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Janet: It's my very great pleasure to introduce Dr Norman Swan. Norman did his medical training in Scotland and paediatrics in London and Sydney and is known to many of you through his hosting of *Radio National's Health Report*.

He is also well known to both Commonwealth and state departments in his involvement in a number of the things that we do. In particular he has over many years been helping develop government plans around information and communication and the systems and the technologies that go with that.

In fact, Norman chaired the committee that created NEHTA that we were hearing about this morning. So Norman is very qualified and appropriate to chair the last session which is a panel discussion and really captures the essence of what we've been talking about all day.

So I'll pass over to Dr Norman Swan.

[Applause]

Norman Swan: Thanks Janet. I'll talk from down here. I'd just like to preface the panel session with a few remarks and then we'll go on. But let me just - rather than have them sitting there in front of you ... let me just introduce the panel to you.

This is Peter Ruzyla. Peter is the CEO of Eastern Access Community Health. [Inaudible – off mike]

Next to Peter is Chris Pearce. Chris Pearce is the Chair of Information Management and IT Committee at the Australian General Practice Network. It is now known as Australian Practice Network but it used to be called the Australian Divisions of General Practice, the national organisation and the state based organisations for general practitioners.

Next to Chris is Lisa McGlynn who has worked in jurisdictional health so she's not a pointy-head from Canberra although – and hastens to tell everybody she's not a career bureaucratic; she's

interested in service which is a radical move for the Commonwealth but we welcome it.

[Laughing]

Lisa is Assistant Secretary of eHealth Branch in the Commonwealth in Primary Health & Ageing of the Australian Government and although it has moved several times in recent times it is very much within primary health care now, that area which is interesting and certainly in sync with what's going on particularly say in Victoria.

Next to Lisa is Andrew Howard. Andrew is the Chief Information Officer of the Office of the Secretary in the Department of Human Services and he is wearing his bullet proof vest for this next session.

Next to Andrew is Guy Walter. Guy Walter is Acting Manager of Aged & Disability Services in Moonee Valley City Council and that front end in the health care system is something that we often neglect when we're talking about it. Not just when we're talking about primary health care but on many different aspects.

Next to Guy is Sue Healy who is representing consumers on this panel and has been nominated by the Health Issues Centre.

Last but not least is Sylvia Barry who is Manager of Primary Health Integration in the Department of Human Services here in Victoria. Please welcome our panel.

[Applause]

It has been a fairly tight schedule for you today with lots of talking and probably not enough time for you to actually express your opinions. I hope to leave some time today during this panel discussion for comments you want to make and if during the discussion we're talking about something that you want to actually talk about, just come up to one of the microphones and I'll take your comments.

So don't feel that this is a highly structured panel and wait for me to bring you in. If you've got something to say, particularly around

the topic that we're talking about at that time, just come up to one of the microphones and I'll take your comment.

Who am I to say where – one of the things I've been asked to just give a few remarks on is the health care system in say 2015 and your guess is as good as mine in terms of where we're going to be. I think though that there's – health care systems move slowly and if you think there is going to be a radical change in health care in the next five to 10 years you're going to be sorely disappointed. There won't be.

Health moves incrementally; it's essentially a conservative system and that actually is probably in the end quite a good thing so that we don't necessarily rush into things. However with the number of pilot projects that we've got on a national basis which seem to just come to an end and nothing happens it would be nice to see some things moving faster.

However, I don't think my view would be that by 2015 you're going to see much different structurally in Australian health care. I still think, quite honestly, you're going to have a Commonwealth/state division of responsibilities and you can sort of pipe on about how ridiculous it is and how silly and what a barrier it is; well I think you're just going to have to get over it and get on with it because it's not going to change.

I cannot see a Commonwealth Minister – an Australian Minister for Health ever wanting to get up in the morning and being responsible for waiting lists. Cannot see what's in it for a Minister for Health who currently doesn't have to look after waiting lists to have to look after waiting lists. Don't need it, don't want it, won't happen.

But what will happen is more cooperation and you're already seeing that at the Council of Australian Governments. You're also seeing it at the level of the Australian Health Ministers' Advisory Committee.

Less game playing, not no game playing. The game playing increases every few years as the states and the Commonwealth

negotiate our health care agreements but there is less game playing around and there is a more common view about where things should be going.

Interestingly whilst – it is interesting that health is not really a major battleground in the current election cycle whereas in past election cycles it has been. It has been a while really since it has been a major battlefield. So whilst there is not obvious bipartisan support in terms of common health policies it's not too different.

I think the best way to think about the health care system in the future is what might be the goals that we set ourselves for the future? I think that if you go around to Western Australia, South Australia, the Territories and so on the goals are pretty much similar.

I've been working with Lisa at a Commonwealth level just looking at where eHealth might go at a national level and I put out to people just what might be a reasonable set of goals and people have largely bought into them.

One is that we continuously improve and develop primary prevention. It has to be the cornerstone of the health care system that we try and prevent problems developing in the first place and of course that is all avoidable conditions. But we continuously improve secondary prevention so when somebody's already got a problem we try and stop it getting worse or at least try and stop them bouncing back.

We try and make it as – and that's probably with a focus more on mental illness, on coronary heart disease, stroke, diabetes and cancer and that in those areas which we commonly now refer to as chronic disease, these are problems which people – these are diagnoses that people will have for the rest of their lives. There's going to be more than one of them and really the cornerstone there is the health care system cannot do it or impose it.

That people actually, to the extent to which they are able and willing, very important qualifications, be involved in the

management of their own care. In other words looking after themselves.

But this is an area that is fraught with possibilities of victim blaming. You're not looking after yourself so you can get stuffed. Or asking people to do things where they simply do not have the social capital in the communities around them to do it and I'm not just talking about Aboriginal and Torres Strait Islander communities. We're talking about outer metropolitan suburbs where infrastructure is lacking. So there is a limit to self-management but it is a very important principle.

Of course we have a national chronic disease strategy which all states and territories have signed up to so we should never again be in a position where we start from scratch and wonder how we do it. It's there; it's for implementation. Of course that is the missing gap here in everything. We've got fine strategies but how do we implement? And this is what this session is about.

Our third goal is that most of us want to care for people in the community and in their homes as much as possible. A lot of the discussion in the last session was shifting care from acute settings to the community setting and how do you do that and moving forward at a key goal.

Safe best practice care whether it be in the hospital or in the community. So high standards of safety and quality and of course whilst it hard and high risk in the acute hospital setting, almost certainly if you're going by any basic epidemiological principles, most injuries in health care today will be occurring in general practice and community health care because that is where most care occurs.

So more people are almost certainly dying as a result of the things that GPs, community nurses and others do in the community or don't do than what happens in an acute hospital. That's where we focus on but the missing gap is what happens in the community. It is not necessarily safe care and the few surveys that there have been of that is there is quite a lot of dangerous stuff going on.

The fifth goal might be – is of course affordable and accessible health care. We believe – it goes under the assumption that Australia is a fair country to live in and that this affordable, accessible care is to a standard that might be reasonably expected of a social democracy like Australia. I think regardless of which party you might vote for in the next election we mostly all subscribe to that.

We don't want a system which wastes which and is inefficient so we don't want and we certainly want a focus on target populations which have the highest need and that can vary. Of course there's a kicker in there which is, again going on the principle that on basic public health principles, if you target high risk populations you will miss people where the most problems occur.

So in other words, if you are trying to prevent coronary heart disease and you only target people with high cholesterols and high blood pressure, you will actually miss the vast majority of people who are going to get a heart attack or a stroke. So you've got to be careful with high risk strategies.

So the challenge in the future will be – the tendency will be to save money and make yourself look more efficient by looking for the high risk populations who are easier to identify but you will actually only have a small public health impact on the conditions you're looking at because you're not affecting the whole population.

Because most people who will have a heart attack have almost normal cholesterols, almost normal blood pressures and very low levels of risk factors. It's when you add them all up that it is a problem and that is the other key that we all need tools to address absolute risk.

Almost everybody in this room thinks about relative risk. Lower your cholesterol, go for a walk, eat better, you'll reduce your coronary heart disease risk – your risk of a heart attack by 30 per cent. Completely meaningless figure; 30 per cent of what?

For most people in this room the chances of a heart attack, unless the Minister calls you for something you've done wrong in the next

year, is pretty small and reducing it by 30 per cent is a fairly meaningless figure. Because what is your absolute risk yourself? Having those tools available so you can truly assess target risk is going to be a key issue.

So those are the kind of goals and how do we get there? People I think on the panel here are actually working in that sort of framework already. I think you are too.

So let's move onto the final thing that I think that everybody talks about, that you all talk about on a day by day basis and its there in the manual that was launched this morning by the secretary. It is consumer centre care. Patient centre care; what does it mean? Because sometimes it is a great word, but if you were actually to really do it, it would turn your service upside down. Because people talk about it but they don't necessarily do it.

So what I want to do in this panel is to clarify what the health policy settings are that we're looking for that eHealth serves. That we don't put in eHealth for the sake it; that eHealth is to support with those health policy goals.

What does it start to look like and where does eHealth fit in and what do we do to actually get ready for that? What adaptations are actually required at a system level, at a high national level, at a state level and at a local level to actually allow eHealth to help rather than having these huge implementation barriers?

Your several fantastic presentations I've just heard – the one from Peninsula Health which I think is one of the most impressive health services in Victoria on their electronic discharge and there are other presentations that we've heard today too.

I heard a presentation where, shock horror, you're actually reducing the number of data points going into your system and that's an amazing advance forward and I'm being serious - in terms of just the gross picture.

So what does it look like if it's truly consumer focussed and then what do we need to change in terms of how we do things so that when eHealth arrives it actually works and serves our needs?

Sue, you're the consumer.

Sue Healy: I feel I'm in a different tribe.

[Laughing]

Norman Swan: You're in about 14 different tribes here so it's okay.

Sue Healy: That's right, yes. No it's not just one tribe. There are the suits and the non-suits.

I feel that you've used client centred etc, etc and then it sort of skimmed over. For me client centred means I am the person who knows most about my own health. I've sought support, I've sought intervention but I feel that I should be able to say you've got that right on my document but you haven't got that right.

But it talks about informing me and engaging me and then whisking away and referring me without me, in a way, having had much say in it and that doesn't seem to me very consumer centred. I feel I'm sort of – there's a circle and there's me on the outside; incidental but providing you with a nice living.

[Laughing]

Norman Swan: Guy, well is that what you're doing to your consumers and clients?

Guy Walter: Well I would say obviously Sue doesn't live in the City of Moonee Valley.

Sue Healy: Yes I do, yes I do.

[Laughing]

Guy Walter: No I think with HACC Services, with Aged & Disability Services at the City of Moonee Valley, we do empower the consumer - the client to be part of the process. I do understand some of Sue's sentiment in terms of feeling maybe left out...

Norman Swan: Sorry can I just clarify this word empower please?

Guy Walter: Well I think we inform the client or the consumer or whatever you want to label that person in the process and step through the process. Now it may be – it depends how the referral has come through to us in the first place, whether it comes through from the

major hospital within Melbourne or whether it comes through from a neighbour or community health in the local government area.

If it has come from another agency then the consumer should be informed of the process. We've reduced the duplication and we've identified the health needs and we'll arrange an assessment within the home.

So at every stage of that process the consumer is aware and informed of what is going on in that process.

Norman Swan: Guy, if there was no eHealth development from hereon in. There was no electronic development. Something happened and there was just nothing now. What would you do to change your system to provide – to meet the sort of goals we've just been talking about?

Guy Walter: I think – well if there was no further progress then I think my message would be that change is always constant and we would be – it needs to be reflective of the new frameworks that are coming through from a state level and federal level in the active model of care and the national framework around assessment. But if there was no further IT technology I guess that we'd all be affected in that situation and we'd have to again build on the practices, processes and policies that we've already got imbedded.

Norman Swan: But my eyes glaze over when you say words like that.

Guy Walter: [Laughs]

Norman Swan: I get up in the morning, I come to work...

Guy Walter: Yes.

Norman Swan: I work in your service and those are the policy goals. What do I do differently that allows those goals to be set up? I mean this is surely the key question you've got to ask before you start talking about what electronic gismos or software you've got on your desktop.

Sue Healy: We've already done an advance in that GPs no longer have sole copyright over their records. I mean – well they do but we've

moved on from the ownership where the patient has no right of seeing them. That's one step...

Norman Swan: Sorry I thought we hadn't moved on from that. That legally the GP owns the records.

Sue Healy: Still?

Norman Swan: Yes. That's the High Court decision is it not?

Chris Pearce: Correct. The GP owns the record but also mandated by legislation is patients' access to it. It is one of those fine lines.

Norman Swan: Sorry, I interrupted you Sue.

Sue Healy: That's okay. No it just seemed to me it's - the cultural thing is the change. The institutions are moving away from a complete institutional framework. Hospitals aren't quite as hierarchical as they used to be though they're still pretty hierarchical. But that's one of the things that I'm hoping the technology will do, will be to flatten everything so that we no longer have those rigid divisions.

Norman Swan: Peter?

Peter Ruzyla: Well I think one of the other pieces of rhetoric that's around aside from patient centred or more patient empowered care has been the word holistic. I'm - I think these sorts of concepts are really important in guiding and driving policy but I'm a great believer that rhetoric outstrips reality and that we're always playing catch-up.

We have the vision in front of us of a holistic integrated service system which has got the client or the consumer at the centre of it but we are always catching up with what that rhetoric actually means in practice.

My view is that the electronic - the use of eHealth is one of the tools that can actually help us change our practice in the direction of the policy.

Norman Swan: And you believe it can be a change engine itself; that in fact whilst I'm pushing the line that eHealth is the servant of health policy, you actually think that it can drive health policy.

Peter Ruzyla: I mean we do talk about making sure that health service policy and practice is not driven by the electronic capability so that we're sort of bouncing on the end of the gizmos and the toys that are out there. But in fact in discussions that I've been part of, you can see how the ceiling on people's thinking does go up – can be raised by the existence of technologies which actually make certain things possible.

I think some of the safeguards around privacy for example, even in the last couple of years, have enabled the discussion to move ahead to the point where we can say quite securely that look the encryption that is available is actually able to safeguard privacy.

There are ways in which we can make or bring clients to be more at the centre of decision making, give them the capability of controlling what actually moves out of the – you know down the electronic tube so to speak and that the capability of connecting up services just has expanded the horizons I think of health service provisions.

Norman Swan: So just tell me what sort of organisational changes you have been or are putting in place – sort of sharing that sort of organisational story with people in the room which, if you like, are in preparation for that raised ceiling.

Peter Ruzyla: I think the most obvious example from within my own organisation is the fact of being able to integrate services across sectors. I think being – the first challenge has been to integrate services in a – perhaps lets – if you take something like chronic illness management within a health service, you've been able to bring on board the allied health practitioners and GPs and endocrinologists and so on but then being able to move across sectors into child and family services or disability services or youth services and so on.

That's the next big challenge for us I think so we're starting to get good at that concept of linking up and getting seamless service systems within a sector. But there is a big challenge to move across the sectors and I think that is really where the concept of a holistic service starts becoming more real.

Norman Swan: But that's nothing to do with electronic systems is it?

Peter Ruzyla: To a certain extent the electronic system has actually stimulated the debate. It has actually become a bit of a catalyst to the necessity to have that discussion. To have the mental health system talking with the disability system, talking with the primary health care system, talking with the GPs has – it's almost like the electronic stuff is happening out there – eHealth is happening out there in the background.

It now provides managers the capability of driving the discussion and to some extent using it a bit like a Trojan horse.

Norman Swan: Chris?

Chris Pearce: Look it's very simple. I think electronic...

Norman Swan: We're actually here so it would have to be wouldn't it?

[Laughing]

Chris Pearce: Electronic communication and the internet is a classic example, empowers individuals and disempowers organisations. Just ask the record companies and where it – the thing we have at the moment is that we don't want to share – health organisations don't want to share their information.

As soon as they do then a lot of the consumer problems will be solved because they will have access to it. It's very hard to get access to a hospital record now.

Norman Swan: Lisa, at a national level?

Lisa McGlynn: I mean I think we're talking about different definitions of consumers. I think it's very important that people's own health care information is accessible to them and that they inform providers about that but I also think we've got to be quite realistic about who else consumes information.

I think we've got to look at the person themselves. We've got to look at empowering the providers to make better decisions and informing those service deliverers who are putting together services and making plans for how limited dollars are spent and those policymakers.

Because we can't just have the information about one person not being aggregated up into informing how our population health is managed, what the best way to manage our services is and where the best dollars are spent.

I mean I think we've got to acknowledge that we've got to talk to consumers and that they are very much driving how we run information. But we've also got to look at the needs of vendors and others in making sure that they are enabled to make it all happen technologically as well.

Norman Swan: So just on that and in fact this is your territory, I was just listening to the presentation from Peninsula Health on electronic discharges and one of the problems is that whilst the vendors says they're compliant with common standards, they're clearly not.

So what are you going to do at a Commonwealth level because you pay the piper in essence? I mean the money that goes to GPs to pay for those software systems comes from Medicare effectively.

Lisa McGlynn: Well I mean I think...

Chris Pearce: She needs a software accreditation system for general practice.

Lisa McGlynn: Oh do I?

[Laughing]

Chris Pearce: I had to get it in.

Lisa McGlynn: Got it.

Norman Swan: And for \$600 million the Australian General Practice Network will give you one.

[Laughing]

Lisa McGlynn: I mean I think it is really important to look at the roles of governments and look at the role of all levels of government; local government and state and territory government and the Commonwealth Government.

I mean we've got to look at – we certainly see ourselves as having a role in – we're a seat around the table with NEHTA that is

looking at standards and things like that. We're looking at how all those members around the COAG table have said that procurement guidelines must start moving towards standards as they're known and those that are coming online in terms of NEHTA and others.

But there is something called market economy and things and I think it's also about when the professions and when state and territory governments look at their own local solutions and the things that they want to achieve for their health systems and what practices want to put on their desktops and all those sorts of things.

We certainly see ourselves as having a role in looking at what the incentives are and who pays for those things...

Norman Swan: Sorry if I could just interrupt you there.

Lisa McGlynn: Sure.

Norman Swan: Whilst the rhetoric – even you know both sides of politics is about deregulation - we allow the market to look after itself. The reality is when you talk to industry they hate deregulation basically and the reason they hate deregulation is that it is left to them to decide whether they do something or not and it stops it being a level playing field.

Industry actually quite likes regulation because it means they've all got to sing the same song and it does level the playing field. Therefore this deregulation jargon and hype is actually impeding progress.

When in fact if you were to do what Chris has said and actually have an accreditation system – this is the way it's going to be chums, they would actually – they might bitch about it to begin with but they'd actually welcome it in the end because they all have to operate according to the same rules rather than it being grace and good favour.

Lisa McGlynn: I mean I think it is how that accreditation system is determined as well. We must do it with the professions. We must do it with state

and territory governments. But the vendors also and I've said – this will be no surprise...

Norman Swan: But you don't have to do it – sorry to interrupt. But general practice is your purview; it has nothing to do with state...

Lisa McGlynn: General practice is but how we share information with...

Norman Swan: Sure.

Lisa McGlynn: ...state and territory governments, we must all be around the table because what suits general practice, we've heard today, doesn't always suit the rest of the primary care sector and that interface with the acute sector.

But the other thing I think that people who have heard me speak before with the medical software industry and things is they also have to have some internal discussions about where their industry is going and what they are prepared to do as a group.

I think there are some hard conversations to be had at all of those levels and around a collective table. But I think having a tick from someone to say this is the right way forward is certainly something we want to move towards but I don't see it as the sole purview of the Australian Government to do that.

Norman Swan: Sylvia, consumer focus and what organisational changes need to occur at a state level and then the eHealth support behind it?

Sylvia Barry: Well I guess I'd like to open by saying that I think that as a state bureaucrat working in a primary health area it is something of an unenviable task where we're actually trying to strengthen a sector where, in terms of state investment, is relatively marginal in terms of the dollars going in.

I guess one of the major ways of us trying to do achieve that goal is through working in the integration space because we believe that that gives us some leverage around Commonwealth as well as state investment. It's really important I think, and Lisa has alluded to it, that we have limited health dollars and we need to make sure that we get the best buy for the investment going in.

But not for integration's sake do we want to do this work but for the – we know from the demographics that increasingly it is going to be difficult for a person's needs to be met by the one provider. Clearly a mix of providers are going to be increasingly needed if these people are going to be able to be effectively looked after.

So essentially we need to keep that at the centre of our work and part of that dialogue is also around the whole concept of every door being the right door so that consumers don't have to get on this merry-go-round of navigating – because the system as we understand it is pretty much organised I think around what's best for the organisation and we really need to shift that focus around to what's best for the client.

So certainly a lot of that has underpinned our work with the PCP strategy in terms of trying to get public providers and increasingly we certainly do need to think about our engagement of the private sector in this as well. We've been doing, as you know, quite a bit of work in that integration space so – and we need to remember that that's not for its own sake but for the benefit of clients.

Norman Swan: Well just tell me the transformation that you're looking for when it truly does become client or consumer focussed and you're turning around an organisation rather than looking at its own needs even if it believes that its own needs well served will serve the consumer and that's not necessarily an argument to be ignored.

Sylvia Barry: Well I think we heard that a bit from [Robbie Chatlin] this morning when she launched the state-wide manual. That concept that it doesn't matter where you are in terms of a client that accesses the system, all your needs are actually identified early in the process regardless of whether they are delivered by that organisation or by a network of providers.

What that means then is the client's access to other services is facilitated. There is one process where the client needs to tell their story and that is shared electronically if you like through eReferral but it is more the function of the practice in terms of how that information is collected and how those needs are screened.

We're seeing some of that transformation in our service system already.

Norman Swan: Andrew?

Andrew Howard: I'd say people deliver care so part of the exciting message today for me is it's a cultural change around the way care delivery is done and whether that's federal or state operational primary care partnerships it's about bringing that care together for the individual.

I'd actually like to ask Sue a question. Who do you actually trust in the healthcare system? Do you only trust yourself? Where does the trust start and stop?

Sue Healy: Well there were a couple of instances. When I was pregnant with my first child I nearly took Thalidomide which has made me extremely nervous since then of any medication so I don't trust – I recently went to hospital to have my knee stitched up after I fell. It wasn't one of those ordinary falls; it was a fall out in the bush. They wanted to give me antibiotics and I said I don't take antibiotics. Unfortunately it went septic so I had to go back again in disgrace.

[Laughing]

Norman Swan: I'm losing my confidence in you Sue.

[Laughing]

Sue Healy: I'm very hesitant about entrusting myself unless I've questioned them rigorously and found that they're going to keep me alive and it is absolutely necessary to have the treatment.

Andrew Howard: So patient-centric care to you means putting that control and that information in your hands?

Sue Healy: And making sure that what is said about me when I'm referred is accurate. I've got a story about a health services commissioner and they started to work on the wrong leg when she'd broken her leg. So I mean safety and quality requires the person to be involved because they are the one that knows most about their own healthcare.

Andrew Howard: I'm going to disagree slightly there because I think the reason that we have specialists and the reason we have healthcare professionals is because they actually have seen many more cases than many more of those things take place to individuals. To me it is about being able to put the technology or health in place that allows that information to be given to those professionals and to the individual so that they can jointly make decisions about healthcare.

It's about the patient developing trust. I guess one of the lessons that I've seen around here is that trust develops between a patient and somebody and it's not necessarily the doctor. It's...

Norman Swan: But Andrew the statistics are just horrifying in terms of the proportion of people who – I just kind of have on the tip of my tongue the proportion of people who don't get care at the right time and when they do get care it is not evidence based care.

It is still horrifying and if you actually look at those statistics and you actually listen to so-called specialists talk about the evidence, they're not practising evidenced based practice. There's not a good foundation here for actually trusting the system to provide people who actually know what they're talking about.

Peter Ruzyla: Aren't we talking about the whole concept of health care moving away from the concept of a patient in a dialogue of one form, hierarchical or otherwise, with a single provider. We're talking about information flooding that engagement. We're talking about the patient having access to other forms of information. We're also talking about that healthcare provider needing to be connected up with other potential forms of support that the patient might need.

I just think that the environment within which we're thinking about how healthcare is provided now and how it's going to be provided in the future is just a completely new paradigm and I think eHealth is just a part of that.

Even if we didn't have any of this electronic stuff happening to support that process, we would still need to be talking about a new

paradigm of healthcare which is really about partnership based approaches; much broader relationship and transactions occurring.

Norman Swan: Yes.

Sara Duncan: I think my question is around what Peter's just said.

Norman Swan: Would you like to introduce yourself?

Sara Duncan: Sorry, my name is Sara Duncan and I'm from the Victorian Healthcare Association. I think we – when we're talking about patient centred care, for me we're talking about [unclear – off mike] ... whereas at the moment we talk about [unclear] so our funding system is about how many patients go through particularly in primary care.

So how do you change – and ... there for people to represent because that is how the money is made in the healthcare system. So how do you shift to outcomes for clients and getting the best outcome for a client and how can things about accountability around that be supported through eHealth?

Norman Swan: Anyone want to comment?

Lisa McGlynn: If I can pick up on that – I mean I think that picks up on a number of points that have just been made. I think you're absolutely right. If we were more and most interested in people's outcomes then that would be a world that we would all probably feel a lot more comfortable with.

However picking up on the lack of information and data and rigour around something that you could make something like a clinical decision support and things like those around and the paucity of evidence in primary care in particular.

But also then how those processes interrupt what we know might be best practice to the level that we do about the discharge from the acute sector, lack of discharge summaries; all the sorts of things we've talked about today.

I mean they're the worlds that we have to get to and where I see eHealth as being something that I've heard lots of people talk about which is not about electronic but about enabling; enabling

those decisions to be made and enabling that information to be collected and then used to inform better patient outcomes. I hope that's where we're going.

Peter Ruzyla: It's also informing better patient outcomes on a population basis. Not just around that individual transaction but by being able to build up data that can be mined and used to build up the evidence and to work with populations that currently don't present in that clinical transaction.

Norman Swan: Sylvia?

Sylvia Barry: I was just going to say that through the MBS I guess and the extension of the MBS through things like the EPC items etc, I guess the Commonwealth is trying – is looking at evidence based care and starting to include that or have the MBS cover that notion of well if you're seeing someone that has a chronic and complex condition, well the evidence base suggests that you need to do a care plan and they need a range of allied health intervention.

So in some way the extension of the MBS I guess is starting to think about what the evidence base is about what those clinical pathways should be and you could argue...

Norman Swan: But hold on a second. We're flinging around words like evidence based. My understanding from the UK is, where they've actually studied self-management and how they're teaching self-management, it's had no measurable impact on outcomes. That in fact the current thinking in the NHS is they've done their dough.

They've done their dough on self-management. So you throw around your multi-disciplinary care and everything. It makes sense and it's shown in cancer care. Absolutely no question, multi-disciplinary care works. It saves lives. It keeps people living longer. But we – the evidence base – and that's the challenge. Measuring outcomes to know that the investment is going to pay off, is it not Sylvia?

Sylvia Barry: Yes, well what I was going to add I guess – you know we can argue about whether the avid evidence base supports EPC and that's not an argument – you know, it's really for the

Commonwealth to – but no doubt that's part of what their thinking was in terms of – so there is some systematic consideration given to how they can change that nature – that focus of practice being just about throughput so they're moving beyond that.

But what other things and how we might build on that in terms of going forward – I think what's missing is that there's no measure of how effective the care planning for instance that you can attract funding for through EPC items; whether it has worked or not. So that's where it falls down.

Norman Swan: So Chris and then Lisa and then I might come back to Andrew on this as well.

Chris Pearce: No.

Norman Swan: No you didn't want to say anything? Lisa did you want to say something?

Lisa McGlynn: I think there's one word I'll say and that's baseline. We don't have any baseline data to know whether we made any difference in anything. So I would wonder also whether or not, if we do something in isolation like self-managed care or whatever, I guess I would ask the question about was there a need to have a better structure and better framework and a menu of things to happen around that person, not just look at self-managed care? What's the baseline we're working from in the first place?

Norman Swan: Andrew I cut you off earlier.

Andrew Howard: I'm going to make a pure technology observation perhaps from Peter's...

[Inaudible – over speaking]

I guess one of the things that frustrates me as well is that that information does exist. The evidence or data is out there and we just haven't put the technology in place to mine it and put that information in your hands to make better decisions.

So I think, while you commented earlier that health has a slow pace of change and it's incremental and so on, when you look at the private sector and it's pace of change, you know it has no

problem adopting these types of technologies; mining – you know, look at a bank that is trying to put together a marketing campaign.

There is no difference in that to us trying to put together a solution cell around a health care package. So I think the technology is there and the information is there. It's the cultural change here that has to come on board and work together to actually look at that information, focus on outputs, focus on patient care and be fast to react to the doctor that is prescribing Thalidomide incorrectly and action it and make sure it doesn't happen.

Norman Swan: So let me ask you a technology question then in relation to the human interface. Do you want to see professionals - practitioners in the Victorian healthcare system change their behaviour to suit your technology there?

Andrew Howard: A combination of both. If I can mine some data and show that there's a triggering event that when a carer dies we should be actually taking an intervention action at that point, let's do the intervention and prevent the following activities.

Norman Swan: It creates imperatives.

Andrew Howard: Yes that the information is there; let's mine it, let's put it out there and publish it.

Norman Swan: Yes?

John Rochelle: My name is John Rochelle and I'm like you Sue, I don't wear a suit so you're not alone.

One of the things that kind of puzzles me is this notion of what constitutes health. We seem to be measuring it and the effectiveness of health services against business models. We've had throughputs like process machines and things like that in a factory.

When we talk about holistic health we don't talk about quality of life and we don't talk about having criteria; that it is a consumer generated criteria of what that quality of health is and measuring the health services against that.

I think that is when you start getting towards client centred health care and I think the empowerment isn't about being given information. It is about who decides and the consumers need to be involved in that decision. Not being given the information of what we are going to decide for you but jointly making that decision.

So I think in a whole lot of things there are a lot of words that get bandied around but we've missed the point that if health were defined by quality of life against consumer criteria then we'd be looking at something totally different than what we currently are I think.

[Applause]

Norman Swan: Guy you'd be dealing with that sort of negotiation all the time would you not?

Guy Walter: Yes absolutely and I pick up on the point John said; I don't usually wear a suit so I'm out of place up here I guess. Recently at the Moonee Valley Melbourne PCP we undertook a care planning project that identified the key worker in the role of the care plan for the consumer or the client and I guess that was in terms of empowerment for the consumer but also identifying consumer needs in terms of their quality of life as well and being part of that process.

At no point in that process is the consumer excluded. There are case meetings and there is a key worker that will assist the consumer in navigating the pathway of the maze if you like. At times it can be a maze.

I guess the thing to pick up on though with service co-ordination, whether it is technology driven or consumer driven or patient driven; whatever it may be. I think the key point is here in Victoria that we have reduced the duplication of the process. We are now talking a common language between agencies; that previously were seen as competitors in the sector are now working in partnerships in the sector.

I think that in itself has helped us refocus what is important for the consumer. We can build on what Sylvia has mentioned about the

ability to build on partnerships and bring other service providers into the care plan which again focuses on the consumer health.

Norman Swan: But maybe just tell me what that looks like. If you've not got the competitive environment to the extent that you have it, what does that actually look like? What's happening? Have you...

Guy Walter: I think what it looks like Norman is that we can actually share the information that we've gathered.

Norman Swan: So you'll accept another agency's assessment and not repeat it?

Guy Walter: Absolutely and the only thing that we would need is to be part of that process and we do that at Moonee Valley and a framework in terms of Veterans' Home Care for example where we are a service provider for veterans in the community care situation and yet the assessments are done by another agency so we accept that assessment.

We'll accept the assessment from Royal District Nurses, from Melbourne Health etc. Our practitioners would need to go and complete a risk assessment in the home and of course always do a home visit to see the client in their environment as well. So again we get knowledge about what the client's needs are.

Norman Swan: But I still hear – 2007 – I still hear people, particularly when it comes to mental health and where mental interacts, people saying we're just allowed to fall between the tracks. The service tells us what they can do and they just allow us to fall between the tracks, particularly from carers and it's just not working.

That carer co-ordination might look okay from a service point of view but when you're sitting at home with somebody who's either dementing or a son who has got schizophrenia, it doesn't look that way.

Peter Ruzyla: I think that's one of the reasons that I'm particularly passionate about the inter-sectoral application of these connected up systems. I think the mental health system is very good at focussing on the mental health of a particular patient or someone who is identified as experiencing an adverse mental health episode.

What is not done though is the connection to that person's family, some family support being brought in, connection back to their carers, connection to the school nurse where their adolescent son might be attending school and experiencing all sorts of stresses and strains.

I think that capacity to connect up systems that work outside of their vertical silos is one of the really important things that needs to be achieved.

Norman Swan: Chris, I mean aren't the least connected people the general practitioners?

Chris Pearce: From this sort of sectorial discussion, absolutely.

Norman Swan: Isn't that a problem?

Chris Pearce: I think it's a significant problem, otherwise I wouldn't be here. The approach that you would take about this quality of life – the trouble is it needs to be done at an individual patient/carer contact level. It can't be done systemically. It's the sort of – that tried that in Portland in the States. They decided what everyone wanted and voted for it and it really didn't work at that level.

The trouble is that when you get down to that individual level, you need really small caring unit structures and that's where general practice does that. But a lot of this other stuff is done at a much larger level and I think this is where it falls down.

The beauty of the eHealth systems are going to be that there is information available; no who you are and no matter where you go to. So you don't have to repeat a lot of the stuff that – any mental health – I mean I work in an emergency department and someone with a mental health problem comes in and you've got no idea of what's been happening and who they're seeing and what's going on and you can't even get the information from them.

That's where if you've got information – if you've got data that you can use to help the care, you can make those decisions much more effectively at the crucial time you need it which is with the patient there and you can talk about it.

Norman Swan: Lisa?

Lisa McGlynn: I think it's also about breaking down the barriers of how people work together and I think an acknowledgment that we talk very much more now about general practice, not general practitioners and sometimes that gives some of my colleagues like Chris a little bit of anxiety.

Chris Pearce: Nope.

Lisa McGlynn: Some others...

Chris Pearce: Some others; not me specifically.

Lisa McGlynn: But it is about looking at teams and having – acknowledging that other people work with general practitioners and that other people have skills to contribute and work with clients more broadly. I think that also then means that they start to share information and also that we start to address that interfaced with the acute care system again that I talked about.

Norman Swan: But Chris it requires a significant change in behaviour on the part of the GP. I mean you've really got to start pulling back and allowing other people to do the work that you're doing at the moment wouldn't it?

Chris Pearce: But the problem is, I think, the GPs will do it – GPs have always had good networks and referred because they refer to private specialists and physios to whom they can develop a relationship. Even now to refer a patient to a lot of mental health services requires sending a referral off to the intake worker.

You hear nothing back; you can't arrange to know what's happening to that patient at that point in time. The patient hears when the intake worker rings back in three days' time. This is not encouraging for GPs to get involved in this process.

Norman Swan: So is eHealth going to solve that problem?

Chris Pearce: Well eHealth will solve the problem if the eHealth system has built in feedback mechanisms that are quick. If the eHealth process speeds up that process – we saw with Peninsula Health how

discharge summaries get out within 24 hours rather than within three months. That can facilitate the process.

Nobody does anything - and GPs are no different. Nobody does anything unless they can see benefit or value and at the moment a lot of this stuff because institutions deal badly with general practice, GPs don't see any benefit in engaging with them. You're getting caught in a loop.

Sylvia Barry: We heard something about this from Geoff [unclear] earlier today when he talked about delivering something of benefit to GPs and then asking them to do something back. That was a really good change management strategy that he employed in terms of getting GPs to use or to improve the quality of their referral practice.

So I think that's a really instructive thing that if we can do something useful for general practice and certainly we've found that with our work more broadly. If we can deliver something for GPs that GPs value for themselves or their clients then that's how you can in fact engage them in the service system redesign that you might want to pursue.

Chris Pearce: [Claire] presented before about how she worked in the western region. In the beginning you only had to convince seven people; her board and her and then there's a change mechanism centrally driven process. You can't deal with general practice in that way. I mean I can sit there and I'll do it but the GP in the next room, in the same practice, in the same structure will just go I'm not interested. It's just a different way of thinking.

Norman Swan: But Peter, in terms of cultural change we're talking about GPs changing culturally but you're managing people who don't believe in the medical model of disease and therefore they think that GPs are a bit irrelevant don't they?

[Laughing]

Peter Ruzyla: No they don't think that GPs are a bit irrelevant. I think they would like to think that they are all relevant to connected up care provision but can I just say that listening to what's been said about how GPs either react or adopt or don't adopt systems even in the

same practice, you can have exactly the same thing, the same mechanisms actually apply across the health sector.

The housing team can't see the point of why they would need to be talking to the Allied Health team or why they would adopt the same practices as the home based outreach workers in the mental health team. Or why the disability sector would need to have a protocol which allows it to talk to the mental health team.

You know it's not that unique. I find that when I hear about the importance of simplifying processes and protocols, making templates really easy and accessible in order to suit divisions of GPs and GP practices - I think as a manager of a large integrated multi disciplinary health service, it's not that different from me having to sell the same message to our housing workers or our youth workers.

Norman Swan: A final question because we're running out of time and it's for Lisa and for Andrew, is one of the murmurings I heard around the place earlier was, well we're doing all this stuff but when HealthSMART actually gets its act together and comes along to our doorstep or when NEHTA gets its act together and starts implementing stuff, we're going to have to throw out all this money we've spent, throw out all this effort. We know it's doing good stuff because somebody else has imposed another standard.

How real is that risk? Is that perception or is that real? So Andrew from a HealthSMART point of view? You know what's going on at state level, you know what's going on at local level; have you done an assessment – a risk management assessment really of how many people are vulnerable to HealthSMART imposing a standard which a lot of people are going to be non-compliant with.

Andrew Howard: Well I think HealthSMART is well underway and the impacts of that are understood. The broader challenge is around the other things in health that we haven't laid out in a strategy. So its things like mental health, its things like the eReferral exchange that we talked about this afternoon.

Those types of initiatives are you know 12 to 18 months off before we start making significant investments in them. So for the next 12 to 18 months people are investing in those types of initiatives; spending money on them.

They are very important to continue to do. There is not a lot of money being spent in there but what's happening with that expenditure in the health sector is it is driving behavioural change.

We've talked a lot about...

Norman Swan: So you're confident it has not wasted money?

Andrew Howard: The technology here isn't the expensive piece. The expensive piece is the cultural change and change of behaviour and change in process. So you're not going to waste your money on the technology. It's going to be lessons that will make implementation at the latter part easier.

Norman Swan: Lisa?

Lisa McGlynn: I'm an optimist but a realist and I think this is where I imagine in my mind the top down meeting the bottom up. Because NEHTA is all about standards and you know GPs are saying all this stuff is happening with NEHTA; what is it? What have I got to do and how come no-one's talking to me? It's the very unsexy end of things. It's very much about we have to have standards so that systems can connect and so that people can share information. That's on one hand.

But we need to transition to the NEHTA world or the post NEHTA world by saying, people this is what we can do with information. So there has to be a behavioural transition to that world where there are standards and systems can talk to one another and we have to do that – it's a messy way of doing it but we've got to start with local implementations and people solving local problems and then moving towards that world.

Norman Swan: Final question?

Female: A comment really from a client centred perspective from my family and myself. I use a range of practitioners that also include

alternative practitioners and as a client I would like to share my information, not only with my GP but with my alternative practitioners.

Norman Swan: Are we looking at that at a state level Andrew?

Andrew Howard: I think the vision around the eReferral exchange supports that type of view. I mean we haven't talked about the privacy issues yet but part of – or again some of my frustration is we keep hearing issues about privacy and you know - I thank you for your comment because what it says actually is most of us want to share that information with providers so that we don't have to repeat ourselves.

So that they can see the types of care we're getting and we can get that comprehensive view. I think that's certainly, at least at the state level, that's the vision of the way we'd like to see information shared in the context of those individuals that would like to see, not only this section of the practitioner community get to see the information...

Norman Swan: But not everybody wants that and they have to be safeguarded. Some people absolutely do not want the fact that they've got depression known or they've had an HIV infection.

Andrew Howard: Yes and I'd agree with that as well. So we need to have the technology to support those decisions.

Norman Swan: And Sue's point earlier which is you've got to be able to see what's there...

Andrew Howard: And who is seeing it and who's looked at it. Yes.

Peter Ruzyla: I mean the system at the moment is a paper based integrated client record where the podiatrist can see that a person might have a gambling problem. The electronic system allows us to deal with that because the client can determine who has got access to which parts of their file.

Norman Swan: Could you please join us in thanking the panel.

[Applause]

Janet:

What a day. I think we've had a fantastic day today that has been stimulating and the fact that all of you are still here at the end of a very full day is testament to the interest that the sector has about the moving towards eHealth. I appreciate your attendance.

I would also appreciate if you would fill in the evaluation form because that will help us to say where we go to next and I'd like to thank the panel and everybody who has spoken today and Norman for his chairing of that last session because it has opened our eyes right across the board to the things we need to think about.

So safe journey home. Thank you very much.

[Applause]

END OF TRANSCRIPT