



COMMONWEALTH OF AUSTRALIA

# Proof Committee Hansard

## SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

**Reference: Healthcare Identifiers Bill 2010**

WEDNESDAY, 10 MARCH 2010

CANBERRA

**CONDITIONS OF DISTRIBUTION**

This is an uncorrected proof of evidence taken before the committee. It is made available under the condition that it is recognised as such.

BY AUTHORITY OF THE SENATE

**[PROOF COPY]**

THIS TRANSCRIPT HAS BEEN PREPARED BY AN EXTERNAL PROVIDER  
TO EXPEDITE DELIVERY, THIS TRANSCRIPT HAS NOT BEEN SUBEDITED



## **INTERNET**

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

The internet address is:

**<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:

**<http://parlinfo.aph.gov.au>**

**SENATE COMMUNITY AFFAIRS**

**LEGISLATION COMMITTEE**

**Wednesday, 10 March 2010**

**Members:** Senator Moore (*Chair*), Senator Siewert (*Deputy Chair*), Senators Adams, Boyce, Carol Brown and Furner

**Participating members:** Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Coonan, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O'Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

**Senators in attendance:** Senators Adams, Boyce, Carol Byrne, Fierravanti-Wells, Furner, Mason, Moore and Siewert

**Terms of reference for the inquiry:**

To inquire into and report on: Healthcare Identifiers Bill 2010

**WITNESSES**

<b>ANDREATTA, Mr Lou, Acting First Assistant Secretary, Primary and Ambulatory Care Division, Department of Health and Ageing .....</b>	<b>18</b>
<b>BANKS, Ms Robin, Chief Executive Officer, Public Interest Advocacy Centre.....</b>	<b>10</b>
<b>BIRD, Ms Sheila Margaret, General Manager, eBusiness Division, Medicare Australia .....</b>	<b>18</b>
<b>CLARKE, Dr Roger, Chair, Australian Privacy Foundation.....</b>	<b>1</b>
<b>DOWLING, Mr Anton, Business Operations Manager, Healthcare Identifiers Services, Medicare Australia.....</b>	<b>18</b>
<b>FERNANDO, Dr Juanita, Chair, Health Subcommittee, Australian Privacy Foundation .....</b>	<b>1</b>
<b>FLANAGAN, Ms Kerry, Acting Deputy Secretary, Department of Health and Ageing.....</b>	<b>18</b>
<b>FORMAN, Ms Elizabeth, Assistant Secretary, eHealth Strategy Branch, Primary and Ambulatory Care Division, Department of Health and Ageing.....</b>	<b>18</b>
<b>GIBSON, Mr Mark, Manager E-health Services, Health Information Exchange, GPpartners and Brisbane South Division of General Practice.....</b>	<b>29</b>
<b>GREENLEAF, Professor Graham, Private capacity.....</b>	<b>13</b>
<b>McGRATH, Mr Mike, Director, Health Information Regulation Section, eHealth Strategy Branch, Department of Health and Ageing .....</b>	<b>18</b>
<b>SILVESTER, Mr Brett, Deputy Chief Executive Officer, GPpartners and Brisbane South Division of General Practice.....</b>	<b>29</b>
<b>SIMPSON, Ms Lenore, Branch Manager, Healthcare Identifiers Branch, Medicare Australia.....</b>	<b>18</b>
<b>THOMSON, Mr Peter, Branch Manager, Information Management, Medicare Australia .....</b>	<b>18</b>



**Committee met at 3.41 pm****CLARKE, Dr Roger, Chair, Australian Privacy Foundation****FERNANDO, Dr Juanita, Chair, Health Subcommittee, Australian Privacy Foundation**

**CHAIR (Senator Moore)**—Good afternoon everyone. This is the Community Affairs Legislation Committee and we are continuing our inquiry into the Healthcare Identifiers Bill 2010 and the Healthcare Identifiers (Consequential Amendments) Bill 2010. I welcome Dr Roger Clarke and Dr Juanita Fernando of the Australian Privacy Foundation. You both have information on parliamentary privilege and the protection of witnesses. We have your submission; thank you very much. If either or both of you would like to make an opening statement you may do so, after which we will go to questions. This session was scheduled to go to four o'clock but we will see how it goes because we started late.

**Dr Clarke**—The Australian Privacy Foundation, as you are probably aware, is the country's primary public interest organisation focusing on privacy. It was formed in 1987 and works in concert with councils for civil liberties and consumer organisations and it frequently provides evidence to Senate committees. The APF has been particularly vigilant in relation to national identification schemes. The Australian Public Service has persistently encouraged successive governments to implement such schemes. Following a rejection by the public and the parliament of the Australia Card and more recently the access card the healthcare identifier is the linchpin of the current attempt.

The APF published its policy statement on e-health data and health identifiers last year. A copy is with our submission. Our policy statement strongly supports the application of information technology to health care and strongly supports a federated approach to e-health. Our policy statement on the other hand strongly opposes data centralisation and a national identifier. Those are designed to benefit the tertiary purposes of administration, insurance and research, not the primary purpose of health care. The APF's written submission, No. 24, was prepared by Dr Fernando and she will briefly speak to that submission.

**Dr Fernando**—Firstly, the key point of the submission is that the Healthcare Identifiers Bill actually contradicts the APF policy, basically entirely, so we oppose the Healthcare Identifiers Bill and the Healthcare Identifiers (Consequential Amendments) Bill. Secondly, we also want to draw attention to the impossibility of evaluating the utility of the health identifiers scheme for patient privacy and health when basically only a fraction of the proposal is on the table. Even the relevant agencies appear to know very little about how it will work in a real-life context. Finally, we are concerned about the utility of using the HI system for patient care when we know so very little about it. I will give you an example: one of the issues for us is the absence of a coherent and convenient mechanism whereby individuals will know what their own HI is.

**CHAIR**—Thank you very much. Senator Mason, would you like to start?

**Senator MASON**—You say in your executive summary:

The current Bills provide only a tiny fraction of a complete plan—  
like a principal or primary objection. What do you mean by that?

**Dr Fernando**—The health identifier is just a number. That is all it is—a number—and, when we talk to health authorities about the health identifier in relation to, for instance, the shared individual electronic health record, there are about five areas where either we have no information or the information we have received is very confusing. The first, as I said, is the absence of a coherent and convenient mechanism whereby individuals will know what their own health identifier is.

**Senator MASON**—So it has not been established yet whether individuals will know what their own number is?

**Dr Fernando**—The first time that lots of them will know their own number is when they go to the doctor or when they go to see a health professional. Alternatively, if they are aware that they have a health identifier they can go through Medicare and find out what that health identifier is through the Medicare operator—so through a third party.

**Senator MASON**—So you will not know you have one until you need to go to a doctor

**Dr Fernando**—Yes, that is the first time that you will know that you have a number. The second thing is that there does not seem to be a whole lot of information relating to access by consumers or their carers to the patient data that is linked to the health identifier, your identification data—that is, your name, your date of birth, your address, your former address, your former names and so on.

**Senator MASON**—You are saying that patients may not have access to that standard identification information?

**Dr Fernando**—Yes, that is right. And so they are not going to have any opportunity, for instance, to amend or correct it if there is any misinformation.

**Senator MASON**—You are saying they should?

**Dr Fernando**—Yes, I am.

**Senator MASON**—So they can correct it.

**Dr Fernando**—And we want patients to take responsibility for their own health care. In order to take responsibility for your own health care you need to know what information is being stored about you and you need to understand whether that information is correct or not: is it accurate, is it really you who is being described in the information attached to the health identifier?

The other issue is that it is really difficult—I would say it is impossible—to provide access control over a scheme where the number is going to be known by half a million individuals. That is using NEHTA's own figures. I used the Productivity Commission—

**Senator MASON**—Was that all these allied health professionals?

**Dr Fernando**—Allied health care professionals, medicos, nurses and, I suspect, their administrative staff but I have not had any confirmation of that. I suspect that what will happen is that the medical receptionist or the triage nurse at A&E will confirm your identity and obtain your identification number. The other thing is that there do not seem to be penalties for organisations that commit or enable information security breaches. In other words, the people who work with the systems—that is, clinicians, doctors, allied healthcare workers and nurses—are responsible for the information breach but, quite often, my research shows that information breaches occur as part of patient care.

**Senator MASON**—What you mean by that?

**Dr Fernando**—The systems that they are using are so cumbersome and, basically, not user-friendly or useful for providing clinical care—

**Senator MASON**—But won't this make it easier?

**Dr Fernando**—Why will it make it easier?

**Senator MASON**—The evidence from yesterday is that e-health will make it easier to store and distribute information about particular individuals.

**Dr Fernando**—Not from the evidence I have collected in my research, no. In fact, when you talk to doctors, nurses and allied healthcare workers they are quite frank about the fact that they share logon details. NEHTA, in their own paperwork, found the same when they were doing their threat and risk assessments. People share logon details, passwords and patient records. What happens is that one clinician downloads a whole range of patient records for a coherent view, to know everything about a particular patient's health condition. That is then printed out on a single form and it is circulated to all of the other clinicians who work on a shift. During the shift, as people go on their rounds to see patients, they update the handover sheets and then at the end of the shift the handover sheet is given to a single person who transcribes the information back into the electronic health systems they are supposed to be using. That is the infrastructure and the environment that doctors are provided with. It is impossible for them to control patient privacy. I have done research with both clinicians—

**Senator MASON**—Is that any worse than the current system?

**Dr Fernando**—Yes, it is worse than the current system, because the health identifier is going to provide a way to index all of that information. So whereas previously I might have breached information security at some hospital somewhere and I then had to find out how I could get that person's individual records from all of the various departments—their tax records, their surgical records, their outpatient records and so on and so forth—with the HI I have got the key to all of that information. So, yes, that is what is going to happen.

**CHAIR**—Dr Fernando, it is not so much the system as that there is going to be wider access to the system.

**Dr Fernando**—I do not understand the question.

**CHAIR**—Senator Mason's question was saying that potential breaches of privacy happen now, but to try to hone in on your concern it is that it could be wider, so there could be more access.



**Dr Fernando**—Exactly.

**CHAIR**—One of the things that we discussed, and Senator Mason highlighted it there, was that the current system allows people's information to be insecure if people have bad practice.

**Dr Fernando**—It does allow people's information to be insecure.

**CHAIR**—Sorry, but I just want to get that clear. Is that so, Senator Mason?

**Senator MASON**—It simply raises the danger; is that right?

**Dr Fernando**—It raises the danger from a few hundred records to millions of records.

**Senator MASON**—I understand.

**Dr Fernando**—So it is important that there be penalties or some ways of ensuring that information security breaches are slated home to the people who are creating the environment in which patient care is operating. The health identifier bill actually indemnifies servants of the Crown. That is really interesting. I do not know what the technical definition of a servant of the Crown is. If the health identifier bill is such a robust bill, then it is really interesting that servants of the Crown are indemnified. As I have said though, I do not know exactly who those servants of the Crown are. Finally, there is also an issue in terms of access logging. One of the problems is this. Although the legislation contains penalties for individuals who commit information fraud or who use information for purposes other than those intended by the health identifier bill, because consumers do not have direct access to that health identifier how are they going to know that their information has been breached? How are they going to form the substance of those complaints?

**Senator MASON**—At least if you had someone with a log you would have a record of who was logging in to check someone's record. I think that is a good thing, isn't it?

**Dr Fernando**—That actually exists in hospitals now. In fact, I think the government has to do audits every couple of years for their licensing. That kind of audit record already exists. The other problem with audit records is that—and I am sorry as I am going on to another topic—if, for instance, the smart card for the identification system is operationalised, then what that means is that each doctor will have a password to various systems hanging around their neck, I am assuming, and if they share passwords as they share everything else why wouldn't they just take a password off and give it to a nurse or to another doctor or to someone else who is going to do the work for them?

**Senator MASON**—Thank you for that, Dr Fernando. We have run out of time. I want to get straight to the nub of what I see as perhaps the most cogent issue. Dr Clarke, you might also be of assistance here. All those issues are fine, and I understand them, but the issue that concerned me was a simple issue. You are setting up a universal personal identifier. You have a number that identifies every Australian. I think e-health is a great thing. I think that as a matter of principle it is terrific. We had evidence yesterday that the medical profession will find it very useful. I think that is all very noble and a very good thing. But it is about what hangs off that number. It is about the capacity for what you would call incrementalism—

**Dr Clarke**—or function creep.

**Senator MASON**—So that is what it is called, Dr Clarke—function creep. What I asked yesterday, and I am sure the chair will recall this, was what the whole scheme was going to look like. One of the witnesses said, 'Look, we can't hold back. We have to establish the number first.' What worries me is that if we establish the number first we establish the infrastructure for a scheme that could be far larger in its scope than simply e-health.

**Dr Fernando**—That is right.

**Senator MASON**—Dr Clarke, do you follow what I am saying?

**Dr Clarke**—Very much so. If I could just do a couple of generalities and then lead to that, from the viewpoint of complex systems generally—and particularly national schemes of this nature—there is far more to it than just the identifier. The identifier provides a link between an individual and data held in records. A system of this nature involves use of the identifier to give a key to records in a database. In this case, it is going to be a record in a central database whose intention is to provide ready access to many other pre-existing databases. So it is, if you like, the hub of a highly distributed network of databases. That is the purpose of the health identifier. It is not something in a vacuum; it is to enable access to large numbers of databases.

That led to the point that has just been discussed: now we have 500,000 people who have access to using this number out to vast numbers of databases that were previously islands. There is a downside to there being

islands: when you want a discharge summary to go from the hospital to the GP, you do not want them to be islands; you want them to connect in respect of that particular data. But now it is going to be unconstrained because those linkages are available to all of the 500,000 people gaining access. Now we have got to build some complex mechanism to somehow limit that access, to somehow authenticate every healthcare provider and every administrator in that 500,000, identify them and authenticate them reliably and keep them out of the stuff that they should not have access to. What we do is create enormous scope for leakage of the most sensitive data in the country, as far as individual consumers are concerned—healthcare data always comes at the top of the list in all the surveys.

**Dr Fernando**—If I could just add, too, this is going to be the most up-to-date, well-maintained database of Australians' names, addresses and ages that is in existence at the moment. So this is going to be the richest source of data that exists in Australia at the moment.

**Dr Clarke**—And if I can apply another buzz phrase that is used in this area, it represents a honey pot. If you are organised crime or if you are a kid in a back bedroom with considerable skills who is looking for interesting things to break into, you look for the honey pots that have got substantial amounts of data that could be interesting. So by pooling all of these hitherto quite isolated databases—subject to varying degrees of existing security; I agree, Chair, that is quite clear—you are creating an attracter for those people to gain access to.

**Senator MASON**—And it is the number, Dr Clarke, that would enable the records to be impaired.

**Dr Clarke**—The number is the enabler of the national database scheme for health data. Now, related to this—and another reason why we say it is impossible to fully evaluate this bill in isolation—is that that set of databases, and access to them and creation of data in them, is subject to very large numbers of business processes. So far we have had one of those business processes described with some degree of precision, and that is the creation of an IHI. That is one of several hundred business processes that one would need to get a bird's eye view of in order to understand the flows in this system. We cannot form judgments on the specifics of what things will be done based on so little information, and that then leads to the cluster of security and privacy questions which are unanswered.

One of the central questions in relation to security is not the one people usually think of which is, 'Oh, we'll have to build a big wall around that data.' It is: 'Who is the person we have just okayed to gain access to it?' It is the authentication of providers and the authentication of administrators and insurers and everybody else who is going to have access to this data. That is a genuinely difficult thing to do. It has got to be done across hundreds of different organisations and we have got to achieve, somehow, consistent and high standard authentication processes. There is no discussion of this. We have no idea of what the proposition is.

**Senator MASON**—The two bills of themselves do not seem to be highly offensive to me at all. There are some issues there but, in a sense, it is the apparatus that it potentially creates. That is how I see it.

**Dr Clarke**—If we are accepting that Australia is to have a national identification scheme, this time built out from Health instead of being built out from Human Services or, as in 1977, built out from the then Health Insurance Commission, if one accepts that then yes, there are a number of things wrong with this bill, but one could perhaps go about amending it.

But, in effect, if the parliament were to pass this bill, it would be agreeing to a national identification scheme on the basis of a specification of a fraction of that scheme. I do not believe that is what the parliament should be in the business of doing. There is a full package on the table and the public votes to go with a national identification scheme—the Australian Privacy Foundation loses on behalf of the Australian public, we would think—and that is that. That would be a full democratic process. This is not, because it is this small amount.

**Senator MASON**—That is a different issue. We have had this debate before, and I know that the chair was involved in the debate. If there is a public debate about an ID scheme, that is a legitimate debate to have. Whether it comes in by administrative subterfuge is a different issue. I accept that.

**Senator FURNER**—Yesterday we heard evidence from a number of witnesses about breaches of privacy already in cases of accessing paper based records, whether it be someone merely walking past a patient's bed and inadvertently inserting the wrong data or whatever the case might be. This bill surely demonstrates an opportunity to eliminate those types of privacy breaches as they exist currently, doesn't it?

**Dr Clarke**—E-health initiatives provide the opportunity to change the pattern of security, including improving it. This bill is not necessary to do that. Something that has to be appreciated is that the existing

breaches that occur with isolated databases—and this applies whether they are hard copy or magnetic disk—are limited in scope and space. To inspect that manila folder, a person has to be in that physical location. When you build a highly distributed network, as is being proposed here, the 500,000 people are almost all remote from the centrally stored data. So there are far more points of weakness that you have to control for, and the security safeguards that have to be built in are far more difficult, far more complex, than they are in respect of, say, protecting two filing cabinets in the local surgery. Those are fairly well-known and physically isolated. So it is quite a complex matter. But, to come back to your original question: no, this bill is not necessary to improvements in security.

**Senator FURNER**—You referred to healthcare data being at the top of the surveys you have conducted. What were those surveys focused on and what was the content of those surveys?

**Dr Clarke**—I am not sure what words I used—I am sorry—but I was intending to refer to the large numbers of surveys that have been done over a period of many years by a variety of organisations. Some of them are commercial organisations. I have been involved as a consultant, assisting organisations to design these things on a couple of occasions. Privacy commissioners in various countries, including at the federal level here, have undertaken studies. One of the sets of questions they tend to ask is: ‘Which of the following categories of information are you most concerned about?’ Sometimes they ask: ‘How seriously do you view breaches of privacy in respect of these categories of information?’ It is in that respect that I am saying that healthcare data ends up very high—usually the highest, but not always—in such surveys, including in the one that I did for MasterCard.

**Senator FURNER**—Would those surveys or questionnaires put a question to a person suggesting that bank records or taxation records would be a consideration for them to be concerned about as well?

**Dr Clarke**—Yes. Generally financial information comes second. Tax information, interestingly, comes rather further down in most of those sorts of surveys. Clearly, it is situational. For example, there is a different age distribution. Depending on where in the age range a person is, the more money they have and the more they are worried about protecting information about that money. So the proportions change. Concern about financial information is high, but concern about healthcare data is normally the highest.

**Senator FURNER**—I would have thought it would have been at the top, given the opportunities for people to milk bank accounts. I think you referred to health being the honey pot of data that people wish to access.

**Dr Clarke**—Yes, financial data is very important. I agree.

**Senator FURNER**—Also in your submission you say:

The lack of direct consumer and patient access to their HI is likely to swell the health black market as individuals self diagnose to protect their privacy.

Aren't we jumping at shadows with that sort of statement? Aren't we talking about people having the ability to access records comfortably and confidently—that is, getting those records without asserting that there is some sort of black market happening here?

**Dr Clarke**—I will start by answering generically. We are having to jump at shadows because we have this much of a proposal available to us. To an extent yes, we have to think ahead, so partly I agree with the implicit proposition, not specifically.

**Dr Fernando**—All I would like to add is to reiterate what Dr Clarke said and also to say that there is evidence to suggest that that is the way that patients who are concerned about their privacy respond to what they perceive to be control of their information. Some work was done in California and also in New Zealand that bears that out. To me, the health black market is fairly simple and that is the number of spam emails that I receive wanting to sell me various prescription drugs for my own purposes so I can self-diagnose and decide what I think I need or do not need and then order it over the internet or through spam.

**Senator FURNER**—But it is up to you whether you respond to that spam?

**Dr Fernando**—That is right.

**Senator FURNER**—It is not a case of spam accessing your records?

**Dr Fernando**—But I am saying that that information is readily available to people who want to look for alternative ways or who want to protect their privacy and they are concerned about the government having their numbers. This is another avenue for those people.

**CHAIR**—What you are saying, Dr Fernando, is it is worse because you are talking about the current situation that is available to people and they use it?

**Dr Fernando**—That is right.

**CHAIR**—Your premise is that this will make more people do it?

**Dr Fernando**—That is right, as they try to protect their privacy more and more.

**Senator MASON**—Did you give evidence several years ago when the chair and I were involved in the inquiry into the access card?

**CHAIR**—Yes.

**Dr Clarke**—Anna Johnston was the lead. I was involved in the background, yes.

**Senator MASON**—Do you think the threats to individual privacy in that bill are replicated or similar in this bill?

**Dr Clarke**—I do. I have to ‘jump at shadows’—to use Senator Furner’s words, which are quite effective—a little bit, but consider the following. The lead agency is in the Department of Health and Ageing, but because it is a national program there has to be a way of drawing in the states and territories so NEHTA is involved. Medicare is deeply involved and, according to recent announcements, Medicare is not only in the Human Services portfolio but is to be increasingly integrated so that the Human Services portfolio will cease to be a small portfolio department with multiple large service delivery agencies. Increasingly, it will become a substantially integrated combination of policy and service delivery. Therefore, from the outset this is a combination of Health and Human Services portfolios. There are not too many left. Centrelink is part of the Human Services portfolio and that leaves tax outside it in Treasury. It is very hard not to see the scope for this being a great deal more than healthcare data. Apart from this, where does healthcare data begin and end? There are so many elements to health care—employment records involve healthcare data. There are a great many tentacles and would it be reasonable—

**CHAIR**—I need to have the statement you are making clarified. Human Services is and always has been a department with a number of service delivery components.

**Dr Clarke**—Since it was formed; that is right.

**CHAIR**—To the best of my knowledge the departments that are involved with Human Services have not changed. It is not that Human Services is changing some of the interaction within it, but Human Services still has the same component elements that it had when it first started.

**Dr Clarke**—There have been some movements, but the Human Services portfolio—

**CHAIR**—Name them, Dr Clarke. You are making a big statement that there is somehow a change in the whole structure of government departments leading to—

**Dr Clarke**—I am quoting the minister, although I cannot quote because I do not have the words in front of me. The Child Support Agency has been integrated into the Human Services portfolio department and this has already been completed.

**CHAIR**—As it was.

**Dr Clarke**—No, it originally commenced as a separate agency and it has transferred across from the Treasury portfolio.

**CHAIR**—Yes.

**Dr Clarke**—Secondly, an announcement was made some months ago to the effect that there would be further integration of the other agencies into the Human Services portfolio department.

**CHAIR**—The same agencies that are already in Human Services. That is all I am referring to.

**Dr Clarke**—Yes, I am sorry if I implied original agencies. Apologies if my phrasing was wrong.

**CHAIR**—So it is the same agencies that were in the original parent department. It is not as though there is growth through sucking up other government agencies?

**Dr Clarke**—There are not many left—that was my point.

**Senator MASON**—Is your argument that there will be a temptation to integrate the records?

**Dr Clarke**—A very strong temptation, indeed. I perceive it as being a further attempt by the bureaucracy to sell the idea to government that there should be a national identification scheme leveraging off one or another of the available databases and progressively integrating with others of those databases.

**Senator MASON**—You might be right but, to be fair to many of the witnesses yesterday—and I know nothing about the provision of medical services—on the face of it, it is a good idea. I think it is a great idea if you can track individuals so you do not get confusions about their identification and if records can be transferred throughout the country. I think there are some good public policy reasons for it. I suppose what I am asking is: is there a way of facilitating e-health rather than through the provision of a universal personal identifying number?

**Dr Clarke**—Absolutely, there is.

**Dr Fernando**—Yes.

**Dr Clarke**—In the event that one adopted the perspective of the French central planners and adopted a socialist, paternalistic state in which the state took over responsibility for individual patient's health care and the management of data relating to health care, okay, that could be a way for society to choose to go. It would be an abrupt change but that is quite feasible. But we do not have to go that way in order to gain benefits from information technology in health. The nature and structure of health has always been large numbers of islands of treatment. That will always remain the case, if only for geographical reasons but also for functional reasons and because of size and scale problems. Huge campuses do not work. It is much better to have multiple campuses for a variety of reasons. There is a natural island structure, and federation amongst those islands and interoperability arrangements—protocol, standards, human interoperability as well as technical interoperability arrangements—are the mechanisms that 15 years ago as a consultant in the health sphere I was trying to encourage, because that is where progress can be made. We have been held up for over a decade because there is this continual temptation to go centralist to try to provide top-down solutions to a huge problem. It is the biggest and most complex industry sector. Smaller sectors cannot work top-down vertically and this one certainly will not. There are far better ways to go about doing this. This is a technical information systems perspective, if you will, rather than a healthcare perspective, but big and complex systems do not work.

**Senator MASON**—You would clearly challenge the argument made yesterday that if we abandon the health identifier it could put back public health a decade.

**Dr Clarke**—I challenge it completely. The focus on centralised top-down thinking—

**CHAIR**—Dr Clarke, we have to go to a division. We will have another 10 minutes for your evidence from whenever we return.

#### **Proceedings suspended from 4.13 pm to 4.52 pm**

**CHAIR**—We will reconvene. I am not going to keep doing it for every witness, but I am just going to put on notice the apologies from our committee. Our schedule has been put back considerably, but we will not compromise on anyone's chance to give evidence. You will get your full chance. I said before we left that you would have 10 minutes from when we returned.

**Dr Clarke**—We were discussing, as I recall, Senator Mason's question relating to whether the bill is necessary for e-health and that related to Senator Furner's earlier question about whether the bill is necessary for e-health data security. One of the key things that I wanted to convey was that there is a real opportunity in e-health not to adopt a centralist approach but to look for what in business we call 'low-hanging fruit' which are the big payback items capable of being addressed now. If the industry were to target some of those then we are in a position to do all the e-health we like taking advantage of interoperability standards, protocols, the various discussion fora that exist, which we believe is NEHTA's real role, to get very high payback.

One of the sorts of things that we are thinking of as an example is chronic conditions. In the event that there were a voluntary IHI arrangement—which was under discussion until quite late in the piece—there is a fair bet that a very large proportion of people who suffer chronic conditions would say, 'The trade off between my privacy and the centralisation and the risk factor to that data versus improvements in care because I have so many people who need access to so many bits of my data is such that I'll sign up.' I think many chronic care patients would love to do that, whereas many of the rest of us would prefer the opposite. So that is one example where, if you target some of those chronic conditions that are of considerable importance, you can achieve a lot of progress.

**Senator MASON**—So this is an opt-in arrangement, Dr Clarke?

**Dr Clarke**—That is an opt-in. A common identifier amongst the cluster of treatment organisations is useful. It does not actually have to be a national identifier scheme to achieve that, because a person with a chronic condition is normally geographically localised and as long as each of the treatment facilities are aware of the small set of numbers the person uses, that would do. You still do not actually need and IHI even to do that, but we could see logic in an IHI proposition as a way of cutting through some of the complexity.

**Senator MASON**—Sure. Thank you, Dr Clarke.

**Senator BOYCE**—The Office of the Privacy Commissioner has been involved in some of the work around the privacy protections put into this legislation. In your view, is the Office of the Privacy Commissioner sufficiently independent of government to perform the role that it has been given to oversight the initial and continuing protection of privacy covered by this legislation?

**Dr Clarke**—Generally over the last five years the Privacy Foundation has been very disappointed with the stance that the Privacy Commissioner has adopted in a wide range of things. In this specific instance there are a couple of examples of the ways in which we believe the Privacy Commissioner has dropped the ball. The Privacy Commissioner is happy with the current arrangements relating to the requirement of organisations to have appropriate security in place relating to the data. But the bill does not go so far as to impose penalties. Instead there is a vague reference to powers to regulate. We believe it is entirely unacceptable for the parliament to delegate to the government whether or not there shall be penalties. Some details, everyone is agreed, are appropriate in regulation, but that is a major policy decision and a major part of the security of the web of provisions that are necessary to achieve security. The Privacy Commissioner has failed to stand up on that point.

Another example is that pseudonymity—the ability of individuals to present to different health care professionals and use different names and identifiers in order to keep parts of the records segregated from all of the other parts—is unmentioned in the bill. It is seriously unsatisfactory as it stands in the healthcare arena. The Privacy Commissioner has failed to address that question and to submit that there should be such arrangements in place and built into this scheme. There are a range of factors, but they are the two that had stood out to us. Does it cover it?

**Dr Fernando**—Yes.

**Senator ADAMS**—Coming back to the person with chronic disease accessing public hospital treatment and then private hospital treatment, how do you see the private hospitals taking up this technology? Do you think they will? Just where will we go with the private providers?

**Dr Fernando**—There are some core difficulties in making that prediction. Part of the core difficulty relates to the technology that is being used for the health identifier. There are basically two core standards that I am discussing in Australia. They are both under the auspices of HL7. One is a HL7 2; the other is HL7 3. At the moment most of the hospitals and health organisations in Australia use HL7 2 technical standards to intercommunicate. The HIA, though, will be based on HL7 version 3, which is completely different. So it is going to require some kind of short- to medium-term reinvestment in terms of technology for those kinds of information exchanges to take place. At the present they cannot take place.

**Dr Clarke**—There is actually a better chance, we would think, that private hospitals and the rather richer components of the healthcare sector—diagnosticians, path labs—could afford the reinvestment, since there are such enormous demands on the public system to make investments in healthcare equipment, leaving aside the additional software and, to some extent, hardware requirements that are going to be needed here.

**Dr Fernando**—And that gets back to Dr Clarke's point about low hanging fruit. There is low hanging fruit, but not in terms of these particular bills.

**Senator ADAMS**—I am looking at it from an economical point of view. So many people are saying that they have been treated publicly and then when they have gone to a private hospital they have had to have all their tests done all over again. So someone might have had one lot of tests done two days ago but now that they are in a different scenario they have to have the whole lot repeated. Have you done any work on the cost savings?

**Dr Fernando**—I have not done any work on it in terms of the cost savings. And I do not have any empirical evidence; this is anecdotal. The anecdotal evidence, though, is that clinicians like to do their own tests. They base their diagnoses on their own tests. Tests are not some kind of substantive or empirical

measurement that is the same for every single person. So my understanding is that, even if the public hospital had done one lot of tests, if that private clinician did not accept the foundations of those tests the tests would have to be done again.

**Dr Clarke**—And the short form is: some of the waste is avoidable—

**Dr Fernando**—Yes, that is right.

**Dr Clarke**—and some probably is not really waste, but there are certainly some savings available. But the way to achieve that, we would argue, is through coordination mechanisms, because there are small numbers of islands that need to be able to communicate with one another—and, indeed, to be encouraged, possibly by law, to communicate and coordinate with one another. Getting the private and public sectors to talk to one another is a very good idea. It does not require this bill. It does not require a single identifier—

**CHAIR**—But it does require standards.

**Dr Clarke**—It requires several coordination mechanisms—in particular, via standards.

**Senator BOYCE**—As to the versions of technology that will be used to underpin this: we have already heard some concerns from the software industry that there has not been enough development now, and standards have not been set as yet.

**Dr Fernando**—That is right.

**Senator BOYCE**—Could you tell us a bit more about your concerns in that area?

**Dr Fernando**—My first raft of concerns are around standards. When I read the IHI bills they refer to Australian standards rather than international standards, and I think that is going to cause problems later on down the line because we are going to have to then devise new forms of standards for interoperability between Australia and other countries of the world. I think that is going to be an enormous issue in the future.

**Dr Clarke**—And to write our own software.

**Dr Fernando**—I was just going to say: and the other issue is that we are going to have to write our own software. What that is going to mean is that people who are writing software for clinicians are going to have to write an Australian version of their software and then another standards based version of their software. So those are my first concerns.

My second concern is as follows. I was talking about the two standards. Most of the hospitals and health services organisations use HL7 version 2 now. They use two kinds of that. They are standards based, by the way, but they are also open to interpretation. So there is a little bit of clunkiness there. With HL7 version 3, that is going to be much smoother and of a much different standard, but there are very few people in Australia who understand how HL7 version 3 works—let alone who are willing enough to convince partners and so on in their medical practice that it is worthwhile investing in hardware and software upgrades as opposed to medical devices for their patients. So, in terms of medical investment, this is going to be very hard to promote. And people who are using HL7 version 2 cannot communicate with machines using HL7 version 3. So that is about it.

**CHAIR**—Thank you very much, Dr Clarke and Dr Fernando. And thank you for your patience.

**Dr Fernando**—Thank you.

[5.05]

**BANKS, Ms Robin, Chief Executive Officer, Public Interest Advocacy Centre**

**CHAIR**—The next witness is Ms Robin Banks, by telephone from the Public Interest Advocacy Centre. Ms Banks, I sincerely apologise for holding you on the line as long as we have had to do so. I know you have another appointment at 5.30. We have your submission. We will hear any comments you want to make and then we will have some very short questions from senators.

**Ms Banks**—Thank you for the opportunity to speak to you today. As we have identified in our submission, PIAC has had a longstanding interest in and concern about healthcare consumer and privacy issues. We are certainly keen to ensure that any implementation of electronic health records and systems in Australia is not marred by failures to ensure adequate consumer protection. The willingness of consumers to engage in electronic health systems will depend entirely on the system being implemented in a way that ensures security and protection of privacy and that also respects the centrality of the consumer, the healthcare recipient in the process. We are keen that parliament ensures that the Healthcare Identifiers Service is consumer centred and that consumers are aware of the service, its purpose and development to date and that consumers can feel, through a sense of openness and transparency about those developments, that they can have confidence that their personal information and access to the records is properly secured.

As the committee members will be aware from our submission, a key concern that we have is that this legislation is being progressed out of step with the reforms to the federal Privacy Act, particularly the reforms in the area of health privacy. From our point of view that is extremely unhelpful and risks undermining the confidence of consumers that the government is taking a holistic approach to health privacy and electronic health records—or even that government has made the clear connection between electronic health record development and the centrality of privacy law.

We believe the scheme is not well understood by the general public. I occasionally hear people say, ‘Oh, I understand there is something going on’, but people do not know what the developments look like or mean. Without better information to the general public it is likely that many people will link it to the failed proposal of the former federal government to implement a health smartcard. While the two proposals are different, both show the potential for privacy breaches that could have significant and damaging impacts for consumers and both show the potential for function creep. That is one of the issues we have raised in our submission. In our view parliament needs to be vigilant to ensure that it does not pass legislation that is insufficiently clear and precise in the scope of the powers that it vests in the executive and it should not pass legislation that is insufficiently clear in its purpose. The current bill fails in both regards. The purpose, in our view, is overly expansive. We are already seeing in the bill the potential for function creep. The potential for key elements to be determined through regulation is also significant in the bill. Our concern about that is that regulatory processes do not enjoy the same level of public or parliamentary scrutiny.

Finally, in our view the bill remains underdone in the area of consumer rights and protection of data. Healthcare recipients seem to be on the periphery of the design of the scheme and have very few express rights. There is also very little comfort, I think, for consumers to be gained from the limited information security obligations.

From our point of view more needs to be done to ensure that this legislation is in step with the major reforms being undertaken in the area of health privacy law at a federal level and to ensure that consumer confidence and trust can be maintained. Without that not only does the legislation risk undermining the development of effective electronic health records but also a loss of trust in this area will inevitably flow to other aspects of government operations, not only in health but beyond. A failure to protect such core information as consumer health information can only spread a lack of confidence in government more broadly. Thank you.

**CHAIR**—Thank you. We have 20 minutes.

**Ms Banks**—I can probably stretch it a little bit beyond 5.30, but I have to be somewhere at six o’clock.

**Senator FIERRAVANTI-WELLS**—Can I maybe kick off. Ms Banks, it is very clear from your submission that you are very much opposed to the bill. What is your suggested course of action? You are obviously concerned that there has not been sufficient consultation at this point, so what would you suggest as a way forward on this?



**Ms Banks**—There are two things. The first would be to ensure that there is a much broader public consultation process, not simply with those who are in the know—organisations like ours. More importantly, we think the legislative scheme should be deferred until the federal health privacy reforms, the reforms in the Privacy Act itself, go through. I heard some of the evidence from the Australian Privacy Foundation, where Dr Clarke referred to the issue of pseudonymity. Certainly, those sorts of issues are going to be picked up, we hope, in the reforms to the Privacy Act and should therefore flow on to anything that has privacy implications, like this legislation. So our primary concern is to defer consideration and further development of this scheme in legislative terms until the privacy reforms have been implemented and legislated. They will then inform this process much better. At the moment we are still waiting for those reforms to be finalised, and it may in fact give people a great deal more comfort if they know what the obligations are under the overarching privacy law.

So those are the two things—firstly, much broader consumer consultation around the whole underlying idea of electronic health records, what their purpose is and how they might benefit consumers; and, secondly and more importantly, bringing it into step with the federal privacy reforms.

**Senator FIERRAVANTI-WELLS**—So you think that if the consultation process had included broader, community-wide consultation there might not be as much enthusiasm for identifiers and, as a consequence, identifiers as the first step in e-health. Is that what you are saying, in a nutshell?

**Ms Banks**—That is a pretty good synopsis. I think that, if people were asked, ‘Do you want to opt into a system,’ as part of this process, there would be a whole lot less concern. But I think, fundamentally, that if you start talking about individual health identifiers without a good community information and consultation campaign, there is a significant risk of push-back.

**Senator FIERRAVANTI-WELLS**—You would obviously be aware of the recent media comments about Medicare Australia, which is where these health identifiers would reside. As a consequence of those reports, have you raised concerns from your perspective or have concerns been raised with you?

**Ms Banks**—We have not had people directly come to us with complaints about Medicare, but certainly the recent reporting suggests that there is some cause for concern that should be addressed before we go down the track of empowering Medicare to do a whole lot more and to link data a lot more than they perhaps already have. So I think we really need to iron out those problems and understand what those problems really are before giving them more power and more control over people’s data.

**Senator FIERRAVANTI-WELLS**—In short, obviously your view is basically that the public has a lot more of a right to know about the policy underpinning of this whole issue, not just the identifiers but the identifiers as the first step in a much broader policy area.

**Ms Banks**—Yes, that is correct. The right to know what is proposed is critical. While I certainly have concerns about Medicare, equally I probably have concerns about any suggestion that somebody else could do it whereby there is a likelihood that there would be even less scrutiny available. So I think we really need to get it right as to whoever does it. I think it should be a government authority, so there is that level of accountability to parliament that government authorities have. We really need to get it right before we go down that track and we need to ensure that the community understands not only what is proposed and what the benefits of electronic health records can be but also who will have access to the information and in what circumstances.

**Senator FIERRAVANTI-WELLS**—Given the evidence thus far—and obviously you followed the evidence yesterday, which was really from those who perceive that there will be a benefit—in summary what you are really saying is that the biggest component of this whole program, starting from the health identifiers and going right through, is the consumers and you are expressing grave reservations from a consumer perspective.

**Ms Banks**—Certainly for us the central question is: what will the impact of this be on consumers? As I said in my introductory comments, I think there are clearly some benefits to be gained through the effective use of electronic health records, but at the moment there is too much risk in the legislative scheme that is proposed.

**Senator MASON**—I think that before you used the words that there is a risk of public pushback. Is that right?

**Ms Banks**—Yes.

**Senator MASON**—Is that because unless the full legislative scheme is outlined by the government it is possible that people will become increasingly concerned about what might happen and what use might be made of that personal identifier? Is that right?

**Ms Banks**—Yes. It is a concern similar to the one we expressed in relation to the health smart card when there were tranches of legislation proposed under the former government.

**Senator MASON**—I remember that.

**Ms Banks**—There was a sense that we were getting dribs and drabs. If people are going to have confidence, particularly if consumers are going to have confidence, that the scheme is going to work, they do not want to be left with unanswered questions around really core elements. They want to know not only that the whole of the legislative scheme has been thought out but that it is being scrutinised by the parliament in one block, because otherwise we are all being asked to trust to some future legislation—and that is really not an adequate protection.

**Senator MASON**—It leaves the notion of function creep as a distinct possibility.

**Ms Banks**—Very much so, yes.

**Senator MASON**—You actually talk about function creep in your submission where you say that already in clause 24 there is an example even with respect to these two first bills.

**Ms Banks**—That is right. I find it quite extraordinary that we could not even constrain this initial bill to the purpose that we are told it is for. The idea that healthcare identifiers are already being contemplated for research and other purposes is extraordinary when we have not even got them for the underlying purpose, so we do not have them in place and already there is an expansion happening. That only suggests that there is a risk of much more significant function creep over time.

**Senator MASON**—There seem to be two principal issues here. One of them is that we have issues that relate to these first two bills setting up the health identifier and then we have the second issue, which is how that health identifier might be used potentially in the future as the platform for other useful social and medical issues but also it is potentially privacy intrusive. In a sense to me it is about the latter: how the development of the number might be used, because we do not have the full legislative scheme. Do you agree with that?

**Ms Banks**—Certainly I agree that, because we do not have all of the details, it is very open to that risk of further uses of the healthcare identifier beyond its core purpose. That is very much a possibility. I would find it interesting—I was trying to understand this as I read the bill—to know why it would be helpful to researchers in the areas set out in the bill to have access to people's healthcare identifiers. If you are doing research about health outcomes, then being able to identify people is actually not helpful at all. It can undermine the credibility of the research. The whole push is for deidentified data and I cannot see how having healthcare identifiers in that mix is helpful.

**Senator MASON**—Could I play devil's advocate for a second, Ms Banks? If you think there is going to be function creep and that this number might be used for other purposes, surely the answer to that is this: it has to come back before the Australian parliament, particularly the Senate, where it will again be investigated and assessed by parliamentarians, and function creep is impossible because a judicious and wary Senate will ensure that that does not happen. That is what the government will be arguing. What do you say to that?

**Ms Banks**—I think that is a somewhat optimistic argument. As we have identified in the submission, there is a lot in the bill that allows things to happen outside the pure legislative framework. The scope of regulation that is permitted in this piece of legislation in my view is extraordinary, and it is core issues. Without looking at the bill again while I am talking to you it is difficult to say whether it is possible for there to be function creep through regulation, but I would be surprised if there was not, just because there is so much left to regulatory alternatives.

**Senator MASON**—I have one last question. Perhaps it is a background question. You have spoken about reform to privacy laws. I am not up to date on this but I know that the Australian Law Reform Commission put out a very comprehensive report a couple of years ago on this.

**Ms Banks**—Yes, that is right.

**Senator MASON**—Has anything happened with regard to that?

**Ms Banks**—Yes. There has been a lot of work done by the Department of the Prime Minister and Cabinet. They have been consulting in respect of two aspects of that reform in detail to date, the first being the privacy

principles and the second being health privacy issues. That is why we have said that, given we are waiting on the first tranche of that legislative reform—which will deal, as we understand it, with health privacy and reforms in that area—it is extraordinary not to wait. I would expect to see certainly this year legislation on health privacy reform.

**Senator MASON**—That was the result of years of work by the Australian Law Reform Commission, wasn't it?

**Ms Banks**—That is right, and it seems a bit odd, particularly given that the government has responded by saying, 'This is the direction we are taking in response to the Law Reform Commission' and given the fact that all this work has been done by the Department of the Prime Minister and Cabinet on the specific issue of health privacy and the reforms in that area following the recommendations of the Law Reform Commission. It is extraordinary not to make sure that those are in place before this kind of scheme, which clearly has privacy implications, is legislated.

**CHAIR**—Thank you very much, Ms Banks, for your evidence and for the quite detailed submission you supplied. Again, my apologies for keeping you waiting.

**Ms Banks**—Thank you, Senator.

#### **Proceedings suspended from 5.23 pm to 5.31 pm**

#### **GREENLEAF, Professor Graham, Private capacity**

**CHAIR**—Good afternoon, Professor Greenleaf. We apologise for holding you up. We have your submission and thank you very much for it.

**Prof. Greenleaf**—My apologies for it being so late, but I was scrabbling to get everything done in time. I apologise for a few typos in it as well. I will send a corrected version.

**CHAIR**—You have information on parliamentary privilege and the protection of witnesses.

**Prof. Greenleaf**—Yes.

**CHAIR**—Please make any opening comments you have and then we will ask questions. I hope this will take about 20 to 25 minutes so that gives you some idea of the time frame.

**Prof. Greenleaf**—I am a professor of law at the University of New South Wales and co-director of the Cyberspace Law and Policy Centre in the law faculty there. The fundamental problem that I would identify with this bill is essentially its incompleteness. It covers a small but central element of a much broader health identification and surveillance system, including the crucial element of electronic health records. Having a bill like this before you is similar to the position that parliament faced when the access card bill was introduced in 2007. That bill was very strongly criticised by the Senate committee that examined it, partly on the basis that it only covered a fragment of the overall legislative proposal. I think here you are looking at an overall identification system which shares a surprisingly large number of elements with both the Australia Card scheme of a couple of decades ago and the access card proposals of 2006-07.

In my view the Senate and the parliament is being put in an unreasonable position of being required to consider this bill in isolation from the full system that the government is proposing to implement, particularly concerning electronic health records. As the Victorian Privacy Commissioner has succinctly pointed out in her submission, this bill is artificial and limited because it does not deal with the broader privacy issues concerning e-health and in her view this guarantees function creep. As a result she says basically what I am saying that this makes it unreasonably difficult to adequately assess whether the safeguards in this bill will ultimately be sufficient or effective. For that reason I consider that this bill should be rejected in its current form until the full package is presented to the parliament. I cannot see any significant adverse consequences coming from delaying this bill until you have the full picture in front of you.

That was also the view I think taken by the privacy impact assessments commissioned by NEHTA. They were adamant that this was a major issue and, as Clayton Utz put it, there needed to be a new regime of privacy laws that were necessary before a universal health identifier was introduced and I have detailed that in my submission. My principal submission is that because of its fragmentary nature parliament should not pass this bill in its current form. I also think there is a significant issue that needs to be examined in the fact that most of the recommendations made by the second PIA Clayton Utz and the third PIA Mallesons Stephen Jaques have neither been implemented by NEHTA nor have they been embodied in this bill. There are about 30 or so recommendations, depending on how you count them, that have not been adopted. While one would not expect the government to adopt all recommendations made in a PIA, in my view, it is an essential part of

the process that, where you have a PIA being done on a really important project like this, the government should systematically state why it has rejected each of the recommendations that it has rejected. Given that one of the main functions of the PIA is to in a sense give the Privacy Commissioner ammunition for considering what recommendations her office should make, I think the commissioner should also be required to state whether she supports or opposes each of those recommendations that has not been followed through on in the PIA. If we do not have these two elements then the PIA process remains substantially incomplete and becomes rather farcical in fact.

A third point I would like to make is that I think it is extraordinary that there is provision in section 6 that who runs the healthcare identifier system, the service operator, can be changed by regulations. One day it could be Medicare and the next it could be a private-sector operator. I would be very surprised if many people in Australia would regard with equanimity a private sector operator running a key element of national identification systems in such a sensitive area as health. I personally do not think any legislation should ever allow a national identification system to be operated by the private sector. Even more strongly than that, no legislation should allow a step like that to be taken without the full scrutiny of the legislative process not merely the potential disallowance by a bills and ordinances committee.

They are the three broadest submissions I have made. I will briefly mention the others in my submission in case they are of interest to particular senators. I think there should be an obligation for healthcare providers or Medicare to proactively tell a person when an individual health identifier has been allocated to them. As the process stands at the moment under the bill, it can and often will happen completely unbeknownst to the individual concerned. There might be elements of it that are wrong—it might have been allocated to the wrong person or the wrong name—but individuals affected by this will not be proactively notified. I do not think that is desirable at all.

There is also the question of the compulsory nature of the number. All of the original proposals in this area, as summed up by the Victorian Privacy Commissioner in her submission, were based around person controlled electronic health records. But, as she says, it does not seem to be consistent with a patient or person controlled system that we now have compulsory allocation of health identifiers. They will very probably become a de facto condition of obtaining health care. So my submission is that the bill should provide and guarantee that the use of the health identifier not be a condition of obtaining health care. No doubt it will be attractive to the majority of people, but there will also be many people who are very wary of providing identifying information in order to obtain health care, and we should avoid forcing them away from the healthcare systems. Furthermore, in the bill at the moment there is not even a right of appeal against the provision of health identifiers. It is left to regulations to provide a right of appeal, which I submit is not acceptable for as important a thing as your rights in relation to this type of health identification system. I have put in further submissions about protection of anonymous health care, but I think many others have covered that in more detail than I have.

Finally, I will make some comments about a couple of aspects that are to do with inadequate controls on function creep and data matching. First, although there certainly is in clause 27 of this bill a serious attempt to stop uses outside the extremely wide—perhaps overwide—definition of ‘healthcare related purposes’ that is in the bill, outside that there is an attempt to stop the usage of the numbers of the private sector. But there is a major hole in the clause 27 prohibitions, and that is that any state or territory law can allow any other uses or disclosures. That was not recommended by Clayton Utz and it does not appear in the Mallesons recommendations either. I think that is an unacceptable avenue for function creep.

Secondly, I would point out that the way in which Medicare can obtain information to create the health identifier database is extraordinarily broad in that, by regulations, any organisation whatsoever can be declared to be a data source under clause 11, which has the effect of authorising them to disclose identifying information of a healthcare recipient to Medicare in order to create the health identifier database. Medicare can, without parliamentary authorisation, end up indulging in perhaps the most massively broad set of what would otherwise be breaches of the Privacy Act since the data-matching legislation. So I would propose that those forces should only be authorised by being specifically named in the legislation, therefore putting the matter back under the control of the parliament, where it belongs for something as important as a huge data-matching exercise like this.

Finally, on the subject of data matching, the Mallesons’ PIA recommended specific legislative restrictions on law enforcement security agencies being able to access the databases that are built for the purposes of operating this health identification service. At the moment in so many areas a very large number of

organisations, not just law enforcement and security agencies but tax and others, have statutory rights to obtain information from other organisations—including government agencies, as you all know—and the bill as it stands completely fails, as did the access card bill, to place any limits on that because clause 15(2)(b) allows Medicare to allow disclosures for a purpose that is authorised under another law. So we have a huge and really undefined array of current demand powers that can be used to extract information out of this new universal database.

I propose in my submission that both the department and the Privacy Commissioner should be required by the Senate to identify all the current situations where disclosures under clause 15(2)(b) may be possible under another law so that the Senate can see whether that is at all justifiable. I think you will find that it is not and that once the breadth of that comes to the light of day it will be obvious that there should be more restrictions on access to this sensitive information.

I think I have probably said as much as I should. The most general theme through what I have said is that as with the access card, and as I found in Hong Kong when I did a study of their ID system, the biggest problem in this type of legislation is that it takes control of the expansion of the system out of the hands of the parliament and gives it to the bureaucracy via regulations, and as a matter of liberties of the citizen I think that is very definitely the wrong approach.

**CHAIR**—Is that it, Professor?

**Prof. Greenleaf**—Yes.

**Senator FIERRAVANTI-WELLS**—Just on that point, Professor, the Privacy Commissioner appeared yesterday. I do not know whether you have had the opportunity to see or hear that evidence.

**Prof. Greenleaf**—No, I have not, Senator.

**Senator FIERRAVANTI-WELLS**—I specifically asked her about clause 15 and a similar provision. One was clause 15(2)(b), to which you referred, and the other is clause 26(2)(b), which is in similar terms. Her response to us was that this is now stock standard phrase, a stock standard insertion in legislation, and effectively she dismissed it in that way. What is your view?

**Prof. Greenleaf**—Yes, I think that is rather extraordinary—although she may well be right in saying that it has become stock standard. But that is not to say that it should be. When you are dealing with parliamentary authorisation of databases containing information as sensitive as this—the key to the medical records of the whole Australian community—the importance of this database surely requires some special attention to which agencies can get access to the information. And what might be fair enough for the customs department or the tax department to get access to in other situations might not be fair enough here. I do find it rather extraordinary that the Privacy Commissioner should think that there is a one-size-fits-all approach to what government databases other government departments should have access to.

**Senator FIERRAVANTI-WELLS**—So, in other words, what you are suggesting is that there be an amendment to those provisions to clearly define the pieces of legislation—or, at least, in the first instance: ask and get further information as to what the legislation envisages could be the potential areas of law to which these identifiers—

**Prof. Greenleaf**—Yes, that is right.

**Senator FIERRAVANTI-WELLS**—You know the question I am asking? I got a bit tongue-tied there!

**Prof. Greenleaf**—Yes, that is what I am suggesting: that, where disclosures from this database are justifiable, that should be specifically stated in this legislation—not a catch-all phrase like it is at present. I do not think many people in the Australian community would be comfortable with there being a long or broad list of other organisations who could get access to this database. I think they would want it very tightly confined.

**Senator FIERRAVANTI-WELLS**—You made a point earlier about state governments accessing information. Is that—

**Prof. Greenleaf**—It is the same point. Yes.

**Senator FIERRAVANTI-WELLS**—It is the same point. So when you say ‘another law’, that could be a state or territory law?

**Prof. Greenleaf**—Yes, but I was just pointing out that there was a separate provision here—another provision that caused the problem as well.

**Senator FIERRAVANTI-WELLS**—Sorry—I missed that. What proposed section was that? I thought you said 24.

**Prof. Greenleaf**—No—proposed section 26(2)(b) is what was in my submission.

**Senator FIERRAVANTI-WELLS**—That was the other proposed section to which I referred.

**Prof. Greenleaf**—You are right—it has a lot of the same effect.

**Senator FIERRAVANTI-WELLS**—Yes, and you envisage the potential extension of state jurisdictions. Okay. I asked this question of an earlier witness: do you believe that, as to these issues, if there had been much wider public consultation in relation to this draft legislation, potentially, we would not even have progressed to this point?

**Prof. Greenleaf**—Yes, I do. I do not believe that the department has consulted in any serious way with the major organisations concerned about this legislation, despite some claims that they have done so. And I think earlier disclosure of the PIAs would have brought other issues out as well. But, yes, I think there has been inadequate consultation and inadequate time for all concerned to really deal with the real details. And, of course, that is part of my major point as well that, even now, none of us are in a position to know what this is about, because we do not have the rest of the legislative scheme.

**Senator FIERRAVANTI-WELLS**—And that is your point: we do not have the regulations.

**Prof. Greenleaf**—That is my primary point.

**Senator FIERRAVANTI-WELLS**—Obviously we have heard about the benefits from the various stakeholders, and they have articulated for us both in written submissions and in oral evidence the various benefits. What is the potential, from your perspective and your expertise in the cyberspace ether, for a system like this to be hacked?

**Prof. Greenleaf**—There is always the potential for that. Given how many databases these health identifiers will be the key to, in that many other systems will be based around this number as the primary access key, there may well be very attractive illegal uses that can be made of access to that set of numbers. So, yes, it becomes a very attractive location for unauthorised access. That increases the dangers that are involved.

**Senator FIERRAVANTI-WELLS**—Professor Greenleaf, you told us earlier of your concerns about the provider—now it is going to be Medicare Australia, and yesterday we heard evidence of recent media stories about people snooping and about one in six Medicare staff accessing and spying on confidential client records. Could you elaborate more on your concerns in relation to Medicare Australia now being the platform upon which these health identifiers will reside and the prospect that it then will go to a private provider, assuming, legitimately, you are thinking that there will be some sort of tender process and that, for example, X, Y, Z Pty Ltd comes up with the cheapest tender and becomes the platform provider for the next two years?

**Prof. Greenleaf**—Whether there is a tender process or not, all of this would be happening without the explicit authorisation of the parliament. The parliament's only role would be in the potential disallowance of a regulation that appoints the new service operator. My main concern is just the fundamental one: this is one of the key information systems, might become the key information system, of the whole Commonwealth government. Whether it is or not, it will certainly be the key national information system for just about the most sensitive information that there is in the community—that is, medical information. My main problem is that I cannot see many people in the Australian community being happy about that happening at all. Putting that aside, they will be even less happy to think that it will be a bureaucratic decision as to whether the key data about all of them goes into the hands of a private operator. I just do not think that can be acceptable.

**Senator FIERRAVANTI-WELLS**—My concern is the responsibility. Who is actually responsible for this data as such and the ownership of it? Do you have any thoughts in relation to that? We received your submission late and I have not trawled through it, so I apologise if you have already answered.

**Prof. Greenleaf**—I have not really addressed the question of ownership responsibility. It seems to be set out to some extent in the bill that the system operator will have certain broadly worded security obligations. They would have those anyway under the Privacy Act. They are not terribly specific but they would have the responsibility. I do not think ownership of the data is really all that important a question, but ensuring that there is real responsibility for the security of the data is very important.

As you pointed out, we have the recent example of quite a bit of evidence about an unacceptable level of unauthorised access in Medicare at present. I would be very interested to know whether the Privacy Commissioner is taking any action about that now that it has come to light. Unfortunately, I think we have a

nonfunctioning privacy enforcement system in Australia at the moment because the current commissioner has not made one single determination under section 52 enforcing any right in any complaint either under the term of the current government or the previous government. We do not have a privacy law system that anyone out there in the community takes very seriously. That is a problem when you talk about who is taking responsibility for major systems like this. There are few repercussions if you get things wrong in Australia at present, so there is not as much pressure toward accountability and responsibility as there should be.

**CHAIR**—I am sorry, we do not have any more time. We are running an hour behind because of divisions in the Senate.

**Prof. Greenleaf**—Thank you very much for your time, senators.

**CHAIR**—Senator Mason, I know that you are waiting to ask questions. If you have some questions, you could send them to the Professor. Would you be prepared to look at them, Professor, and get back to us?

**Prof. Greenleaf**—Yes, certainly.

**CHAIR**—That would be really useful if we could get that evidence on record. Thank you for your cooperation.

[6.03 pm]

**ANDREATTA, Mr Lou, Acting First Assistant Secretary, Primary and Ambulatory Care Division, Department of Health and Ageing**

**BIRD, Ms Sheila Margaret, General Manager, eBusiness Division, Medicare Australia**

**DOWLING, Mr Anton, Business Operations Manager, Healthcare Identifiers Services, Medicare Australia**

**FLANAGAN, Ms Kerry, Acting Deputy Secretary, Department of Health and Ageing**

**FORMAN, Ms Elizabeth, Assistant Secretary, eHealth Strategy Branch, Primary and Ambulatory Care Division, Department of Health and Ageing**

**McGRATH, Mr Mike, Director, Health Information Regulation Section, eHealth Strategy Branch, Department of Health and Ageing**

**SIMPSON, Ms Lenore, Branch Manager, Healthcare Identifiers Branch, Medicare Australia**

**THOMSON, Mr Peter, Branch Manager, Information Management, Medicare Australia**

**CHAIR**—Thank you for your patience. We do apologise for the time. You all have information on parliamentary privilege and the protection of witnesses. As departmental officers you will not be asked to give opinions on matters of policy though this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We have the submission. Thank you very much. I expect that you have been following the evidence that we have received. The reason we have asked the department to appear at the end of the hearing, which is standard practice in this committee, is for you to actually look at the evidence and pick up issues. We have a number of questions that we have drawn up from that evidence. Who is going to make an opening statement?

**Ms Flanagan**—We have decided that we will not make an opening statement. We have given you, as you have indicated, a submission.

**Ms Bird**—On behalf of Medicare Australia I would like to make an opening statement. First of all, I thank the committee for the opportunity to provide information and to respond to questions about the proposed role of Medicare Australia as the initial healthcare identifier service operator. Under contract with the National E-Health Transition Authority, Medicare Australia has been working to scope, design, build and test a healthcare identifier system. Medicare Australia was selected to undertake the work because there was an opportunity to leverage, wherever possible, Medicare Australia's existing infrastructure, systems, policies, procedures and experience. This work is nearing completion and Medicare Australia will be ready to operate the service from 1 July 2010, subject to the legislative authority to do so.

Over the last few weeks and over yesterday and today in this committee, there has been considerable criticism of Medicare Australia's privacy record. I would like to take this opportunity to address those criticisms. Firstly, Medicare Australia takes its privacy obligations very seriously and considers that even one breach of privacy is not acceptable. In November 2006 Medicare Australia began proactively auditing staff access to systems as part of our commitment to the best privacy practice. In the first full year of privacy auditing, 290 cases of unauthorised access to records were identified.

**CHAIR**—Is that 2006-07?

**Ms Bird**—The first full year was 2007-08. In that year there were 290 cases of unauthorised access. The following year that was reduced to 140. In the first six months of this financial year 50 cases were identified. The number has reduced significantly over that period as a result of both staff education and also staff understanding that unauthorised access to records will be punished.

Furthermore, more than half of the unauthorised access since 1 July 2008 involved a staff member looking at their own record. This is contrary to Medicare Australia policy and staff are disciplined for doing so. However, this is not a breach of privacy. In 2008-09 there were 70 privacy breaches. In the first six months of this financial year there have been 16 privacy breaches. I am sure the committee will appreciate, therefore, that with some 6,000 staff in Medicare Australia the allegation that one in six Medicare Australia staff breaches privacy is totally incorrect.



Medicare Australia is proud to have received the Privacy Commissioner's grand award for privacy in 2008. We are confident that we have a culture that values and respects privacy and that, as a service operator of the healthcare identifier service, the privacy of individual records will be protected. Thank you.

**CHAIR**—Thank you. When you said that there were 70 and then 16, would they be breaches that would fall under 'incorrect use'?

**Ms Bird**—That would be accessing a person's record without the staff member having the authority or the need to do so.

**CHAIR**—Senator Fierravanti-Wells, I suggest that we look at that issue first. You have been raising it, so it would probably be useful to knock that off as the first issue of business.

**Senator FIERRAVANTI-WELLS**—I have. There was a report in the *Australian*. So what you are saying is that the report in the *Australian* is wrong?

**Ms Bird**—That is correct. The report in the *Australian* is wrong.

**Senator FIERRAVANTI-WELLS**—Did you rebut it in any way?

**Ms Bird**—We provided information to the journalist when she was researching that story that advised that the information was wrong.

**Senator FURNER**—You should not be surprised by that, though.

**Ms Bird**—We provide information as much as we can to journalists and they choose to use that information as they see fit.

**Senator FIERRAVANTI-WELLS**—Is this statement correct:

In a statutory personal information digest submitted to the federal Privacy Commissioner, Medicare reports 948 staff members out of a total of 5887 employees were being tracked on an unauthorised access database as at June 30 last year.

**Ms Bird**—In the period leading up to that—and I am sure Peter can clarify the numbers for me—that was approximately the number of investigations that were undertaken of possible unauthorised access to systems.

**Senator FIERRAVANTI-WELLS**—That is still one in six.

**Ms Bird**—No, that is the number that were investigated. They were not found, in more than half of those cases, to actually have unauthorised access to records.

**Senator FIERRAVANTI-WELLS**—But my point is the fact—and I guess this is really the gist of it—that you have obviously set up this system. The article is headed 'Medicare sets honey pot'. You have obviously had a problem in Medicare Australia because you have seen fit to set up some sort of system to try and find people who are actually snooping. Is that correct or not correct?

**Ms Bird**—I would say that every organisation that provides service delivery to members of the public sets up a system so that it can identify if its staff are inappropriately accessing records so that it can take appropriate action to investigate that and, if found to be upheld, take appropriate action against staff members.

**Senator FIERRAVANTI-WELLS**—Is this the first time you have done it, or have you done it in the past?

**Ms Bird**—November 2006 was when Medicare Australia started proactively investigating staff access. So that has been in place—

**Senator FIERRAVANTI-WELLS**—Right. So you did not do it before that.

**Ms Bird**—Not in that same way. Prior to that, if breaches of privacy were complained about, then action was taken. But this is a systemic, proactive approach to identifying possible unauthorised access to records.

**Senator FIERRAVANTI-WELLS**—So the bottom line is you do have in the current system avenues for breaching. Therefore, it goes without saying that the same would be true of any other system that Medicare Australia would be responsible for, such as this health identifier system. Can consumers and members of the public have confidence that Medicare Australia is not going to have its staff snooping? Can you give this committee that assurance, given the sorts of things that the public has read about Medicare Australia? That is a simple question. It is a question of public assurance and public confidence in Medicare Australia, that your staff are not going to go snooping around, and particularly now with a much more complex system of having identifiers and potentially a much broader pool of information there for them to access.

**Ms Bird**—I think the figures that I provided to the committee speak for themselves in demonstrating that Medicare Australia takes breaches seriously—

**Senator FIERRAVANTI-WELLS**—That was not my question. I am asking you—

**CHAIR**—Senator, if you could just moderate your tone, I would appreciate it.

**Senator FIERRAVANTI-WELLS**—Ms Bird, I am asking you, in your position as head or general manager of your division: can you give the public of Australia an assurance that there will not be breaches if you are given much greater responsibility and, as you would agree, the potential for accessing a greater scope of information? Can you give this committee and the public assurances along those lines? Yes or no will suffice.

**Ms Bird**—When you have staff who have access to systems, it is impossible to give you or anybody else a 100 per cent guarantee that no staff member will ever access somebody's record that they are not entitled to. If I were to give you that assurance today I think I would lose any credibility whatsoever with this committee. However, what I can assure you is that Medicare Australia has education and training in place so that all staff understand what their responsibilities are. All staff get refresher training and all staff receive a message from our CEO twice a year which reminds all staff of their roles and responsibilities. So we have a very proactive education program. We also have the big stick which is our very proactive audit program so that staff know that if they do inappropriately access records then they are likely to be found out and action will be taken in relation to that unauthorised access.

**Senator FIERRAVANTI-WELLS**—What, a rap over the knuckles?

**Ms Bird**—There are a range of actions that are taken. Yes, these range from a rap over the knuckles and also involve demotion, fines and dismissal.

**Senator FIERRAVANTI-WELLS**—Can you take on notice to provide further details in relation to that. In other words, you had 290 in 2007-08 and 140 in 2008-09. In relation to those, can you give us an outline of what sanctions they received, whether they were rapped over the knuckles and the sorts of breaches we are talking about?

**Senator FURNER**—Would that not involve privacy issues?

**Senator FIERRAVANTI-WELLS**—No, I am not asking for the names of people.

**Ms Bird**—We can certainly provide a summary of the actions that were taken.

**Senator FIERRAVANTI-WELLS**—All you need to do is give us the category of person, the sorts of breaches that we are talking about and the sanctions that were imposed on people in relation to those.

**Ms Bird**—Yes, we can provide that.

**Senator FIERRAVANTI-WELLS**—How much will you be charging the department to take over the administration and running of the Health Identifiers Service for two years?

**CHAIR**—Do you have that information or do you need to take that on notice?

**Ms Flanagan**—I am being told by the officials we do not have that, but we can take it on notice and get that figure to you.

**CHAIR**—That is the figure in the contract.

**Ms Flanagan**—Okay.

**Senator FIERRAVANTI-WELLS**—You probably heard the earlier questioning in relation to the responsibility for the data.

**Ms Flanagan**—Yes.

**Senator FIERRAVANTI-WELLS**—Members of the public would be entitled to know who is in charge of this data and who it belongs to. Who is ultimately accountable to my constituents for breaches, problems or if their records are left on a computer in a public place?

**CHAIR**—Under the proposed new system?

**Senator FIERRAVANTI-WELLS**—Yes, under the proposed new system. What is the responsibility trail?

**Ms Bird**—Perhaps I can respond for the data that Medicare Australia as a service operator would hold and then the department can look at the other side. The information that will be stored by Medicare Australia as the Healthcare Identifiers Service operator does not contain any health or clinical data about any individual. The information that the service operator stores is the name, date of birth, gender, address, birth order, whether the person is deceased and dates associated with that.

That information cannot be browsed by any provider, whether it is an organisation or an individual. To access that information, a provider needs to provide information that would perfectly match with the individual's healthcare identifier demographic data. If there is a perfect match then Medicare Australia would disclose the person's individual healthcare identifier to that provider. The information that is contained in Medicare Australia's database for the Healthcare Identifiers Service is essentially owned by the government but access is strictly regulated.

**Senator FIERRAVANTI-WELLS**—Do you own the data?

**Ms Forman**—Ms Bird has talked about the ownership of the data when it is in the database—in the Healthcare Identifiers Service operator. Once the data leaves that database into a healthcare provider's system, they are protected by the same rules, regulations, protocols and processes that control the data flow of information in that organisation, so it becomes part of a record—the identifier would get attached to my record in my GP's surgery—and the same rules that apply to that record would continue to apply.

**Senator FIERRAVANTI-WELLS**—This is the first step in personal e-health records—this bill builds that foundation. You might have heard the evidence that the professor gave earlier. Why isn't the Australian public aware of the whole picture? Did you hear the evidence that the professor gave?

**Ms Forman**—Yes.

**Senator FIERRAVANTI-WELLS**—Do you have any comments in relation to that? Why is this bill not looking at the whole picture, the whole policy that underpins what you are beginning to do?

**Ms Forman**—You are probably aware that there has not been a government decision to fund, design or consult on a national electronic health record as yet. It is one of the key recommendations of the National Health and Hospitals Reform Commission. I am aware that the government has consulted quite widely on these recommendations but, as you have said, the concept of a national electronic health record is very complex and there are a wide range of issues that would need to be consulted on and debated. A lot of expertise needs to be brought in to look at different design options and to look at the privacy impacts. There is a whole body of work that would need to lead towards the development of legislation and a regulatory framework that would apply to electronic health records.

**Senator MASON**—But why should we pass this now? Why should we do that?

**Ms Forman**—I found the evidence yesterday very compelling.

**Senator MASON**—I didn't.

**Ms Forman**—I think the immediate benefits—

**Senator MASON**—Honestly, we take you on trust!

**CHAIR**—Senator Mason, do not talk over the witness.

**Senator MASON**—I have got to go.

**CHAIR**—I am not asking you to leave, Senator Mason.

**Senator FIERRAVANTI-WELLS**—You have obviously increased staff in the e-health area to prepare what is in effect the next stage of the personal e-health record process. Is that the case? What are your staffing levels?

**Ms Forman**—A new branch has been created which has been looking at developing a business case for an electronic health record.

**Senator FIERRAVANTI-WELLS**—How many people are you talking about?

**Ms Forman**—Five? Maybe we can take that on notice.

**Senator FIERRAVANTI-WELLS**—All right. I guess the point that Senator Mason was making is that surely the public has the right to know what are the policy issues surrounding the planned for healthcare record as it considers this bill. That is really the point: you are enacting a very small proportion of what is a much, much broader policy point and this is the point that Senator Mason and certain witnesses were making. Surely the public should be aware of the bigger picture about what these identifiers are going to do before this piece of legislation is enacted?

**Mr Andreatta**—I will address the question. The points made by the witnesses yesterday about this legislation delivering benefits on its own to the health system were very important. It is a foundation or building block to enable the use of health information in the future around electronic health records, e-referrals

and e-prescribing. By itself, it is important legislation that needs to be embedded into the system, and it will take a number of years before it is embedded and government is able to implement an electronic health record system, if it chooses to do so. Yesterday we were told that there was some urgency in investing in e-health. Identification is paramount and it needs to be accurate before any consideration is made of future uses of such identifier functionalities as the electronic health record.

**Senator FURNER**—I think it is important that we establish this issue about public awareness of records. I am wondering whether somebody from the department can answer this: when you go along to a GP or a clinician to get a test or a check-up, how do you know what is on your private record of the history of your health?

**Ms Forman**—Does this question refer to existing records available when you go to your GP at the moment?

**Senator FURNER**—It refers to existing records, yes. When you go to your GP for a check-up, how do you know what is on the record of the history of your health?

**Ms Forman**—My understanding—and Mike will correct me if I am wrong, because he is more qualified in legal matters—is that, as the patient, you would have a right of access to that record to see what information is recorded there.

**Senator FURNER**—I would. But I put it to you: how many people would go along and want to access those records? They have trust enough in the patient-doctor relationship to accept the fact that those records are there and that they are there for the purpose of checking to make sure the patient is healthy. I get the impression that this is a bit of a conspiracy issue—that is, people want to know every detail of what their records are and, if we move one step closer to some form of technology, people are going to be exposed by having those records spread far and wide.

**Mr Andreatta**—It is important to make the point that the identifier system that is to be introduced will not change the way providers exchange information. So you are right: this identifier system is really there to improve the accuracy of medical records and to avoid any mismatching of records, as currently happens in the paper world.

**Senator FIERRAVANTI-WELLS**—The point is that you are not doing this, Mr Andreatta, because you want people to better identify; you are doing this is a first step to the next program, and I take it that the next step is to deliver e-health. Otherwise, are you doing this just for the sake of helping people to identify records? Do you understand my point? You are doing this as part of a much broader program, and you have obviously invested quite a bit of money in it already. The point that Senator Mason and others have made is that surely the Australian public, before it gives its okay to the first steps, should have the right to know what the bigger picture is of where this department is trying to go. That is a simple question.

**Mr Andreatta**—As Ms Forman said, government has not decided on progressing with an individual electronic health record system as yet. It is still under consideration, so we are not able to provide the full scheme information that was discussed yesterday with witnesses.

**Senator FIERRAVANTI-WELLS**—I want to understand why you are embarking on this if you are not going to take the next step, which is e-health and e-health records. I do not know how much you have spent already on this, but obviously quite a bit of money has been spent. I am not saying one thing or the other; I am not arguing pro or anti. I am just trying to understand why you are taking the first step if you have not thought the second and the third steps through.

**Mr Andreatta**—The e-health strategy is a sequential strategy. The building blocks need to be in place before we look at what products or functionality can be rolled out in the future. The emphasis has been on getting those building blocks in place—the secure messaging, the identifier service. That is all part of preparing ourselves for what we can do in the future in e-health.

**Senator FIERRAVANTI-WELLS**—But surely you must know where you want to go to prepare a proper framework to start with. You must know where you are going to go to ensure that what you are building now is adequate for what you are trying to do in the future. I do not understand why you have not thought that through. That is the point that a lot of the witnesses have made in their submissions. It seems to me that you are putting in place the building blocks in isolation from the long term plan. If you think that that is fine and you are happy to spend millions of dollars with this process, say so. That is my point.

**Ms Forman**—There has been quite a bit of thinking and work done around where e-health is headed. While there are a lot of benefits that can be reaped along the way, there are steps in that journey. I think identifiers have been identified by a few of the witnesses here at the hearings, based on international experience, where electronic health records have relied for their accuracy and indexing on a national identifier. We do understand enough about the endpoint to know what needs to be in place as building blocks.

**Senator FIERRAVANTI-WELLS**—So do you have a business case for the next stage?

**Ms Forman**—There was funding provided to the department to develop that business case.

**Senator FIERRAVANTI-WELLS**—So you have the building blocks first, and the business case for the next stage covers how much it costs—and what is that?

**Mr Andreatta**—That is still under way. We are still working on the business case.

**Senator FIERRAVANTI-WELLS**—How much has that cost so far?

**Mr Andreatta**—We will have to take that on notice.

**Ms Forman**—We can get that from the department—the allocation of funds that have gone into the project up till now, is that right?

**Senator FIERRAVANTI-WELLS**—And I would be very interested to know how much you have looked ahead. A lot of this involves specialist IT and, given some of the evidence that we heard yesterday, what specialist skills do you have in the Department of Health and Ageing that will ensure that you will be able to meet your goals? Do you have a plan for e-health in the department? I assume that is where you are heading. Has somebody drawn up a plan for the ultimate route you want to go down on e-health?

**Ms Forman**—We have a national e-health strategy that has been agreed by health ministers, which is the guide to e-health implementation for governments.

**Senator FIERRAVANTI-WELLS**—So you have a general outline. Has somebody worked out what the e-health strategy is going to cost?

**Ms Forman**—There are costings for some elements in the e-health strategy. That is available publicly; it is on our website.

**Senator FIERRAVANTI-WELLS**—And you have the specialist skills in the department of health, which is running that?

**Ms Forman**—We ensure that we recruit specialist skills for each item on a work plan within the e-health branch in the department.

**Senator FIERRAVANTI-WELLS**—Have you got time lines around those?

**Ms Forman**—Time lines for our current work plan? We do.

**Senator FIERRAVANTI-WELLS**—How far into the future have you worked a time line?

**Ms Forman**—You would probably be aware that most governments government departments work on their immediate work plan rather than into some possible work that they might be doing in future.

**Senator FIERRAVANTI-WELLS**—Have you worked on how long you think it is going to take for your e-health plan to be implemented?

**Ms Forman**—The national e-health strategy is a plan that runs over 10 years. I think it was released in December 2008.

**Ms Flanagan**—There is a publicly released plan of what I believe governments have agreed to do. You would appreciate that, in order to enable that to occur, the decisions need to be taken about funding, et cetera.

**Senator FIERRAVANTI-WELLS**—We have heard a lot about plans. At the last estimates I asked about health plans and I asked specifically to have a document produced. That is why I am interested, rather than the big picture, in how far you have progressed—in something concrete rather than just some grandee health plan. I want to understand what concrete point you are at, how much money you have expended, how much money you are going to expend and where you are going.

**Ms Flanagan**—As of today, it is very clear where we have got to—the intention to introduce this legislation and put in place the unique identifier. I think witnesses have already indicated that, even if we stopped there, there would be particular benefits—even just in having that particular building block in place. If we move to an electronic health record, there will need to be legislation when we move to the next stage or

stage 3—I do not know where on the plan that would be. At that time it will be much clearer. What it might look like will be more fleshed out. But we have to do the preparatory work within the department to move to that next stage. As of today, we have an important building block that needs to be put in place and that has its own benefits. That is what the committee is considering. We can get you the publicly released plan on the e-health strategy, which, as Ms Forman says, goes out 10 years, but you would appreciate, as we have just discussed—

**Senator FIERRAVANTI-WELLS**—Yes, that is the broad brush. That is fine.

**Ms Flanagan**—Decisions need to be taken along the way, you would appreciate.

**Senator FIERRAVANTI-WELLS**—I am more interested in concrete planning. Yesterday some evidence was given about funding of the system. You may have heard the evidence of the AMA and other people who attended yesterday. Obviously software vendors, doctors, specialists and other medical professionals are going to have to invest in such a system. Do you envisage that the government will be helping them or will they be out there on their own? How is the system going to be funded? Is it envisaged that they will be compensated for taking up a new system?

**Ms Flanagan**—There was some interesting discussion on costs yesterday. Our view is that it will vary significantly depending on the type of organisation, the type of systems they will be using, the size of the organisation and the approach they will be taking to adopt identifiers. Upgrades of systems are pretty much par for the course for organisations that are using IT systems to administer their services and to maintain patient records, so the introduction of identifiers may well be picked up as part of that regular upgrade process. It is an issue on which we are continuing to have discussions. We have programs within the department that we have been using for a number of years to assist the primary care sector to adopt and improve their capability in e-health.

**Senator FIERRAVANTI-WELLS**—Yes, one was the PBS. It was referred to, I think, by one of the organisations that you helped incentivise uptake of those things. I guess what I am asking is: what assurances will these vendors, doctors, specialists and other medical professionals be given as to how the system is going to be funded? Is that something that you are planning?

**Ms Flanagan**—It is an area of further consideration and consultation. I think as we—

**Senator FIERRAVANTI-WELLS**—It is new, so you are not sure whether you are going to fund it, they are going to fund or it will be a bit of both?

**Ms Flanagan**—That is right.

**Mr Andreatta**—Senator, it might be worth noting that there is already an incentive in place for e-health take-up for general practice providers. They are incentivised to adopt some of the building blocks for future use of e-health—for instance, secure messaging and encryption products on their software. So we are already at this stage incentivising practices to improve their software and systems to take advantage of what is coming around the corner.

**CHAIR**—Mr Andreatta, in evidence yesterday, though I just cannot remember which evidence, we were told of the very high percentage of medical practices that now have—it could well have been the AMA who talked about it—

**Senator BOYCE**—No, it was the Privacy Commissioner, and they were going to give us more information about other professions.

**CHAIR**—We were told of the extraordinarily high level—

**Senator SIEWERT**—It was 98 per cent.

**CHAIR**—of medical practices that already have e-health provisions in their surgeries. I think it was said that only the ‘conscientious objectors’ are still holding out—I remember that term very well.

**Mr Andreatta**—I think it is almost 100 per cent in reality.

**Senator BOYCE**—We were given a figure of 98 per cent.

**CHAIR**—My understanding is: that was a result of a long-term government process, over a couple of governments, to incentivise. Is that right?

**Mr Andreatta**—This is our third iteration of the IT incentive in the Practice Incentives Program. In future we will be lifting the bar to provide further incentives when new requirements are needed in general practice

software. We are always looking to see what needs to be in place and aligning our incentives around those requirements.

**Senator FIERRAVANTI-WELLS**—You may have heard the evidence of Professor Greenleaf, before—and we touched on this yesterday—on the provisions allowing for disclosure for purposes authorised under another law. Professor Greenleaf spoke of the Privacy Commissioner telling us—and you may have heard the evidence of the Privacy Commissioner yesterday—that it was stock standard. But, because we are dealing with personal health information, do you have any comments in relation to what the professor said, the concerns he raised and the potential for function creep? I do not know if you have a copy of his submission, but he was particularly concerned about function creep at state and territory level. Do you have any comments, Ms Forman?

**Ms Forman**—I do. The provisions you referred to were included in the legislation because they are standard provisions in the Privacy Act, which does apply to very sensitive information. I am not sure that there is a strong argument for the healthcare identifiers to deviate from that. I understood the professor's concern about state and territory legislation. There are also protections in our national partnership agreement, which sets out the governance arrangements between the jurisdictions and the Commonwealth for the Healthcare Identifiers Service which would limit any state legislation trying to override the healthcare identifiers bill. Do you want to add anything, Mike? I probably have not covered it all.

**Mr McGrath**—No, that is fine.

**Ms Forman**—You also asked about scope creep, which has cropped up periodically in questions. In response to public consultations that we held, the bill has been drafted to be very narrow and focused on the healthcare sector. Earlier there was some reference to the provisions about research. That is only research that has been approved by a human ethics committee. In some cases the identifier is required for that type of research. For example, clinical trials require the identity and the patients must consent to their information being used. In those situations the identifier can form part of the information. The bills have been very tightly drafted and there would need to be further legislation to expand the scope of the identifiers beyond the healthcare sector. That would be exposed to the same sort of parliamentary rigour as this bill.

**Senator FIERRAVANTI-WELLS**—Ms Forman, there has been some criticism of the department about the consultation process. Do you have any comments in relation to that? Do you think it has been adequate?

**Ms Forman**—Are you referring to the comments that it was not public enough?

**Senator FIERRAVANTI-WELLS**—Various evidence has been given today on this and, in a nutshell, if more members of the public were aware of what is about to happen would they be as supportive of it? Do you think that you have consulted sufficiently?

**Ms Forman**—Both rounds of consultation were advertised in the national newspapers and I recall that they were picked up in press articles as well. The documents that were being consulted on were released on our website, NEHTA's website, and we circulated to a mailing list of around 300 stakeholder groups, quite a number of whom are consumer representative groups. Those consumer representative groups did send information to their individual members who are in fact consumers and other consumer organisations that consulted their members, so we did feel that we went quite widely. We did receive a number of submissions from individuals who had an interest in applying. We have also had quite a bit press and we are responsive to the letters that have been in the press, that we receive relating to issues around the identifiers.

**CHAIR**—Ms Forman, could we get a copy of the advertisements and the schedule? It would be very useful to see what the schedule—

**Ms Forman**—Absolutely. The list of organisations—

**CHAIR**—That would be useful. In terms of just addressing the issue of consultation, we would like to see the advertisements and where they were held—

**Senator FIERRAVANTI-WELLS**—I am interested in national papers—whether it goes to the *Australian*. Did it go into the *Daily Telegraph* or something like that?

**Ms Forman**—All the national broadsheets in every capital.

**Ms Flanagan**—It is amazing when you think that you have tried to give every opportunity to publicise that there is consultation on the issue how many times you hear people say, 'But we did not know about it.' We try very hard to make these highly consultative processes effective because we know that is the best way of getting good policy and the best way of getting support.

**Senator FIERRAVANTI-WELLS**—I appreciate that, Ms Flanagan. We have heard evidence and I am basing my comments on that evidence.

**Senator BOYCE**—Ms Bird, you would have heard evidence I think this afternoon suggesting that individuals should be advised when a health identifier is issued on them. Is that possible?

**Ms Bird**—The design at the moment is that all individuals that are on the Medicare Australia or the Department of Veterans' Affairs database will automatically be assigned a Healthcare identifier. What the committee has not been made aware of, I think, is that individuals will be able to access that identifier themselves and they will be able to access that identifier through web services via the telephone or face to face at a Medicare Australia service centre.

**Senator BOYCE**—How will they know to do that? How will they know what the number is if they have not been advised that they have got one?

**Ms Bird**—They can contact to find out what their number is.

**Senator BOYCE**—Over the internet?

**Ms Bird**—Yes.

**Senator BOYCE**—As well as well as by phone and in person?

**Ms Bird**—Yes.

**Senator BOYCE**—What about the issuing of health identifiers to people who do not have Medicare cards?

**Ms Bird**—Where a person does not automatically receive a healthcare identifier, they can apply to get a verified healthcare identifier via a Medicare Australia service centre. They would need to provide evidence of their identity and they would be able to have a verified identifier allocated—

**Senator BOYCE**—But can a health identifier be provided to someone who has not asked for it?

**Ms Bird**—They will only get one automatically if they are on the Medicare database or the veteran's affairs database. If they are not picked up in that process, then they will be able to get an identifier in one of two ways. They can apply to Medicare Australia for a verified one, and that would only be on their application, or if they are having an episode of health care the healthcare provider can allocate the person what is referred to as an 'unverified health care identifier' that that person will be able to use.

**Senator BOYCE**—It is like a temporary one.

**Ms Bird**—Yes. They can then have that identifier verified by providing the appropriate evidence of identity through Medicare Australia.

**Senator BOYCE**—How would people know that they had an identifier? I know you are saying that everyone automatically gets one if they are on Medicare, but where are they told that?

**Ms Flanagan**—My colleagues tell me there will be a communication strategy.

**Senator BOYCE**—Oh good; do tell.

**Ms Flanagan**—They can possibly provide more detail than that statement.

**Ms Forman**—There is a team that was formed some time ago of communications experts from each of the state and territory jurisdictions, from the Commonwealth and from NEHTA. Medicare staff have also been involved in developing a communication strategy and plan. The intention is that people will be informed. That may not necessarily be by a direct mail but could be posters and pamphlets at healthcare providers. That plan is still being developed and finalised.

**Senator BOYCE**—When would that start, Ms Forman?

**Ms Forman**—That is a good question. I do not have the date but I am sure there will be information out there.

**CHAIR**—Ms Forman, is that a COAG thing? Has it been formed for the COAG process that actually endorsed the e-health strategy, or is that specifically on the HIA?

**Ms Forman**—This communication plan is specifically for the healthcare identifiers.

**CHAIR**—Who does that report to? Is that part of DOHA?

**Ms Forman**—That group reports back up through the same line of the bar of committees we have that run back to COAG.



**Senator BOYCE**—To the ministerial council?

**Ms Forman**—At the moment it is reported back up to the AHMAC.

**Senator BOYCE**—If you could tell us what the date for that would be, that would be good.

**CHAIR**—Can you tell us who is on it? You can give that to us on notice. If you could give us as much information as you have on the communication strategy and confirming that there are going to be representatives from every state. We would like a nifty answer about the communication strategy to the best of your knowledge. That is what you are after, Senator Boyce?

**Senator BOYCE**—Yes, the start date and that sort of thing. I think people have a right to check what is there, and to do that they have to know it is there. What is the business arrangement between Medicare in being the platform manager for the next two years?

**Ms Bird**—There will be an operational contract signed between Medicare Australia and NEHTA.

**Senator BOYCE**—Why is it for two years?

**Ms Bird**—Because the legislation says so.

**Senator BOYCE**—So I suppose I am back to: why does the legislation say so?

**CHAIR**—And we know you cannot answer that question.

**Ms Forman**—Could I just clarify that the contract will be in place for two years because I think that is the period that NEHTA has received funding for the operation of the service.

**Senator BOYCE**—Except that we have a review that is different and does not go over two years. There have been some quite legitimate concerns expressed about who might end up being the platform manager after two years if it is not Medicare. There are concerns out there, so that is why I am asking you: why two years? If anyone can, within the confines of their abilities to do so and of being allowed to do so, tell us why it was two years, particularly given the fact—

**CHAIR**—Senator, I am just going to step in now. We are running out of the time and that goes beyond the ability of the officers to answer. We can put your question through to the minister's offices.

**Senator BOYCE**—Let's do that, especially given that the rollout probably will not even be finished in two years. It seems an unusual period.

**Mr Andreatta**—With the introduction of the identifier service, it is anticipated that it will take around 18 months to bed in before the bulk of the population will be assigned the identifier. When we say two years, it will not be reporting or reviewing in two years, it will be a following year after. What we anticipate doing is reviewing the whole system given that all the population has an identifier and the system is fully operational. It is an opportunity to take stock and review the operation itself including the service operator role.

**Senator BOYCE**—Can you understand that that causes concern?

**Ms Flanagan**—Senator, I do not think it is anything about Medicare Australia.

**Senator BOYCE**—No, I am saying that people are concerned it could be other than Medicare Australia; that is the point.

**Ms Flanagan**—There are other reasons why it has been decided to structure it in terms of what Mr Andreatta has said. Those are the reasons why we are doing it. It is not about us possibly looking around for another service provider at that time.

**Senator BOYCE**—Could we have some details on that contract when they become available, please?

**Senator FIERRAVANTI-WELLS**—On the same point I am conscious of the line of responsibility. The contract is with NEHTA and Medicare Australia. NEHTA of course is a body that has been set up with membership of the Commonwealth government and state governments. I am conscious of the continuity component and, in relation to some of the questions I asked before about ownership, I am a little bit confused. Can you just take that on notice and explain to me the legal liability issues associated with that arrangement?

**Senator FURNER**—Your submission is appropriately referenced to a number of statistics I wish to refer to. I would like you to elaborate on things like 18 per cent medical errors as a result of the introduction of the bill and further on down the track there will be a saving in that area; a conservative 10 per cent reduction on messaging costs, and overwhelmingly from yesterday's evidence, an enhancement of safe and efficient lifesaving outcomes. Can you just expand on those references and, based on the evidence we heard yesterday, on the positive outcomes of these bills?

**Mr Andreatta**—We can table the details of those statistics referenced in the submission if you would like. They basically give you the background to what the statistic refers to and referenced to the complete document.

**Senator FURNER**—Is that consistent with what you already have in your submission?

**Ms Forman**—In our submission we did not actually provide the source references, so this provides those.

**Senator FURNER**—That is the same as what is in your submission and I already have that in front of me. I was hoping you would be able to elaborate further on what I have already seen and heard.

**Ms Flanagan**—In terms of the evidence that was given yesterday about the benefits of having this new identifier, Jane Halton the secretary was going to be here tonight but she was called away to another meeting, so at the last moment I got deputised to do this. She received an email from somebody yesterday who had been listening to the evidence. He provided a real life example of his father who was 86 years old with type 2 diabetes. This goes to privacy issues about the fact that his father is in a major university teaching hospital with pneumonia. He says that the care provided in the hospital was absolutely excellent. He has been an inpatient for four weeks and, because of the manual systems in place, there is very little security and privacy about his father's medical history. As we would all know, if we have been in hospitals, the records are frequently open and available in nurse bays, they are left on trolleys and they are often stuck to the end of the bed so that anybody can see them. They indicate the patient name, location, type, diet and other personal information. That is not the fault of staff, of course; that is the way that the paper system operates at the moment.

I think that evidence was also given yesterday about the varying quality of the handwriting of some of our clinicians working in hospitals. This man thinks that it would be very easy at the moment to gain access to information without consent or authority and that an online system with security and PIN access would allow an audit trail and more readily detect unauthorised access. The secretary wanted to talk about a personal example that was brought to her attention and outline what she thinks and what the benefits of this identifier will be.

**Senator FIERRAVANTI-WELLS**—Senator Adams has asked me to place a question on notice with you. Clause 8 of the bill refers to the meaning of 'national registration authority'. This appears in our briefing papers at page 51, which says that from 20 July a national scheme is to be established for the registration of health practitioners in 10 professions—medical, nursery, midwifery, pharmacy, physiotherapy, dental, psychology, optometry, osteopathy and chiropractic. A further four professions—Aboriginal and Torres Strait Islander health practice, Chinese medicine, medical radiation practice and occupational therapy—are expected to be added to the scheme in 2012 and other additional professions may be added in the future. The submission by the Medical Software Industry Association asks:

Why are we waiting until 2012 for Aboriginal and Torres Strait Islander Health Practices when the Closing the Gap initiative focuses on that area and starts on July 1?

Senator Adams would like to place that question on notice with you.

**Ms Flanagan**—We will take that on notice. That is my area of responsibility, so I can deal with that.

**CHAIR**—I thank the officers and apologise for holding you up. Ms Bird, you did not put on record the fact that Medicare won a privacy award for its proactive work in privacy. It looked at all the processes in place. I thought it was very important and I put on record that I have raised these issues of Medicare's privacy record in a number of inquiries by this committee. Also, we have a number of specific questions to place on notice that have emerged from the evidence and we will give you those this evening. Because of the inquiry's tight reporting time frame, we really need the answers by tomorrow, if possible, as we have to report on Monday.

[7.03 pm]

**GIBSON, Mr Mark, Manager E-health Services, Health Information Exchange, GPpartners and Brisbane South Division of General Practice**

**SILVESTER, Mr Brett, Deputy Chief Executive Officer, GPpartners and Brisbane South Division of General Practice**

**CHAIR**—Good evening and thank you for your patience. You have received information about the protection of witnesses and information. We have received your submission—thank you very much. Would either or both of you like to make an opening statement?

**Mr Silvester**—Certainly. Firstly, I would like to thank you for inviting us to appear. Today I am representing GPpartners, which is a division of general practice in the northern suburbs of Brisbane, as well as Brisbane South Division of General Practice, which is a division of general practice in the southern part of Brisbane. Together we support about 1,000 GPs, who service somewhere in the order of one million patients.

We support the introduction of national health identifiers. We have been delivering nationally recognised e-health programs for about five years. This has come out of the Brisbane South HealthConnect work and also the GPpartners coordinated care trials.

Chronic and complex patients are using more and more of our resources. We also know that chronic and complex patients require multi-sector, multidisciplinary team based approaches to plan and provide their care. It is essential to share information between the members or the team who are providing these patients' care—this is an essential component. Today we run a shared electronic health record system that links providers like GPs, community healthcare organisations, public hospitals and private hospitals. It delivers services to patients—team-care patients, Department of Veterans' Affairs veterans, aged-care residents, Queensland Health patients, Medibank Private patients et cetera.

Some of the key elements of a team based approach to care are a need to coordinate health services and you have to have some information infrastructure which underpins the coordination of those health services. Some of the key components of that information infrastructure that we have are shared electronic health records, patient consent and privacy. We also have providers who are securely connected. It is really important to be able to identify the providers and the patients. We are ready to adopt a national identifier so that we can really coordinate care for patients. Thank you.

**CHAIR**—Thank you, Mr Silvester. Mr Gibson, do you have anything you would like to add?

**Mr Gibson**—No.

**Senator FIERRAVANTI-WELLS**—In your submission you observe that many projects:

... can fail at the point of implementation due to human and social factors. We recommend that **early demonstration projects** be suitably funded to showcase the potential for eHealth ...

Funded by whom? And do you have any sorts of demonstration projects in mind?

**Mr Silvester**—We are implementers. The passage of the bill is for you guys to deal with. We are being funded to do things like Closing the Gap programs for Indigenous populations. We are being funded to deliver chronic disease programs so we try to link better delivery of healthcare services and use this as an information infrastructure. You asked who should lead it. We think the ones who are actually delivering some sort of community based healthcare services.

**Mr Gibson**—A key part at the start of your question related to the failure of projects. Our view would be that it is the change management. How do those projects get accepted in the community by general practice and different organisations that need to collaborate, interact and work together? There is a lot of community based change and the fear of technology has to be overcome when you introduce technology. When we introduce shared electronic health records, our view is you have to work with various aspects of connectivity at the front line. You have to work with clinicians to look at their work practices and what happens in their practices, the sorts of impacts you have to have and make sure that the changes you are going to bring about are managed in a way that fits in with their normal practice so they will use what you provide and it will be effective. The area we are highlighting is that change management needs to be emphasised in terms of going forward and the funding for that is often ignored in projects. We believe by doing change management a lot of lessons can be learned in key exemplar projects. Then those lessons learned can be transferred to other parts of Australia and scaled to a national approach.

**Senator FIERRAVANTI-WELLS**—Are you saying that the government should fund those?

**Mr Gibson**—In simple terms, yes, we are saying the government should be funding those at this stage.

**Senator FIERRAVANTI-WELLS**—Okay. Earlier you may have heard some of the questions that I asked about assurances about how the system should be funded. I did not quite get the sort of straight answer that I was interested in, but I guess that, from your perspective, those are the sorts of assurances you would want. The cohort of people who are going to have to implement the new system will take up new systems. Would you be looking for full compensation or, if not full compensation, at least some part involvement? In other words, if you have this new system and the government says, 'That's great; we'll provide the framework but it's over to you,' how much, at the coalface, do you think people are actually going to uptake—do you see what I am getting at?

**Mr Silvester**—The benefits of better health care systems are actually to do with the patient, and what we all have to be focused on is better health outcomes. You have to derive the benefit from the healthcare program, so, ultimately, my opinion is that the healthcare programs themselves should fund their use of the healthcare infrastructure, much like a hospital currently funds its use of water or power. So, we need to get to the tipping point where everybody relies on that, and we are suggesting that you do need to fund e-health separately until you get to the point where it is business as usual.

**Mr Gibson**—Part of this is going to be: what are the sources of funding and how do funds manifest in the community to get e-health going? Public health organisations have a density of funds that they put into infrastructure, so hospitals will have IT systems and e-health systems being built. In the community it is much more fragmented. The density of funds is not high so the uptake is very low, and it is a challenge for us and other organisations as to how you start to take this up. So you do rely on sponsorship out of DOHA for community based infrastructure to initially kick-start these sorts of projects. There are various tools and mechanisms for doing that, but our belief at this early stage, where we are still trying to understand what sorts of things will work in the community, how uptake will work, what sort of change management, work practices are going to be adopted—there is a lot of experimental discovery to go on as to how that will work best in the community, and that represents a high risk. I do not think the private sector would be prepared to go into that uncertainty, so we rely on government funding and DOHA funding to get those initial projects going. That is why I said that I believe it needs government funding for those initial projects.

**Senator FURNER**—You indicated in your introduction that you have been in operation for five years with your e-health outcomes. Why was there a need to commence that program?

**Mr Silvester**—One of the major reasons is that we ran a coordinated care trial funded by the Department of Health and Ageing. We were able to show that we could reduce hospital admissions. Today we run programs funded by Queensland health and by Medibank Private and, in the past, by departments of veterans' affairs to do what is called 'coordinated care'. We call it 'team care'. That means they have a care team and if you manage someone well in the community they do not have to go to hospital as much. A fundamental thing we found as we did that was that you must share information amongst the team providing that care, so we then had to build shared electronic health records or a way of sharing summaries amongst the team so that they were all informed and they could actually participate in that care.

**Senator FURNER**—You indicate you have a million citizens. Is that a million citizens on your books?

**Mr Silvester**—We do not have a million citizens on the shared record.

**Senator FURNER**—How many do you have on the shared record?

**Mr Silvester**—They come in and go out, as you can imagine. When you do aged care patients they tend to exit. Right now at any one time we have about 2,000 and that is because our funding comes from the clinical programs that they support. So we cannot take on patients who are not already in one of those funded programs because we do not get e-health funding at the moment.

**Mr Gibson**—They are high-care complex patients who see multiple providers on a regular basis.

**CHAIR**—They are active patients?

**Mr Gibson**—Yes.

**Mr Silvester**—Typically, results from that system going back last year show we have about 15 accesses a year and about—

**Senator BOYCE**—That is 15 provider accesses?

**Mr Silvester**—Yes, about 15 accesses. That is fairly consistent with a patient who sees a doctor or who has a health service more than about once a month.

**Senator FURNER**—You also indicate in your submission that the introduction of e-health will facilitate increased privacy and better privacy transparency. What do you mean by that statement?

**Mr Silvester**—First of all I will talk about identification of the provider. We need to be absolutely sure that the person who is connecting to our system is a validated provider. So we absolutely need provider identifiers. Today we are using the certificates issued by Medicare Australia as a proxy for our identification of providers. But we would like something which is stronger—we would like to have even better provider identifiers.

The second one is that when you transfer something from one provider to another you need to be absolutely sure of the patient's identification. Anything which can make that identification better and easier is a good thing for the patient. The third thing is that we also want to give the patients access to this type of information, so what are we going to use to give them access? Technically, we could use the Medicare card number today but legally we cannot. What we need is something that we can legally use to actually pass information between the providers and also to the patient.

**Mr Gibson**—We make that statement, too, based on the fact that our current system came out of the health connect trials some four years ago, and it was part of the design that complied with that. Within that, it had the ability to capture patient records, to identify the provider organisation through the certificate that provided that and to log it; any accesses on that record are also logged and able to be seen so that patient records being accessed are logged in the system and a patient or a provider can see who has access to those records. Our experience is that the tightness of and the approach to that design has told us that you can manage privacy, and the same principles are now being talked about for the national e-health approach.

Our view is that once you have a system like this your privacy transparency—the ability to test and validate that privacy is being maintained: who is looking at records and what activity there is on the records—is increased. In a paper world it is not—you do not know who has read a piece of paper. The system that we have was based on that health connect design at that time and it incorporated those sorts of features, so our system runs that way at present.

**Senator FURNER**—During that five years have you identified any privacy breaches at all?

**Mr Silvester**—No, we have not.

**Senator BOYCE**—None at all?

**Mr Silvester**—No.

**Senator FURNER**—I think you were present in the room when Medicare was here and you heard their record of going from 290 down to 50 recently—have you actively gone out to see whether there are any breaches at all?

**Mr Silvester**—Sure. We have a health information manager and we also have automatic scripts every night which actually use the access logs as a mechanism. We send notifications back to the GP.

I will take that back a step: in the initial design we had roomfuls of consumers and we asked them these questions: 'We can log the access; do you want access to that?' They told us that they wanted to be able to get access to it if they needed to. We said, 'Is it okay if your provider can get access to the logs and provide that to you on your request?' They said that was exactly what they would prefer.

We went further than that. They actually wanted notifications to go back to the provider if there was a breach, so right now if someone accesses a record of a patient—let's say an emergency department in the Royal Brisbane Hospital accesses a patient's record—overnight the scripts will run and actually send a notification back to that patient's GP that that patient has likely entered the emergency department at Royal Brisbane Hospital. We are using those logs for healthcare purposes, but there is automatically a notification back to other providers that have been accessing it.

**Senator FURNER**—Just one last question: who provided your software for the program?

**Mr Silvester**—The software which was provided by us has a long history—

**Mr Gibson**—I was involved at the time with a cooperative research centre that won the contract under the HealthConnect project to develop a technology for one of the HealthConnect trials that was done jointly with Brisbane South, Queensland Health. The technology developed out of that was being commercialised into the market through an organisation, Extensia, that now provides the support services to the technology. So the

technology came out of the cooperative research centre funded by DOHA and Queensland Health under the HealthConnect trial.

**Senator BOYCE**—Is that software used by other practitioners, other groups, other divisions?

**Mr Gibson**—Yes, I believe it is used in Western Australia and elsewhere in Queensland and, I think, probably Victoria as well.

**Senator BOYCE**—How long did it take you to get the glitches out?

**Mr Silvester**—A good question.

**Mr Gibson**—How long would it take us to do it again?

**Mr Silvester**—We were lucky that about a number of years ago we received about \$200,000 of ITOL funding. They gave us some money and it took us about 12 months, even after that software was developed, to get to where we considered it ready to be rolled out. The test data works perfectly; it was when we started to use live data that we really had the problems. The problems were not with the software, because if you took good data and fed it in it worked every time—

**Senator BOYCE**—Rotten people went and mucked it up again for you, did they?

**Mr Silvester**—The real world was not like that. The test lab stuff worked perfectly, but the real world did not.

**Senator BOYCE**—Does it concern you at all that there is as yet no developed software whatsoever for the health identifiers which are supposed to start rolling out in July?

**Mr Gibson**—It does represent a concern to us and we are certainly keen to see activity that would cause that momentum. However we have been looking at the adoption of the health identifier in our environment for over 12 months now and we have been looking at different ways that we would start doing that, and we believe that with some of our current technology and some of the products on the market we could start to adopt that in general practice and start that process. We believe that with the right incentives industry over time will start to provide those functions. But if industry were to provide that today, we would probably still take 12 months or more before you would see that cycling into general practice and being taken up. So our view is to say: how would we start today with what will already have to start that process; but then to take on new technology and updates on that software over time to allow more of those functions to occur. So we have looked at different ways that we can start that process and we are ready to start that process in our community with what we have done so far now, as soon as we have the ability to start receiving those identifiers and start incorporating those into current general practice processes.

**Senator BOYCE**—So you would want to be using with your existing software or are you looking at attempting to tender for software contracts with NEHTA in this area?

**Mr Silvester**—We had been in discussions with NEHTA and have been working with them for about 12 months. We want it; we need it. If there is not a national identifier, we have to create local identifiers. We have no choice.

**Senator BOYCE**—But you would be hoping to provide software nationally?

**Mr Gibson**—We would source systems and software from others but deploy and implement those with the change management across our community. We have put our hand up to be an adoption site or an initial site for taking the health identifiers and starting to incorporate and implement that. There will be a whole lot of lessons that come from that in terms of practices to be shared.

**Senator BOYCE**—Mr Fleming gave us a list, verbally, of sites that would be starting to do different aspects of the project, and he mentioned one in Brisbane. Are we talking to the people who will be doing that test?

**Mr Gibson**—I believe so and hope so, yes—to the best of our knowledge, and I will have to confirm that with Peter.

**CHAIR**—Thank you very much, Mr Gibson and Mr Silvester. We do appreciate your submission and your interest and, again, I apologise for keeping you later than you had planned. We are due to report on this issue on Monday before three o'clock. I would like to thank Hansard again for holding you up well over the time you thought you would be finished, and I thank the senators for their patience.

**Committee adjourned at 7.25 pm**

