

INFORMATION PAPER
on
Main eHealth activities outside of the EU

Annex 2
Main Australia eHealth policies and activities

LIST OF ABBREVIATIONS

ACRONYM	DEFINITION
ATSI	Aboriginal and Torres Strait Islanders
COAG	Council of Australian Governments
DVA	Department of Veterans Affairs
HI	Healthcare identifiers
IHI	Individual Healthcare Identifier
LHN	Local Hospital Networks
MBS	Medicare Benefits Schedule
NEHTA	National eHealth Transition Authority
PCEHR	Personally Controlled Electronic Health Record
PIP	Practice Incentives Program

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Preamble

Object

The present document is an Annex to Joint Action to support of the eHealth Network (JAsEHN) Deliverable 8.1.4 in WP8 "Report on main eHealth activities outside of the EU". It has been prepared by Norbert Paquel (external, director of Canope cabinet – France) under the control of Michèle Thonnet (Work Package leader-FRNA), then corrected and approved by the sPSC.

The objective of D8.1.4 is to observe the situation in various countries in order to better understand the development factors and main trends in the worldwide movement towards a tighter integration of ICT tools in healthcare but also to be able to initiate cooperation when advisable and possible. To that end, concrete projects have been identified as potentially interesting for eHN Member States (MS) exchanges or cooperation. These opportunities would need deeper analysis, through direct contact with experts, notably local representatives of the concerned MS or participants in EU projects.

Methodology

As explained in the main D8.1.4 document, the research was based on a desk study carried out between 2017/02 and 2017/08. It is important to note that time runs often very fast in the eHealth and mHealth domains. Accordingly, contrary to healthcare organizations and fundamental policies trends, concrete programmes and projects can change rapidly. However, if they correspond to clear needs and sustainable methods, they should not disappear. Moreover, when possible, some of the main important developments that have occurred since August 2018 have been taken into account.

Australia: basic information on the country

Australia is the second country on the Human Development Index (HDI) scale, second only to Norway. Australians can expect to live on average to about 82 1/2 years, have a mean 13 years of schooling and the gross national income per person is \$58,618. The country has not known economic recession in the last 25 years.

Australia is the planet's sixth largest country after Russia, Canada, China, the USA, and Brazil. At 7 692 024 km², it accounts for just five percent of the world's land area. With a population of 23,78 million, it has an average population density of 3.2 persons per square kilometer (for comparison, US population density is 33 persons per spare kilometer).

Australia's prosperity was built on its position as a commodity producer. Its more recent attraction is based on a depreciated currency, which made its exports more appealing. Australia benefits from a growing number of Chinese consumers, who buy Australian food products that are widely seen as safer than their home-grown equivalents. Australia also attracts many middle-class Asian students, which has led to a creation of a relatively young, well-educated, multicultural workforce.

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Health and Healthcare background

1. Elements on health situation

1.1 Health expenditure

The Australian health system is straining to deal with increasing cost and demand pressures and a shortage of skilled health care workers. Total expenditure on health (recurrent and capital expenditure combined) has grown continually, from A\$95 billion in 2003–04 to an estimated A\$155 billion in 2013–14 (after adjusting for inflation).

This growth can be attributed in part to societal changes such as population ageing, and to increased prevalence of chronic conditions, diseases and risk factors. Personal incomes, broader economic trends and new technologies also affect spending on health.

An important challenge of ICT implementation in health is thus to use technologies that not only improve the health and well-being, but are also cost-effective.

1.2 Health inequities

There are various groups experiencing health inequities within Australia. These groups require extra resources and funding that aims to help close the gap in health outcomes between these groups and the rest of the Australian population. The people groups experiencing health inequities include: Aboriginal and Torres Strait Islanders (ATSI), people with low socio-economic status, people living in rural and remote locations, people born overseas, the elderly, and those with disabilities.

Roughly 30% of Australians live in regional and remote areas. Living in rural and remote areas fits into the environmental determinants of health, which include geographical location and access to health services and technology, so it is not a surprise that people in these environments have poorer health outcomes compared to other Australians. People living in rural and remote areas have shorter lives and higher rates of disease and injury. Death rates increase with increased remoteness with very remote having 1.5 times the rate of major cities.

1.3 High levels of preventable chronic disease, injury and mental health problems

High levels of preventable chronic disease, injury and mental health problems are part of Australia's health priorities and the target of many health promotion campaigns. Chronic disease is Australia's most pressing health priority. Most are caused by lifestyle choices and can be prevented or delayed by simple adjustments to people's life choices.

1.4 A Growing and Ageing Population

Australia's growing and ageing population is a product of increased life expectancy, and decreased birth rates. In 2013, 14% of the population were aged 65 or more. It is projected that by 2053, this number will rise to 21% of the population will. The increasing survival rates for chronic diseases means that the elderly population have greater prevalence of major diseases, such as: cancer, cardiovascular disease, diabetes, and musculoskeletal disorders, as well as suffering greater levels of disability.

2. Healthcare system

Australia has a federal system of government, with a national (Commonwealth) government and six States and two Territories. The Commonwealth Government holds the greatest power to raise revenue, so States rely on financial transfers from the Commonwealth to support their health systems. Public hospitals are funded by the state, territory and Australian governments, but they are managed by state and territory governments. This makes the Australian health care system a complex division of responsibilities and roles across levels of government. It is also marked by a complex interplay of the public and private sectors.

The Australian Government and state and territory governments fund and deliver a range of other health services, including population health programs, community health services, health and medical research, Aboriginal and Torres Strait Islander health services, mental health services, and health infrastructure.

Primary health care is typically a person's first point of contact with the health system and is most often provided outside the hospital system. Through assessment and referral, individuals are directed from one primary care service to another, and from primary services into secondary and other health services, and back again.

3. Motivations for selecting Australia for eHealth study

Australia and the EU have a long history of productive research collaboration, underpinned by the first treaty-level science and technology agreement signed by the EU with an Industrialised Country in 1994.

Australia's health system is extremely performant (as measured by indicators such as life expectancy, infant mortality, etc.).

The federal government has put an important political will in the process of creating coherence in ICT implementation in healthcare in the context of a complex and fragmented system.

A radical shift in digital health policies took place in the last couple of years after a decade of relative failure, notably because of fragmented system and non interoperable silos.

Moreover, Australia is now a forerunner in eHealth development methods and processes: in fact, the process being thought over by the Australian Digital Health Agency has been the model for the development of the WHO Toolkit (*see D8.1.4*)

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Telemedicine and eHealth development

4. The need for a coherent national strategy

The Australian health information landscape is characterised by many thousands of discrete islands of information, many of which are paper based. This has created significant barriers to the effective sharing of information between health care participants, an issue compounded by Australia's multiple health service boundaries and geographic distances. It also poses real challenges when trying to understand and report what is really happening in the Australian health care system to support population health surveillance and guide policy, service planning, innovation and clinician and operational decision making.

Since 2005, the Commonwealth, States and Territories have been investing, in key building blocks for a national eHealth platform. At the same time, every Australian State and Territory is in the process of either defining or implementing some form of jurisdiction wide eHealth strategy, and making significant investments in foundational infrastructure in the health sector. Within the private health sector, individual clinicians, professional groups and organisations are also investing in eHealth infrastructure and initiatives. The result is a very large and growing number of disparate eHealth initiatives being delivered within local geographic regions, within acute and primary care settings, and across health sector disciplines in this country.

At the end of the 2000s, a number of Australian eHealth projects had delivered promising results and had allowed individual parts of the health care system to address specific local needs. However, in almost all cases these projects produced IT solutions that could not be easily connected with other health information systems or scaled to support larger consumer and care provider populations. This severely limited the ability for these solutions to provide more than a narrow, localised set of benefits and, at a system level, undermined the nation's ability to promote equity in health outcomes, drive meaningful safety and efficiency gains and ensure appropriate safeguards for personal health information.

In 2008, a National Strategy was introduced in order to provide a more coherent and focused approach to eHealth and several important eHealth developments took place in the following decade.

5. Healthcare Identifiers Service

Healthcare identifiers (HI) were introduced in 2010 as the foundation for digital health in Australia and as a building block for the My Health Record system (see below) and other government digital health initiatives.

The HI Service is a national system for uniquely identifying individuals and healthcare providers. Healthcare identifiers help to ensure that individuals and providers can have confidence that the right information is associated with the right individual at the point of care.

The capacity to accurately identify individuals seeking healthcare, healthcare providers and organisations is critical in order to communicate health information between providers with a high level of confidence that the information is being sent about the right person, to the right person and to apply security and access controls that will give the community confidence in the system and in eHealth.

A healthcare identifier is not a health record; it is a unique 16-digit number that identifies an individual or a healthcare provider. The information that the HI Service Operator holds is limited

to demographic information—such as an individual’s name, date of birth and gender—that is needed to uniquely identify the individual and their healthcare providers.

The identifiers are assigned and administered through the HI Service which was established to undertake this task. The HI Service is operated by the Chief Executive Officer of Medicare. If a person is enrolled with Medicare or holds a Department of Veterans Affairs (DVA) treatment card, they are automatically allocated an Individual Healthcare Identifier (IHI).

Patients do not need an IHI to receive healthcare or to claim healthcare benefits such as Medicare: if a healthcare provider is unable to obtain an individual’s healthcare identifier from the HI Service or the IHI is not available for any reason, treatment will not be refused.

There are three types of healthcare identifiers:

- Individual Healthcare Identifier (IHI) number—for individuals receiving healthcare services
- Healthcare Provider Identifier–Individual (HPI–I) number—for healthcare providers involved in providing patient care
- Healthcare Provider Identifier–Organisation (HPI–O) number—for organisations, such as hospitals or general practices, that deliver healthcare.

6. My Health Record

A National eHealth Transition Authority (NEHTA) was established in 2005 as a collaborative enterprise by the Australian Commonwealth, State and Territory governments to identify and develop the necessary foundations for electronic health. In 2011, it oversaw the implementation of The Personally Controlled Electronic Health Record (PCEHR), a shared electronic health summary set up by the Australian government. However, in 2014, a review underlined many shortcomings of the system, which fewer than 10% of the population had by then adopted and suggested radical changes. This included the transition of relevant activities and resources from NEHTA, and also from the national “My Health Record system” - the revamped name of PCEHR- operation activities managed by the Department of Health, to a new entity called the Australian Digital Health Agency.




However, the main shift in policy was to propose the transition from an “opt-in” system into an “opt-out system” for patients. Trials took place in 2006 (in the Nepean Blue Mountains and Northern Queensland) and resulted in only 1,9% opt-out and the decision to adopt the opt-out participation model for the My Health Record on a national scale was made in early 2017. Opt-out participation arrangements are due to be implemented starting in 2018.

6.1 Main operating principles

- **Content**

The My Health Record system is a national system that enables people to share their health information with their healthcare providers. Its objectives are to provide access to people’s health information to help overcome the fragmentation of health information, improve the availability and quality of health information, and improve the coordination and quality of healthcare provided to people by their healthcare providers. It is an electronic summary of a person’s key health information. A My Health Record will grow to contain a summary of a person’s key healthcare events and activities, including medical history, allergies and medications. This is supposed to improve the accuracy and speed of treatment decisions, and drive efficiencies by reducing unnecessary tests, hospitalisations and follow-up consultations.

Figure 1: Main information sources for My Health Record¹

Patient	Health professional	Medicare
		
<ul style="list-style-type: none"> • Medications and allergies • Personal health notes (cannot be viewed by providers) • Child development • Advance care directives • Emergency contacts 	<ul style="list-style-type: none"> • Shared health summary* • Event summary^ • Discharge summary • Referrals and specialist letters • Prescriptions and dispensing • Diagnostic imaging 	<ul style="list-style-type: none"> • Medicare claims • Pharmaceutical Benefits Scheme • Australian Childhood Immunisation Register • Australian Organ Donor Register • DVA claims
<p>* Shared health summary: details allergies, medications, immunisations and significant medical conditions. Uploaded by the patient's regular provider, most commonly a GP. Patient must approve the content.</p>		
<p>^ Event summary: details a significant healthcare event by a provider who is not the patient's regular provider, e.g. an after-hours medical service.</p>		

- **Access**

A person and their authorised healthcare provider organisations can access it online whenever and wherever it is needed for providing care to that person.

Third party mobile applications can access a person's health information in the My Health Record system and as well as other health-related services, subject to their consent. Certain information entered by the person are not accessible by healthcare provider organisations under any circumstances.

The My Health Record system allows people to monitor access to their My Health Record in two ways:

- a person can elect to be notified by email or short message service to their phone when certain activities occur in their My Health Record
- an audit log available to people with a My Health Record, via the system, contains information about access to their My Health Record including the date and time the record was accessed/edited, the organisation that accessed/edited the record and the role of the individual who took that action, whether the record was accessed because of an emergency, and details of the action(s) that occurred – for example, if a clinical document was created or deleted, or the person's contact details amended.

6.2 Governance

The Australian Digital Health Agency assumes governance responsibilities for all digital health strategy, design, development, delivery and operations and functions. It is also the My Health Record System Operator. The Department of Health has retained responsibility for national digital health policy and certain parallel activities, including the participation trials.

The Commonwealth Minister for Health has the authority to make the My Health Records Rules, which set out operational details to support the My Health Record system. The Minister must consult with the System Operator and a subcommittee of the Council of Australian Governments (COAG) Health Council before My Health Records Rules are made. Similarly, the

¹ www.mdanational.com.au

Minister must consult with the COAG Health Council before making any My Health Records Regulations.

6.3 Privacy

A Privacy Act regulates the handling of personal information about individuals. This includes the collection, use, storage and disclosure of personal information, and access to and correction of that information. The Australian Information Commissioner has various enforcement and investigative powers in respect of the My Health Record system and also delivers an annual report on the digital health system's compliance with privacy law throughout the year.

The key privacy protections provided by the My Health Records Act include:

- the ability for an individual to control which healthcare provider organisation can access information in their My Health Record
- closely defined limits on the circumstances in which information can be accessed outside of those controls (e.g. to treat the individual in an emergency)
- the ability to view a history of all access to a person's My Health Record
- civil and/or criminal penalties for unauthorised access to My Health Records
- requirements to report data breaches.

6.4 Main concerns

- **Data comprehensiveness**

Despite incentives (see below), there is no guarantee that all the health professionals involved in the care of a patient will participate and supply information, nor that the information supplied will be complete. Furthermore, patients have the ability to hide aspects of their record thus creating an incomplete final picture, which could become a significant clinical risk. The Australian Medical Association's own guidelines details that the personal record is only a "memory prompt" for the patient and that "remains the treating medical practitioner's responsibility to take a clinical history from their patient".

- **Computing and health literacy**

Not knowing how to use computers, navigate the My Health Record, or save and upload documents could prevent many people from taking advantage of the system. Currently, the My Health Record places high demands on reading and e-health literacy, making it difficult for many people to use, especially people who are already at a health disadvantage (the elderly, people with disabilities, etc.). This could be a barrier for a large number of people. Information about the My Health Record needs to be inclusive, easier to read, and translated into many languages – and use pictures and videos – to enable everyone to use the system.

- **Privacy concerns**

Only 147 of the one million Australians automatically given a record under the opt-out trial set up a PIN number to protect their health information (0.0151%), rising concerns whether information about privacy and security were relevant and available enough. The Australian Privacy Foundation criticised the lack of detail in the announcement about how individuals could opt out of having a record created. The Foundation also noted that the eHealth record could be accessed by agencies not connected to healthcare, including police, the Australian Taxation Office, and the immigration department.

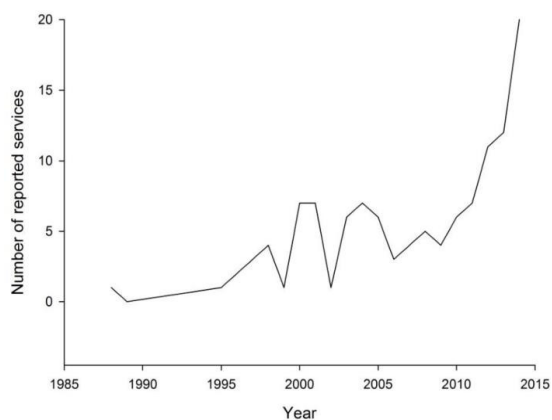
7. Telehealth

Telehealth has the potential to address many of the key challenges to providing health in Australia, with its substantial land area and widely dispersed population.

Recognising the potential of telehealth to support Australians living in rural and remote areas, the Australian Government in 2011 introduced an important policy on telehealth funding. This policy led to the introduction of specific funding opportunities through Medicare. There must be a visual link between the patient and the eligible specialist, consultant physician or psychiatrist in order to bill a video consultation; a guidance on technical issues is provided, including a set of minimum standards to abide by, but no particular technical solution is mandated. The Medicare Benefits Schedule (MBS) lists the scheduled fee for consultations, procedure and diagnostic tests that the government considers appropriate and that it reimburses to healthcare users or providers when that item is claimed. The intention of the new Medicare funding items was to encourage the use of telehealth, to improve access to specialist health services for patients in remote areas and enhance engagement between clinicians working in rural areas and specialists in major cities. For example, with the introduction of new telehealth Medicare item numbers, a specialist medical practitioner who provides a consultation by videoconference could claim additional payment from Medicare of up to 50% of the standard scheduled fee for providing the consultation face-to-face. Similarly, a general practitioner or nurse supporting the patient end of a video consultation can also claim payment through Medicare for the same consultation.

The Medicare telehealth items have created a much-needed incentive for clinicians to deliver telehealth, and from a national perspective telehealth activity is steadily increasing. In response to these funding opportunities, many professional societies and colleges including the Australian College of Rural and Remote Medicine, the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners and the Royal College of Nursing Australia have developed specific guidelines and standards to support the use of telehealth. Currently, MBS items for telehealth are only available for real-time (video) consultations involving a medical specialist. Under certain conditions, reimbursement for medical officers, nurses and Aboriginal health workers is available if they accompany the patient during a telehealth consultation with a medical specialist. However, funding opportunities for general medical and allied health practitioners for the provision of telehealth services are very limited or non-existent, as are funding opportunities for store-and-forward telehealth applications.

Figure 2: Number of reported Australian telehealth services over time²



² Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability - Rural and Remote Health 16: 4268. Bradford NK, Caffery LJ, Smith AC

8. eHealth Practice Incentives Program

The Practice Incentives Program (PIP) eHealth Incentive aims to encourage practices to:

- keep up to date with the latest developments in digital health
- adopt new digital health technology
- improve administration processes and patient care

The PIP eHealth Incentive encourages the meaningful use of the My Health Record by healthcare providers, including uploading of clinically relevant information to the My Health Record embedded into day to day clinical practice.

To assist general practices to meet PIP requirements, training and materials to support self-paced learning as well as face-to-face classroom style training on the My Health Record system are available on the My Health Record website. This online training allows general practices, GPs and other healthcare providers to become familiar with My Health Record system and functionality, tailored to the clinical information system that they are used to using.

To be eligible to receive the eHealth Incentive, practices must:

1. integrate Healthcare identifiers into Electronic Practice Records.
2. have a standards-compliant secure messaging capability
3. work towards recording the majority of diagnoses for active patients electronically
4. ensure the majority of their prescriptions are sent electronically to a Prescription Exchange Service
5. use the My Health Record system

9. Current National Digital Health Strategy

Despite the progress made within locales, individual health services or within a health sector, there is a risk that uncoordinated investment in technology will exacerbate the risk of isolated silos in the health system, with each service or sector using a different “rail gauge”. The need for a truly inclusive national digital health strategy to underpin public and private digital health planning and investment is critical. A national strategy that sets out agreed priority areas and is underpinned by standards sends a signal to the market of areas of interest to governments and can encourage investment in both the public and private health systems in the same direction. The Australian Digital Health Agency was established in July 2016 and tasked with leading the development of this National Digital Health Strategy and its implementation framework.

The following guiding principles have underpinned the development of Australia’s National Digital Health Strategy:

- Putting users at the centre
- Ensuring privacy and security
- Fostering agile collaboration
- Driving a culture of safety and quality
- Improving equity of access
- Leveraging existing assets and capabilities
- Judicious use of taxpayer money

The Strategy proposes seven strategic priority outcomes to be achieved by 2022.

1. Health information that is available whenever and wherever it is needed. By the end of 2018, every Australian will have a My Health Record, unless they choose not to. By 2022 all healthcare providers will be able to contribute to and use health information in My Health Record on behalf of their patients. Patients and consumers will be able to access their health information at any time online and through mobile apps.

2. Health information that can be exchanged securely. Every healthcare provider will have the ability to communicate with other professionals and their patients via secure digital channels by 2022. Patients will also be able to communicate with their healthcare providers using these digital channels. This will end dependence on paper-based correspondence and the fax machine or post.

3. High-quality data with a commonly understood meaning that can be used with confidence. By the end of 2018, a public consultation on draft interoperability standards will confirm an agreed vision and roadmap for implementation of interoperability between all public and private health and care services in Australia. Base-level requirements for using digital technology when providing care in Australia will be agreed, with improvements in data quality and interoperability delivered through adoption of clinical terminologies, unique identifiers and data standards

4. Better availability and access to prescriptions and medicines information. By the end of 2018, all patients and their providers will have access to comprehensive views of their prescribed and dispensed medications through the My Health Record system. This will reduce the incidence of medication errors and adverse drug events – minimising harm to patients and creating significant cost savings. By 2022, there will be digitally enabled paper-free options for all medication management in Australia. People will be able to request their medications online, and all prescribers and pharmacists will have access to electronic prescribing and dispensing.

5. Digitally-enabled models of care that drive improved accessibility, quality, safety and efficiency. The Strategy proposes a number of pioneering initiatives – co-produced between consumers, governments, researchers, providers and industry – to test evidence-based digital empowerment of key health priorities investigate and collectively solve any technical obstacles and then, where appropriate, to promote them nationally. These include:

- support for the Health Care Homes trial and more integrated management of chronic illness
- development of new digital services to support the health of babies and young children
- improvement of digital services for advance care planning
- improvement of information sharing in urgent and emergency care
- widening access to telehealth services, especially in rural and remote Australia.

6. A workforce confidently using digital health technologies to deliver health and care. Healthcare professionals want more support in learning how to maximise the benefits of digital health tools and services. The Australian Digital Health Agency will collaborate with governments, care providers and partners in workforce education to develop comprehensive proposals so that by 2022 all healthcare professionals have access to resources that will support them in the confident and efficient use of digital services. In addition, the Strategy proposes rapid promotion of a network of clinician digital health leaders and champions across Australia.

7. A thriving digital health industry delivering world-class innovation. The Strategy proposes a new initiative to support an expanding set of accredited health apps as well as delivering an improved developer program to enable industry and entrepreneurs to expand existing services and create new services that meet the changing needs of both patients and

providers. Government will be a platform for industry and innovators to foster an agile and self-improving health system that is sustainable.

- III -

Main conclusions

10. A complicated road to making eHealth a cornerstone of the Australian healthcare system

Australia has provided considerable resources and political will to the process of making eHealth services a cornerstone of its health system on a national level. The process has not been an easy one, especially when considering the relative failure of the first iteration of patients' health records after 10 years of development. As a shift to an opt-out system is scheduled to start in 2018, concerns have been raised by various stakeholders, and it remains to be seen whether appropriate measures will be taken.

Furthermore, apart from medical considerations, an important objective of ICT implementation in health in Australia is to help limit the expansion rate of healthcare cost. The government expects the My Health Record to save A\$2.5 billion a year. Where this number came from is unknown but it is different from the original estimates which put the annual savings at A\$7.6 billion.

11. Good practices

Australia's digital health strategy stands out thanks to the political will to implement an opt-out system for the My Health Record program.

It also proposes many incentives and guidelines to help practitioners integrate ICT in various areas of their work, from tele-consultations to record-keeping and prescriptions.

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Potential for cooperation

12. Main domains and axes for exchanges and cooperation

The Forum for European-Australian Science and Technology cooperation (known as FEAST) was an Australia-EU joint initiative that highlighted and promoted international research collaboration between Australia and Europe. It operated from 2001 until 2012. It was succeeded by another EU-Australia bilateral dialogue platform for Research and Innovation connecting Australian-European Science and innovation Excellence, the CAESIE project which ran from September 2012 to August 2015. Such collaboration should be continued, and could modelled after the agreement between Australia and Germany, which focuses on Information Sharing on Digital Health. The Australian Digital Health Agency and Department of Health hold regular discussions on domestic digital health policy with Germany.

13. Programmes and projects

The following paragraphs use basic elements of the provisional grid described in the D8.1.4 main document (II – 12.3). There are four categories:

- Learn: the project is a rich source of information for a country confronted to similar problems or working in a similar international action
- Mutual enrichment: development of exchanges between project actors and concerned parties among eHN MS, active in similar projects in their country or abroad.
- Help and support: which can be technical, promotion, financing.
- Participation: co-construction of the project and similar ones.

13.1 EHR and Patient empowerment

- **My Health Record** - 2014 to be implement 2018 after trial (*see 6*)

Objective for following

Learn: The project is now launched (2018) after a trial phase. It will be very interesting to know the detailed results and the process that led to effective choices, especially in the domain of opt-in opt-out, consent, privacy present interrogations

13.2 Identification of citizens, HPs and HcPs

- **Healthcare Identifiers Service** - 2010 (*see 5*)

Objective for following

Learn: How it works, what difficulties, what usages, where can be practically used those different identifiers

13.3 Social insurance

- **The Medicare Benefits Schedule - 2011** (see 7) – scheduled fees for teleconsultations, for participating HPs at both ends

Objective for following

Mutual exchange: many have certainly occurred with eHN MS – fact is that telemedicine remuneration is still a difficult problem (limited here by the special status of Medicare beneficiaries)

13.4 Education training

- **Practice Incentives Program** - 1990s but only conceived more recently for eHealth (8) – encourages HPs to keep up to date with the latest developments in digital health and in particular to use "My Health Record"

Objective for following

Mutual exchange: the system exists since 1990 for Health procedures and information but it is only recent for eHealth and has been practically tested in the "My Health Record" testing phase. Many countries encounter the same problem.

13.5 The 2016 Strategy Programmes – 2016 (9)

- **Interoperability standards** - Interoperability between public and private healthcare services - a public consultation will be conducted in 2018

Objective for following

Learn: how will be designed the process of the public consultation, results, method to maintain and evolve in the long term

- **Products: link with My Health Record** - Access to prescriptions and medicines information

Objective for following

Mutual exchange or Learn: depending on the state of such project in countries – linkage between a patient empowered personal record and drug information raises many issues, notably for safety and privacy

- **Home NCD prevention** - Support for the Health Care Homes trial and more integrated management of chronic illness

Objective for following

Mutual exchange or Participate: following the trial phase is also rewarding for countries that have conducted studies on similar approach, notably to compare with alternative solutions and propose rigorous evaluation tools

- V -

Main sources

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