National Rural Health Alliance Response to the Draft National Health Information Strategy - Framework

Introduction

The National Rural Health Alliance commends the Australia Health Ministers' Advisory Council (AHMAC), via its Health Services Principal Committee and the Australian Institute of Health and Welfare (AIHW) on providing a draft of the National Health Information Strategy – Framework (the draft Framework) and welcomes the opportunity to provide a response.

The National Rural Health Alliance (the Alliance) is comprised of 44 member organisations. The Alliance is committed to improving the health and wellbeing of the almost 7 million people living in rural, regional and remote Australia. Our membership is diverse and geographically dispersed and this reflects the complex nature of rural health. Members include consumer groups, Aboriginal and Torres Strait Islander peak body organisations in the health sector, health professional organisations and service providers. For a full list of our members see Appendix A.

In this response to the Draft Framework, the Alliance mostly agrees with the proposed opportunity focus areas to improve health and wellbeing outcomes and access to health care for people living in rural regional and remote Australia.

The Alliance supports that the National Health Information Strategy (NHIS) is important in providing a unified direction for the health and disability sector to make better decisions about how to improve the quality and availability of health information. The Alliance would like to draw AHMAC's attention to the following four priority opportunities with a focus on rural and remote communities:

1. Data are used to drive better services and better health outcomes
2. Data are fit for purpose
3. Data are accessible
4. Health information structure is agile and innovative
5. Data support improvements in Aboriginal and Torres Strait Islander Peoples health

Data are used to drive better services and better health outcomes

The National Rural Health Alliance would welcome having access to data sets that can be analysed readily according to measures of remoteness, thereby allowing for better planning of health services that will lead to better health outcomes for those in rural, regional and remote locations. At present, there are two main classification systems, firstly, the Australian Standard Geographical Classification-Remoteness Area (ASGC-RA) is a geographical classification which defines locations in terms of remoteness, i.e. the physical distance of a location from the nearest Urban Centre;[1] secondly, the Modified Monash Model (MMM), which defines whether a location is a city, rural, remote or very remote on a scale of MM 1 to MM 7, with MM 1 being a major city and MM 7 being very remote.[2]

[1] Australian Institute Health and Welfare Remoteness classification (ASGC-RA) N. [Internet]. Canberra: AIHW; n.d. [Cited 2020 March 26]. Available from: https://meteor.aihw.gov.au/content/index.phtml/itemId/466873.

[2] Department Health. Modified Monash Model. [Internet] Canberra: Australian Government; 2020. [Cited 2020 March 2020]. Available from: https://www.health.gov.au/health-workforce/health-workforce-classifications/modified-monash-model

Having data sets that use consistent classification systems would allow for greater comparisons between data sets, which could be recommended as part of this NHIS framework.

Data are fit for purpose

The Alliance supports the vision of the draft Framework that data quality is fit for purpose, measurable and comparable so that maximum value can be made of the information sources.

Internationally, there is a growing realisation that a single electronic health record (EHR) that ties together everything in one physical repository is not a practical nor an affordable solution. The more successful overseas models are adopting 'distributed' EHRs where information can be spread throughout many different physical information systems[3] [4]. Information can be linked and can be referenced electronically, so that when a clinician is making a decision about care, relevant and appropriate information about the patient, and what has been done in the past, is readily available at the point of care.

In rural and remote health care settings, there are many added barriers unique to EHR implementation such as, prohibitive costs of many EHR systems/ limited access to capital and infrastructure, access to EHR vendor information and technical assistance, the suitability of EHR products for rural health care settings, connectivity difficulties, limited health information technology workforce, limited opportunities for collaboration with other rural health stakeholders and limited buy-in from rural practice/ hospital/ health centre staff with multiple roles and busy schedules[5]. The Alliance envisions that EHRs should be distributed at local, regional and national levels. The priority focus should be on communication and connectivity required for the health and disability sector to use and share this distributed information in a manner that leads to better health and participation outcomes for rural and remote Australia.

Data are accessible

Improving the consumer and carer experience of the health care system—to ensure the care received is timely, is consistent with treatment needs and does not impose undue burden on either the consumer or their carer—is an outcome that the Alliance would welcome. The Alliance notes that while the draft Framework identifies the need to make data accessible, it needs to expand on what building blocks are required to have in place to create a more effective and efficient working solution. The current disparity in access to health care in rural areas needs to be urgently addressed if this goal is to be met and the Alliance has concerns as to how this will work in a rural setting.

Health information infrastructure is agile and innovative

The Alliance recognises and supports the draft Framework's priority to make the health information infrastructure agile and innovative. As the rest of the world rapidly catches up, we need to rise to the next round of information system challenges for improving the health and wellbeing of rural and remote Australia. In addressing new and innovative opportunities for information systems to

[3] Adel, E; El-Sappagh, S; Barakat, S and Elmogy, M (2017) Distributed electronic health record based on semantic interoperability using fuzzy ontology: a survey. Int. J. Computers and Applications. 40(1):1-19. DOI: 10.1080/1206212X.2017.1418237

[4] Li, Z; Roberts, K; Jiang, X and Long, Q (2019) Distributed learning from multiple EHR databases: Contextual embedding models for medical events. J Biomed Inform. 92:103138. doi: 10.1016/j.jbi.2019.103138.

[5] Mason, P; Mayer, R; Chien, W.W and Monestime, J.P (2017) Overcoming barriers to implementing electronic health records in rural primary care clinics. Qualitative Report. 22: 2943-2955.

contribute to improving health outcomes, we need to realise that in rural and remote communities, different parts of the sector have very different levels of information systems capability.

In rural and remote areas, the not-for-profit providers of alcohol and other drugs, mental health services and disability services and sole allied health practitioners tend to have less digital capability than General Practitioners and local health districts (LHDs) operating acute care services, which are comparatively well computerised in delivering clinical services and for administrative processes. Unless, the different parts of the health and disability sector have comparable information systems capabilities, the interoperability gap will be highly pronounced and even less user-friendly in the health information infrastructure in the rural and remote settings. From an ethical perspective, it is imperative that interoperability mechanisms are established to ensure secure messaging of client personal information between all providers.

The Alliance also feels that we must not re-invent the wheel when it comes to either public sector or private organisations making investments in complex information systems. Duplicate or conflicting solutions implemented in different organisations across the health and disability sector will mean that we are unlikely to achieve true collaboration or economies of scale.

Data support improvements in Aboriginal and Torres Strait Islander Peoples health

The Alliance is pleased that AHMAC recognises the need to improve data support in Aboriginal and Torres Strait Islander Peoples health including access, transparency and trust with a “health gap” focus. The Alliance also agrees to the strategy to represent Aboriginal and Torres Strait Islander Peoples numbers in the health data sets in a culturally sensitive manner.

Appendices

Appendix 1. National Rural Health Alliance Members List (January 2020)

National Rural Health Alliance 2020 **44 organisations with an interest in rural and remote health and representing service providers and consumers:**
Allied Health Professions Australia Rural and Remote
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)
Australasian College of Health Service Management (rural members)
Australian College of Midwives (Rural and Remote Advisory Committee)
Australian College of Nursing - Rural Nursing and Midwifery Community of Interest
Australian Chiropractors Association Aboriginal and Torres Strait Islander Rural Remote Practitioner Network.
Australian College of Rural and Remote Medicine
Australian General Practice Accreditation Limited
Australian Healthcare and Hospitals Association
Australian Indigenous Doctors' Association
Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
Australian Physiotherapy Association (Rural Members Network)
Australian Paediatric Society
Australian Psychological Society (Rural and Remote Psychology Interest Group)
Australian Rural Health Education Network
Australian and New Zealand College of Anaesthetists
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives
Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus
Country Women's Association of Australia
Exercise and Sports Science Australia (Rural and Remote Interest Group)
Federation of Rural Australian Medical Educators
Isolated Children's Parents' Association
National Aboriginal Community Controlled Health Organisation

National Aboriginal and Torres Strait Islander Health Worker Association
National Rural Health Student Network
Paramedics Australasia (Rural and Remote Special Interest Group)
Pharmaceutical Society of Australia Rural Special Interest Group
RACGP Rural: The Royal Australian College of General Practitioners
Regional Medical Specialists Association
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian and New Zealand College of Psychiatrists
Royal Australasian College of Medical Administrators
Royal Australasian College of Surgeons Rural Surgery Section
Royal Far West
Royal Flying Doctor Service
Rural Doctors Association of Australia
Rural Dentists' Network of the Australian Dental Association
Rural Health Workforce Australia
Rural Optometry Group of Optometry Australia
Rural Pharmacists Australia
Services for Australian Rural and Remote Allied Health
Society of Hospital Pharmacists
Speech Pathology Australia (Rural and Remote Member Community)