



The Royal Australasian
College of Physicians

**RACP submission in relation to a
National Digital Health Strategy
for Australia**

January 2017

1. Introduction

The RACP welcomes the development of a new National Digital Health Strategy for Australia and appreciates the invitation to provide comment on the “Your Health, Your Say” Discussion Paper. We note that this is not itself a draft Strategy, and that this consultation is therefore at a preliminary stage. We look forward to providing input and feedback in relation to a detailed draft Strategy in due course, but acknowledge the methodical and orderly approach being taken at this time.

The development of the new co-developed strategy is an opportunity to look forward, capitalise on technological advances, and contribute to building and shaping a health system capable of effectively and efficiently delivering Australia’s current and future health needs. It offers an opportunity to engage meaningfully with patients, consumers, carers, clinicians, researchers, information managers, technology specialists, health informaticians, vendors and the many other relevant stakeholders to ensure we develop and successfully implement digital tools, technologies, resources and systems that are fit for purpose for all, and that focus on improving patient care. We strongly urge the Agency to engage meaningfully with physicians to fully understand and be able to deliver on their specific needs and to engage their clinical leadership within and beyond clinical settings which, as evidence shows, is a vital aspect to the successful implementation of future digital advances.

The strategy must ensure the substantial benefits that can be gained from digital technology are realized and avoid inadvertently creating new problems. Previous strategies have not clearly articulated a vision of how digital health will drive high quality patient care. Digitising health is a means to an end, not the end itself. The quality, safety, and efficiency of healthcare must be the aim, and the Strategy should articulate how the Agency aims to utilise digital health to achieve this. Moreover, the Strategy must enable and promote the service delivery reforms that are underway, such as the upcoming Health Care Homes trials, the move to patient-centred, better integrated models of care, and reducing low-value care.

There has been considerable change since the 2008 National eHealth strategy, and considerably more evidence is available on what works and what doesn’t in developing and delivering a digital health system. It would be useful for the Agency to specify how this evidence is informing the approach being taken.

Furthermore, the key feedback and findings from previous reviews of the approach to eHealth to date must be taken on board. The RACP believes that digital health will continue to struggle to gain widespread uptake and use until these issues are adequately addressed. The strategy must acknowledge the failure of past approaches to engage with and seriously consult clinician stakeholders, including medical specialists, and set out a plan for ongoing mutually beneficial consultation. This need was identified by the 2014 Review of the Personally Controlled Electronic Health Record chaired by Richard Royle (the Royle Review). That Review includes valuable reflections and recommendations on what is needed to ensure a more effective and accelerated uptake of eHealth in Australia. The co-developed Strategy must include clinical leadership and must address adoption and change, clinical workflow, and emerging technologies.

2. A Digital Health System to drive high-quality, patient-centred care

2.1 21st Century patient-centred Australian Health System

The co-development approach being taken by the Agency is an opportunity to look forward and contribute to shaping and building a health system to deliver on Australia's changing healthcare needs. This means we need to look at the challenges in our current system and the reforms needed to deliver an effective and efficient healthcare system. These reforms include the health system being more patient-centred, integrated, and outcomes-focused.

The strategy must involve much more than simply digitising the paperwork involved in our current transactional, provider-centric, and fragmented health system. For example, the previous draft Strategy referred to 'specialist letters'; which, although necessary, seems to imply the limited perspective of digitising our current transactional paper-based system. Additionally, although there was reference to shared care plans, again this seems to be in the context of the plan as a record rather than the context of ongoing use of the plan (including amendment, in consultation with other practitioners and the patient). There is little indication that much thought has been given to the concept of shared care as an aspect of a fluid, virtual, multidisciplinary healthcare team and how digital health could support this being seamlessly 'wrapped around' and available to the patient.

The future strategy must encompass integrated care pilots, reforms such as hospitals without walls, Health Care Home trials, multidisciplinary teams, just-in-time care, and personalised medicine. Moreover, all new elements of a Digital Health strategy must incorporate measurement of outcomes and sophisticated analysis of effectiveness, safety and cost-effectiveness.

The strategy must also incorporate the potential for and value of digital health to drive the collection and use of real time data on clinically meaningful outcomes. The ability to have more rapid and comprehensive evaluation of practices and outcomes – both for individuals and populations, and whether the outcomes are positive or not – can lead to a range of opportunities for early intervention and improvement. This could revolutionise our approach to continuing quality improvement.

The ability to connect digitised health and clinical data is fundamental to clinical, translational and health systems research. For example, an effective digital strategy would generate and support usage of clinically meaningful data on the safety of medicines, including for particular populations such as paediatrics (and in pregnancy) where such data is often lacking. It would also improve our ability to implement effective preventive strategies to address risk factors impacting on morbidity and mortality.

More broadly, a forward-looking digital health strategy needs to encompass scope for innovation and re-conceptualising health care in a truly digital age for a digital-savvy population, so advantages offered by new technology can be harnessed productively, cost-effectively, and in a way that maximizes clinician productivity.

2.2 Clinical leadership

Clinical leadership is a well-documented determinant of successful eHealth initiatives [3-6]. It reduces the risks of developing a strategy that is not widely adopted by clinicians [7]. Even though the lack of clinical engagement is a commonly cited reason for failure [8], strong and consistent clinical advocacy is often absent in the forums where key strategic decisions are made [7]. Reviews show that non-clinicians have little chance of effecting change in clinical practice [9]. Despite this, previous e-Health strategies have not engaged with a sufficiently diverse range of practising clinicians to enable this clinical leadership to develop and have impact. This is a significant issue and a significant risk, and must be urgently addressed.

The Royle report [2] highlighted the significance of and need for clinical leadership:

“Care providers are considered the key to meaningful use and will provide leadership in the adoption of eHealth care practices” (p. 8)

Unless there is a critical mass of clinical leaders, involved in the change process from developing the initial strategy to the final implementation and advocacy, the desired outcomes are unlikely to eventuate [10]. This is made harder, but also even more important, when false starts and confidence-denting policy changes have preceded the current iteration of national policy.

We have been heartened by recent willingness from ADHA to engage with the College, and we await the formation of the five Advisory Committees required by the Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016. The makeup of these committees will be a signpost to the nation’s physicians about the seriousness with which the Agency takes their concerns.

2.3 Collaboration and Consultation

Clinical engagement is also well-documented as pivotal in bringing about change in health care, including driving successful eHealth initiatives [3]. Evidence indicates that it is important to ensure that the necessary specific functionalities associated with delivering care to certain patient populations, such as children, are included. This means that the wide variety of clinical specialties must be considered and consulted [11]. The Royle Report also reiterates that the “engagement, effective consultation and *buy in* from a number of stakeholder groups is important” (p. 14; our emphasis).

This engagement cannot be added in later; buy-in necessarily involves appropriate engagement and involvement from the start of the process. The lack of genuine consultation with medical specialists is a major challenge, and we believe will impede progress and success unless the Agency undertakes efforts to address and overcome it.

It has been widely recognised and acknowledged that the previous eHealth strategy focused on general practice more than other medical professions. This narrow view was highlighted as a key concern in a number of submissions made to the Royle Review and acknowledged in its report as a major factor contributing to the low uptake and use of electronic health

records and electronic communications, especially in the private sector. We foresee this continuing, unless a fundamentally different and more effective approach is taken.

Design aspects and incentives that may work for general practice may not work for physicians, especially physicians who may work in and out of hospitals and have multiple practice locations requiring technological and software capital investments, only some of which are theirs to control. Broader policy design should be cognizant of this distinction. Medical specialists have some needs in common with general practice, but many needs unique to their specialty—and, unlike general practice, the diversity of specialties means that policy settings must be finely tailored across the medical landscape.

We remain concerned that the approach being taken by ADHA on consultation and representation continues to be insufficient and inadequate. For example, the recent request to supply physicians to be interviewed about pathology and diagnostic imaging reports provided less than a week to reach out to our members for their input. Especially coming as it did in early January, when many people are still on leave, this is not a feasible or useful timeframe in which to be able to communicate with our large and diverse membership.

We do not believe ADHA will obtain the best advice and input from clinical leaders unless the RACP is given more than a handful of days to connect with its members to promote surveys, select and nominate members to advisory committees, and conduct internal consultation on submissions. Setting extremely short deadlines belies an apparent willingness to be satisfied by sub-optimal outcomes. The desire for swift progress is commendable and shared, but a lack of real engagement will continue to stymie and impede this unless it is improved. Engagement will be effective only when it is realistic, sustainable, and genuinely consultative.

Clinician engagement by the Agency cannot be a tick-the-box effort. It must be focused on securing engagement with and input from the right people, with the right expertise and experience. It must also respect the RACP's consultation processes. We have very well established and effective mechanisms to engage with our members, who span a greater diversity of medical specialties than any other college. This ensures an open, transparent, and inclusive process that supports us in being able to access significant and wide-ranging expertise. This must not be compromised or bypassed.

2.4 Fit with clinical workflow

The usability or usefulness of information and communications technology (ICT) in health is significantly affected by how well it supports the clinical workflow. If the use of a system or tool impedes the provision of care to patients, or adversely impacts clinicians' work – including by additional time needed to complete 'on-screen forms' – even though there may be some clinical benefit, whether immediately or further down the line, it will likely not be taken up. There must be a recognition that digital health offers an ability to streamline or change the current workflow to fit better with new ways of delivering care. Merely adding a digital health element to current work, or force-fitting digital health to a process or workflow that was well-suited to a paper-based system, is unlikely to be successful.

We note the Royle report's acknowledgement of this:

"This [low] level of utilisation is most likely the consequence of the issues raised by stakeholders around the usability and clinical value of the PCEHR" (p. 6)

"The usability improvements to be designed to complement everyday workflows" (p. 17)

Systems need to "fit in to and streamline current workflow" (p. 34)

"There is a need for early engagement with the private specialists and private hospitals to support and integrate with their existing workflows" (p. 35)

Without adequate clinical engagement and collaboration with medical specialists we are concerned that the central understanding of clinical workflow will be limited and that this will continue to impede uptake.

2.5 Looking to the future

E-health is more than digitising health records, and more than efficient and secure communication between health practitioners. It offers the potential for data analysis to benefit individual patients and public health, as well as the evidence-based crafting of a health care system to meet Australia's future needs.

Although future technologies cannot be perfectly anticipated, there are a number that are already affecting care provision and patient outcomes. For example, biologic medicines are an increasing proportion of new drugs coming to market. As yet we have limited data on the impacts of many aspects of their use, for example, the impact of switching between these agents. If considered now, this strategy could play an important role in driving substantial and much needed improvements to Australia's pharmacovigilance systems, to support the safe and effective use of these medicines in the future. This would include the collection of the actual brand of medication dispensed each month, which involves and affects community and hospital pharmacists. Australia has the opportunity to be a world leader with data collection on this important and growing area, but only if the digital infrastructure, governance, incentives, and ethics are properly aligned, and if all parties (including prescribers, GPs, pharmacists, and patients) are appropriately engaged with the process.

Previous digital health strategies have focussed on consumer input to their health record, in addition to the traditional view of what a clinician might record about a person's health. However the already widespread and increasing use of digital technologies by consumers and patients offers opportunities to collect information on a much broader perspective of consumer health information. There needs to be greater consideration of what this information might be, including patients' views, adherence, behaviours, preferences, desires and choices. This data is already starting to be captured and collated, but often not by groups who are usually considered to be health stakeholders, for example Qantas [14]. Although the draft Strategy does mention appropriate data privacy and access, this explosion in the collection of health-related data by other stakeholders emphasises the need for consumers to be able to have oversight and control of who can see, update and use their information. There must be well-considered, robust and transparent processes in place.

There is the opportunity to consider, not only consumer engagement with but well-informed and supported consumer “ownership” of their health data and of choices that affect their health and their healthcare. This is vital throughout the lifecycle of patient care, from effective preventive strategies to good end-of-life care. Previous strategies have not adequately outlined an approach to these trends. Nor have they engaged meaningfully with privacy concerns, privacy legislation, or the Commonwealth and state law reform required to deal with the real-world impact of digital health technology.

Conclusion

The RACP is strongly supportive of the need for a National Digital Health Strategy, and is committed to contributing to its effective development and implementation. However we believe this must be done with a new approach that is broader in its thinking and its engagement, and which takes seriously the needs of specialists, their varied roles and workplaces, and their patients.

The aim of the strategy must be to drive high-quality, high-value care, and Australia must learn from the evidence on how best to ensure digital health can achieve this. Fundamental to that is the evidence that clinical leadership, clinical engagement and clinical workflow are paramount prerequisites for a successful system.

More must be done to drive, promote and support patient-centred care and to support consumers being able to effectively ‘own’ their health information and be actively involved in decisions affecting their health and their health care. We would also like to see the co-production of the strategy take more account of health reform developments, and actively focus on how digital health can drive these much-needed reforms.

Finally, the forthcoming strategy must be considered within the broader social and political context. “Digital health” per se is neither a policy goal nor an accomplishment. It is similarly not a policy response to improving the management of chronic disease. Any technological approach to improving the health of the nation must be seen as a part of a bigger strategy encompassing all areas of policy. This notwithstanding, a truly national digital health strategy must address the inequitable status quo, not just in health but in the access to technology, including affordable and reliable high-speed broadband.

The RACP looks forward to productive and mutually beneficial engagement and involvement with the Australian Digital Health Agency, and to contributing to a wider, more inclusive and effective approach so that Australia can benefit from the substantial improvements and opportunities on offer.

Suggestions and observations from members of the College's E-health Reference Group and affiliated Specialty Societies (anonymised and edited for clarity)

- Relying on faxes and handwritten letters, and the manual entry of clinical information and prescriptions into medical records, is error prone. It compromises patient safety and is inefficient.
- We need real-time digitised patient records and related databases with fluidity/transferability of data across local health networks/states.
- We need digital communications with data linkage for priority access to drugs, treatments and devices through regulatory agencies.
- We need one system that we can all use, 24/7. A virtual platform that we can all access is the key.
- Beyond health records, we need an integrated system that has accurate and direct way to communicate with healthcare professionals across all sectors and locations, and with options depending upon priority/urgency of the matter (e.g. email, messaging and calls).
- Barriers include time, funding and the absence of a good, simple to use system that is nationally accepted by all health providers. There are already many competing software packages that may work for one specialty but not for all.
- Lack of a clear vision of how a “Digital Health” future might actually look is another barrier. Much of this endeavour appears nebulous to the ‘coalface’ clinician who ought to be engaged but does not see him/herself as an ‘innovator’. For example, what does it actually mean when it is claimed that ‘digital innovation’ will ‘give people more access and control of their health and care’? Are there examples where this is true? Is there evidence that this improves outcomes?
- Immediate priorities don’t necessarily imply (just) immediate benefits. We should not trade off short term apparent benefits for long term pain. It is still vitally important to get clinicians onside. This will involve establishing trustworthy systems that address their short- and long-term needs with clear education about why the long-term picture is more important, and how things will credibly be fixed over that time frame.
- To be trustworthy, a system must be secure and resilient in the face of attacks. This is manifestly not the case with any current system. (An easy measure of this is to ask someone who assures you of the robustness of their system what payment they are prepared to guarantee per intrusion or DDOS-related outage). Security in particular is a fundamental design property that cannot be “engineered on” afterwards.

- Systems must be maintainable for at least the lifespan of a patient. This is difficult to assure unless the entire source code of the system is freely available for viewing, criticism and appropriate modification, something that is generally not the case with most commercial systems.
- A real-time E-health record would assist with assessing:
 - the duplication/overuse of investigation/medication
 - real time prescribing
 - doctor shopping
 - substitution at the pharmacy level
 - allied health professional referral uptake and benefits
 - outcomes of interventions such as pharmacy reviews/exercise regimes.
- We should be utilising coded health information wherever possible to improve coordination and safety across health care settings. Proprietary EHR providers have already harmonised some data definitions as part of the Australian Primary Care Collaboratives Program to ensure that definitions in these different programs mean the same thing. As a practical example, when a specialist RACP physician makes an expert assessment and review of a patient's medication during hospital admission, it would be ideal if the patient's primary care providers receive the new medications and ICD-10 discharge codes electronically for import into their records (with provider approval, akin to electronically reviewing pathology results).

REFERENCES

1. Deloitte National E-Health and Information Principal Committee. National E-Health Strategy. Canberra: Department of Health and Ageing, 2008 (accessed 17 January 2017) <http://www.health.gov.au/internet/main/publishing.nsf/Content/National+Ehealth+Strategy>
2. Royle, R, Hambleton, S & Walduck, a 2013, Review of the Personally Controlled Electronic Health Record, review panel report to the Australian Government Minister for Health, publicly released 19 May 2014 (accessed 17 January 2017) <http://health.gov.au/internet/main/publishing.nsf/Content/ehealth-record>
3. eHealth competency framework: defining the role of the expert clinician, Academy of Medical Royal Colleges and the Scottish Government, June 2011
4. Diamond, E., French, K., Gronkiewicz, C., Borkgren, M. 2010, 'Electronic Medical Records: A Practitioner's Perspective on Evaluation and Implementation'. Chest, 2010 Sep;138(3):716-23
5. Boonstra, A., Broekhuis, M. 2010, 'Barriers to the acceptance of electronic medical records by physicians from systematic review to taxonomy and interventions.' BMC Health Services Research, 2010 Aug 6;10:231

6. Yackanicz, L., Kerr, R., Levick, D. 2010, 'Physician buy-in for EMRs.' Journal of Healthcare Information Management, 2010 Spring;24(2):41-4
7. Kos, Simon, and James Kavanagh. "Clinical Leadership." The Role of Clinicians in Ehealth Reform, Microsoft, Redmond, WA (2011).
8. Coiera, E.W. 2007, 'Lessons from the NHS National Programme for IT', Medical Journal of Australia 2007; 186 (1): 3-4
9. Garling, P. 2008, 'Final Report of the Special Commission of Enquiry. Acute Care Services in NSW Public Hospitals.'
10. Halligan, A, 2010. Quoted by eHeathInsider in 'Ex CfH lead says NPfIT has no engagement' on 29/4/10 at <http://www.digitalhealth.net/news/25790/ex-cfh-lead-says-npfit-has-no-engagement> (accessed 17 January 2017)
11. Dufendach, Kevin R., Jacob A. Eichenberger, Melissa L. McPheeters, Michael W. Temple, Haresh L. Bhatia, Mhd Wael Alrifai, Shannon A. Potter, Stuart T. Weinberg, Kevin B. Johnson, and Christoph U. Lehmann. "Core Functionality in Pediatric Electronic Health Records." (2015).
12. Public Governance, Performance and Accountability (Establishing the Australian Digital Health Agency) Rule 2016 (accessed 17 January 2017) <https://www.legislation.gov.au/Details/F2016L00070>
13. Minister for Health Sussan Ley. Developing a 21st century electronic health record system. Department of Health. 9 October 2015 (accessed 17 January 2017) <https://www.health.gov.au/internet/ministers/publishing.nsf/Content/health-mediareel-yr2015-ley122.htm>
14. Qantas. QANTAS and NIB to create a more rewarding health insurance experience <http://www.qantasnewsroom.com.au/media-releases/qantas-and-nib-to-create-a-more-rewarding-health-insurance-experience> (accessed 17 January 2016).