Deloitte plan.

Lastly I am deeply suspicious of the NHHRC motives in the formulation of this proposal. On page 11 we read “While we support this overall vision for e-health, we have long debated the most cost-effective means of enabling and encouraging the development of personal electronic health records.” I take this to be inferring that the NHHRC has cast around for a low cost way of seeming to be doing something in e-Health, has ignored the need to provide provider e-Health solutions and is hoping that by offering a voluntary PHR that the issue will go away – as the PHR will be made available cost free, or at low cost, by the likes of Microsoft or Google.

Let me be quite clear – a PEHR does not in any way replace the need for provider systems and networks and to think this proposal provides reform enabling e-Health for the NHHRC and the country is just utterly fanciful.

There are two things I also need to make it clear. First I am totally convinced of the necessity of an appropriate, funded e-Health plan as part of the overall NHHRC final report. Second I need to disclose I was an unpaid advisor to the consulting team who developed the Deloitte plan and that I have also made unpaid contributions to the work undertaken by Booz and Co.

It is my belief the NHHRC should issue a clarifying press release placing this document in its proper context as a discussion document for PHR directions in the overall context of the Deloitte National E-Health Strategy. The NHHRC then needs to say that it endorses the Deloitte work fully or explain how it will actually develop an implementable replacement that fully addresses the e-Health needs of all the stakeholders in the Australian Health System.

To not do so has the potential to set the cause of Health Reform and of E-Health in this country back a very long way.

Appendix:

Following are two blog posts and some external commentary on my thoughts from other contributors. These reflect the evolution of my thinking on this paper of the last week or two.

<http://aushealthit.blogspot.com/2009/04/important-e-health-release-from.html>

Thursday, April 30, 2009

[Important E-Health Release from the National Health and Hospital Reform Commission \(NHHRC\)](#)

The following has just been released:

NHHRC BACKS PERSON-CONTROLLED ELECTRONIC HEALTH RECORDS

The National Health and Hospitals Reform Commission (NHHRC) today released a supplementary paper to its Interim Report, which outlines the Commission's support for person-controlled electronic health records for every Australian.

NHHRC Chair, Dr Christine Bennett, said today that the supplementary paper spells out the Commission's position that an electronic health record is arguably the single most important enabler of truly person-centred care.

"The timely and accurate communication of pertinent, up-to-date health details of an individual can enhance the quality, safety and continuity of health care," Dr Bennett said.

"A person-controlled electronic health record would enable people to take a more active role in managing their health and making informed health care decisions."

According to recent research commissioned by the National Electronic Health Transition Authority (NEHTA), 82 per cent of consumers in Australia support the establishment of an electronic health record.

The Commission has made seven recommendations to make person-controlled electronic health records a reality. These include:

- By 2012, every Australian should be able to have a personal electronic health record that will at all times be owned and controlled by that person;
- The Commonwealth Government must legislate to ensure the privacy of a person's electronic health data, while enabling secure access to the data by the person's authorised health providers;
- The Commonwealth Government must introduce unique personal identifiers for health care by 1 July 2010;
- The Commonwealth Government must develop and implement an appropriate national social marketing strategy to inform consumers and health professionals about the significant benefits and safeguards of the proposed e-health approach; and
- The Commonwealth Government must mandate that the payment of public and private benefits for all health and aged care services be dependent upon the provision of data to patients, their authorised carers, and their authorised health providers, in a format that can be integrated into a personal electronic health record.

The NHHRC supplementary paper, Person-controlled Electronic Health Records, is available on the NHHRC website at www.nhhrc.org.au under Interim Report of the NHHRC. Feedback can be sent to talkhealth@nhhrc.org.au but must be received by Friday 8 May.

----- End Release

Comments on Document Welcome.

I was given access to a late draft.

My comments (as provided to the NHHRC) are as follows:

I am very keen on the PHR concept and I am very supportive of the need for these records.

I have 4 main issues with the present draft which I would like to see addressed.

1. Balance of EMR and other Source Systems and the PEHR

I believe this approach is unbalanced in that it over-emphasises the role of the personally held record and does not properly recognise the place and importance of the provider held record. (Remember it is these records which will contribute a large part of the information held in the PEHR)

In my view the personally held record needs to be adjunctive to the record, and the systems, used by each health professional to optimise the care they deliver.

The care deliverer needs information of known provenance and trustworthiness from external sources (labs, referrers etc) and needs to have decision support and knowledge available at the point of clinical decision making. This proposal does not permit / facilitate the proper exchange of professionally validated information in the way I see as crucial.

The benefits case for Health IT rests on clinical decision support provided at the point of care and that is not recognised clearly enough in this document I believe.

2. Vocational and tertiary training

There is a clearly identified need to ensure sufficient numbers of skilled health IT resources as this is looming as a critical barrier to the successful implementation of a national E-Health work program. The building of Australia's E-Health skills capacity and capability will require the national coordination of changes to vocational and tertiary training programs. The emphasis of these changes should be to strengthen the understanding of the importance and use of health IT as part of care provider training programs and to increase the number of specifically trained Australian health informatics practitioners. This last action should involve consideration of the establishment of nationally recognised tertiary qualifications in health informatics in a similar manner to countries such as the United States.

3. Governance.

I believe the Commission does need to properly consider the issue of governance of the e-Health domain. NEHTA is ill equipped to do this at the strategic level and clear leadership is needed if any progress is going to be made.

4. A Patient and Professional Information Portal for Health Information and Knowledge.

This was recommended at the 2020 Summit and is not an expensive thing to do, but has been proven by Australian research to improve the quality of care.

I also have some concerns that having this document, the National E-Health Strategy and the Booz document may lead to policy confusion and inactivity.

I understand there will be a more complete plan included in the final report (due in June). So there is very little time to comment. Get to it!

David.

Posted by Dr David More MB, PhD, FACHI at [Thursday, April 30, 2009](#)  

2 comments:

Anonymous said...

Is the PHR considered a "safe" political approach to EHR maintained centrally too "courageous". My personal experience is that the people most at risk, needing thoughtful diagnosis and treatment are generally least likely to have maintained a complete PHR. My view is that health providers should not be reimbursed from the public/private health fund purse unless they properly contribute to a central EHR. Similarly, the patients should not expect to pay for their central EHR if it is maintained. Who is defined as a health provider and is authorized to add to a central EHR is a separate issue to this note. The patient may carry/maintain their own PHR to accommodate recording of "alternate" services/medicines. Correspondingly, providers should be indemnified if they rely on the EHR after obtaining confirmation (method to be defined) from the patient that no "alternate" provided service/medication is to be added to the EHR and the central EHR they are using for that patient is complete. Every day practice continues to reinforce this opinion.

[Friday, May 01, 2009 10:24:00 AM](#) 

Anonymous said...

A unique patient identifier is known to be needed but is yet to be determined and legislated. The structure/content of any PHR/EHR is yet to be determined. The means to code patient conditions/treatment soe exception review or reporting is yet to be determined. Is an electronic "gold-standard" treatment regimen for stand-alone patient conditions been established by the specialist colleges? What has been achieved to actually establish an OZ E-health system to benefit the patient?

[Friday, May 01, 2009 3:03:00 PM](#) 

<http://aushealthit.blogspot.com/2009/05/nhhrc-gets-e-health-very-badly-wrong-at.html>

Monday, May 04, 2009

[The NHHRC Gets E-Health Very Badly Wrong at the First Go!](#)

The following is going to form the basis of my submission regarding the e-Health plan proposed by the National Health and Hospital Reform Commission (NHHRC).

First some press reaction to last week's announcement.

Quickly of the mark we have the Australian IT Section.

Patients may have to foot e-health bill

Karen Dearne | April 30, 2009

PATIENTS may have to pay for their own electronic health records, with the key healthcare reform body urging the federal Government to mandate "person-controlled" systems commercially available from providers like Microsoft and Google.

"We believe that the rapid development of new IT applications required across the health sector to give people the opportunity to have an electronic health record is best undertaken by

commercial IT developers in an open competitive market," the [National Health and Hospitals Reform Commission](#) (NHHRC) said in a supplementary paper released today.

While tech-savvy patients are increasingly keen to manage their own medical records, public agencies worldwide have opted to maintain control over health information-sharing systems to ensure confidentiality, technical security and data quality.

But in an unexpected turnaround, the NHHRC said "every Australian should be able to choose where and how their personal e-health record will be stored, backed-up and retrieved", and that the records should be "at all times owned and controlled by that person".

Instead of providing a national health IT infrastructure, the Government's role should be "to regulate privacy and technical standards", and allow the market to come up with products that suit both consumers and healthcare providers.

"By 2012, every Australian should be able to have a personal e-health record," said NHHRC chair Christine Bennett. "The Government must legislate to ensure the privacy of a person's e-health data, while enabling secure access to the data by the person's authorised health providers."

To thwart likely objections from doctors over sharing information contained in their patients' records, the NHHRC wants the payment of public and private benefits to health and aged care services "to be dependent upon the provision of data to patients, their authorised carers and other health providers, in a format that can be integrated into a personal e-health record".

Microsoft has previously told the NHHRC it was feasible to establish an affordable, consumer-controlled e-health record nationwide within one year. Its Health Vault web-based platform has been designed to allow people to collect, store and share their own medical information with doctors and family members.

The commission's [interim blueprint](#), released late last year, has been criticised for its failure to put information technologies at the heart of planned health sector reform.

While today's papers said the nationwide adoption of individual e-health records would return between \$7-\$9 billion in economic benefits from increased productivity and reduced adverse event over 10 years, the federal and state governments have balked at providing the necessary funding.

More here:

<http://www.australianit.news.com.au/story/0,25197,25409711-15306,00.html>

Second we have the professional press

GPs face MBS restrictions under proposed e-health agenda

Friday, 1 May 2009

GPs who do not sign up to the Government's e-health agenda could find their access to the MBS restricted, under a radical new proposal touted by the National Health and Hospitals Reform Commission.

The new proposals—released yesterday—recommend public and private benefits for health and aged care services be tied to the provision of personal electronic health records to all patients. GPs would have until January 2013 to comply.

However, AMA e-health committee chair Dr Peter Garcia-Webb criticised the proposal, claiming it could greatly disadvantage patients.

<http://www.medicalobserver.com.au/News/0%2C1734%2C4453%2C01200905.aspx>

And here:

Push for e-health records by 2012

1-May-2009

Doctors should lose funding if they fail to integrate referrals, discharge and patient information into a national system of e-health records, the Federal Government's main advisory group has said.

Yesterday the National Health and Hospital Reform Commission released a series of recommendations designed to kick start the development of national e-health records.

Its key message is that Federal Government should guarantee every Australian can "own and control" their own e-health record by 2012.

But as part of that process it also said the government should make funding to health providers dependent on their ability to send and receive information in a way that is compliant with the e-health record system.

That includes GPs, medical and non medical specialists, pharmacists and health and aged care providers being able to transmit key health data – including referrals, discharge information, prescriptions and synopses of diagnosis and treatments - in a format that can be "integrated into a personal electronic health record" by January 2013.

The commission said hospitals would also face loss of funding unless they were able to provide referral and discharge information under a national e-health system by 1 July 2012. And the same deadline has been suggested for pathology and diagnostic imaging providers.

More here (if access available):

<http://www.australiandoctor.com.au/articles/ec/0c0607ec.asp>

And finally the mainstream press health section

Push for electronic health records

Adam Cresswell, Health editor | May 01, 2009

Article from: [The Australian](#)

THE federal Government's main health reform advisor says every Australian should be able to have their own electronic health record.

In one of its most definitive statements, the National Health and Hospitals Reform Commission said yesterday that any electronic health records should be under the control of individual patients, instead of doctors.

It also called on the federal Government to take steps to enable health records to be introduced. These steps include introducing unique personal health identifiers - code numbers for each individual - by July next year. Medicare numbers are not suitable for this purpose because entire families can be included on one Medicare card.

More here:

<http://www.theaustralian.news.com.au/story/0,25197,25411894-23289,00.html>

Interestingly, in parallel we have this paper appear.

Acceptability of a Personally Controlled Health Record in a Community-Based Setting: Implications for Policy and Design

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ABSTRACT

Background: Consumer-centered health information systems that address problems related to fragmented health records and disengaged and disempowered patients are needed, as are information systems that support public health monitoring and research. Personally controlled health records (PCHRs) represent one response to these needs. PCHRs are a special class of personal health records (PHRs) distinguished by the extent to which users control record access and contents. Recently launched PCHR platforms include Google Health, Microsoft's HealthVault, and the Dossia platform, based on Indivo.

Objective: To understand the acceptability, early impacts, policy, and design requirements of PCHRs in a community-based setting.

Methods: Observational and narrative data relating to acceptability, adoption, and use of a personally controlled health record were collected and analyzed within a formative evaluation of a PCHR demonstration. Subjects were affiliates of a managed care organization run by an urban university in the northeastern United States. Data were collected using focus groups, semi-structured individual interviews, and content review of email communications. Subjects included: n = 20 administrators, clinicians, and institutional stakeholders who participated in pre-deployment group or individual interviews; n = 52 community members who participated in usability testing and/or pre-deployment piloting; and n = 250 subjects who participated in the full demonstration of which n = 81 initiated email communications to troubleshoot problems or provide feedback. All data were formatted as narrative text and coded thematically by two independent analysts using a shared rubric of a priori defined major codes. Sub-themes were identified by analysts using an iterative inductive process. Themes were reviewed within and across research activities (ie, focus group, usability testing, email content review) and triangulated to identify patterns.

Results: Low levels of familiarity with PCHRs were found as were high expectations for capabilities of nascent systems. Perceived value for PCHRs was highest around abilities to co-locate, view, update,

and share health information with providers. Expectations were lowest for opportunities to participate in research. Early adopters perceived that PCHR benefits outweighed perceived risks, including those related to inadvertent or intentional information disclosure. Barriers and facilitators at *institutional, interpersonal, and individual* levels were identified. Endorsement of a dynamic platform model PCHR was evidenced by preferences for embedded searching, linking, and messaging capabilities in PCHRs; by high expectations for within-system tailored communications; and by expectation of linkages between self-report and clinical data.

Conclusions: Low levels of awareness/preparedness and high expectations for PCHRs exist as a potentially problematic pairing. Educational and technical assistance for lay users and providers are critical to meet challenges related to: access to PCHRs, especially among older cohorts; workflow demands and resistance to change among providers; inadequate health and technology literacy; clarification of boundaries and responsibility for ensuring accuracy and integrity of health information across distributed data systems; and understanding confidentiality and privacy risks. Continued demonstration and evaluation of PCHRs is essential to advancing their use.

(JMedInternetRes2009;11(2):e14)

doi:10.2196/jmir.1187

KEYWORDS

Medicalrecords;medicalrecordssystem,computerized;personallycontrolledhealthrecords (PCHR);personalhealthrecords;electronichealth record;humanfactors;researchdesign; user-centereddesign;publichealthinformatics

Full paper is here:

<http://www.jmir.org/2009/2/e14/>

My initial response (associated with the announcement of the plan) is found here:

<http://aushealthit.blogspot.com/2009/04/important-e-health-release-from.html>

With the advantage of a few days of thinking and reading around this topic I can only say that, while I am entirely happy with what I said last week I now believe I was not sufficiently condemnatory of the vast number of weaknesses contained in this proposal.

My purpose here is not to say we should in any way slow or constrain the overall development of e-Health in Australia but that we should be doing it in a balanced, co-ordinated, consultative way.

It is simply absurd to propose a national deployment of Personal Health Records without addressing a range of other critical issues.

These critical issues in the e-Health domain include governance, funding, leadership, communication, professional and provider education and consumer involvement. I believe the necessary balance was properly and consultatively achieved in the National E-Health Strategy which was developed last year and which I am deeply concerned may not receive the attention and funding it is due because of the release of this new document.

The NHHRC needs to absorb two key pieces of information it seems to be ignoring.

First it needs to recognise there is no established benefits case for PHRs (they are essentially too new for the work to have been done) so investment in this area is speculative and not evidence based at present. (see paper cited above)

Second it must be clear that when it has been talking of EHRs it has been – to date – talking of provider maintained and used EHRs – for which there is a much longer history of use and an overwhelming benefits case – including work done by organisations as diverse as the RAND Corporation and NEHTA.

No-one, just no one, has asked to public if they want their own personal health record to which their health professionals will be financially compelled to contribute. This is a nonsense of a just staggering magnitude.

The new NHHRC document is essentially a semantic and definitional con job as it takes evidence of value and success from 'real' electronic health records and just assumes the same can be said about PHRs. This is just not true!

Balance and leadership is critical here and what I am seeing are a range of vested interests subverting what should be a quite simple staged strategic implementation.

The drivers are the Commonwealth wanting to minimise expenditure on e-Health but needing to be seen to doing something, NEHTA recognising the real Shared EHRs are complex and slow to implement and fundamentally require quality provider systems in which they have essentially no expertise and various health software providers seeing PHRs as something they have already done and can easily bring to our market at a very good profit. The NHHRC also does not seem to have the depth of understanding in e-Health that can really help it optimise overall health sector outcomes through the use of e-Health. If it had this expertise e-Health would not have been left to being an afterthought.

It is also important to recognise that with Internet access being nowhere near universal there is significant policy discrimination against the poor, the older and the IT illiterate who will miss out on access to PHRs.

Overall the NHHRC has two reasonable ways forward.

The first is to make it clear that the present paper is adjunctive to the already developed National E-Health Strategy and formally recommend that this strategy be funded and implemented.

The second is to develop a new balanced National E-Health Strategy and insist it be funded and implemented.

Given the NHHRC does not have the time to do the latter the first is the only way forward. I see any other outcome as deeply flawed.

In passing the NHHRC has to recognise that the medical profession is presently being battered by all sorts of regulatory changes, PIP vagueness and uncertainty, probity reviews, challenges to professional autonomy and a threat to its vital role in the health system.

This shift seems to many of them to be part of a pattern. As a result many are finding the professional practice of medicine dramatically less attractive and fulfilling.

Love or hate them the medical profession is key to any success in e-Health and alienating them will sink any progress before it even starts. This sort of jackboot compulsion to supply information for patient systems at their cost will spark a backlash the like of which I can only imagine - once they realise what is going on.

Lots of issues also remain in this NHHRC proposal such as the data quality and reliability of PHRs. Care should never be based on untrustworthy information and this proposal encourages that deeply flawed approach.


David.

Posted by Dr David More MB, PhD, FACHI at [Monday, May 04, 2009](#)  

3 comments:

Anonymous said...

A few questions: what impact or influence (what unintended consequences) might we encounter if medical records are 'patient controlled'? What of medico-legal issues? Duty of care? The old chestnut of "if it's not in the record it didn't happen"? How will medical misadventures be objectively reviewed, assessed and in some instances compensated? Doesn't shifting the control of the record to the (often underinformed and untrained) patient undermine the completeness, reliability or accuracy of the documentation, which various and numerous clinicians might later rely upon for deciding a treatment regime? Isn't that just plain dangerous? Doesn't the PHR proposal potentially 'shift the blame' to the patient when the medical record is 'wrong'?

[Tuesday, May 05, 2009 5:47:00 AM](#) 

Anonymous said...

Good questions Tuesday, May 05, 2009 5:47:00 AM.

One could go on and on - so many important questions need to be asked before government rushes blindly ahead on the basis of the NHHRC Supplementary Paper.

The NHHRC would have done it itself and then the nation would have every great favour if it had resisted the temptation to appear knowledgeable and pontificate on the very complex issues of Health, EHRs, PEHRs and all the issues embodied therein; about which it has little or no experience.

What it should have done is give some definitive leadership. That should not have been a time-consuming or onerous task. Instead it has muddied the waters and confused the already complex agenda still further.

Giving credit where it's due the NHHRC did refer to the "National E-Health Strategy, Summary, December 2008, www.ahmac.gov.au" on 13 occasions. In deed it went so far as to say "we believe that implementation of this particular strategy must be accelerated as a matter of urgency by giving individuals control over their electronic health records in conjunction with strong national leadership and genuine stakeholder engagement."

Then it got itself all tangled up with its discouragement of the consumers' having control of their health records, and in doing so it lost sight of the starting point it decided it was best qualified to 'reposition' the starting point. That, was a fundamental error of judgment which needs to be rectified.

All that had to do, as Dr David Mores rightly says, "is to make it clear that the present paper is a adjunctive to the already developed National E-Health Strategy and formally recommend that this strategy be funded and implemented".

[Tuesday, May 05, 2009 10:38:00 AM](#) 

Anonymous said...

I agree wholeheartedly more with your last comment (10.38am). However, the question remains - will the NHHRC recommend implementation of the National eHealth Strategy or not?

[Tuesday, May 05, 2009 12:02:00 PM](#) 

