

**Review by Consumers e-Health Alliance**  
*of the*  
**PCEHR – draft Concept of Operations**

**30<sup>th</sup> May 2011**

The **Consumers e-Health Alliance (CeHA)** is a collective of consumer oriented organisations and people who have displayed active positive interest in Australia's e-health program. Our initial activities are to highlight the major blockages to effective implementation i.e. Ownership, Governance, Leadership and the need for community wide 4C's:-

| Communication | Co-operation | Collaboration | Coordination |

## Executive Summary

The Consumers e-Health Alliance welcomes the Commonwealth Government's \$467 million two year funding commitment to develop a system of personally controlled electronic health records and welcomes the opportunity to respond to the Commonwealth's call to provide feedback on the draft Concept of Operations for the PCEHR system. The main aspects of this system that CeHA addresses in this review are:-

### **The Governance of the PCEHR system.**

The draft Concept of Operations includes no reasonable discussion on Governance. CeHA believes that the issue of governance is critical to the success of the whole PCEHR endeavour, and unless and until this fundamental shortcoming is addressed, there is a high likelihood that a successful outcome will not occur. In particular we believe that:-

- the Commonwealth should take immediate action to engage the 4 pillars of the community as equal partners in overseeing the design, development and implementation of the PCEHR system. The 4 pillars comprise governments and their agencies; healthcare providers; consumers; and the software industry. Experience, both here and overseas has shown that without strong community involvement, large national e-health programs have floundered.
- the viability and sustainability of the PCEHR can only be ensured if e-health, and the PCEHR system in particular, is placed on a firm business footing and a proper business plan, involving costings, options, priorities, risks, development and implementation plans, milestones, expectations and obligations of all parties, etc. is created.

These concerns and others are discussed more fully in sections 2 – 7.

### **The nature of the PCEHR system.**

Whilst the draft Concept of Operations (ConOps) tries to explain the nature of the PCEHR system, the value of such a system will ultimately depend on how this 'vision' is translated to an operational system; what healthcare functions the system supports; and how well those functions contribute to improved healthcare for Australians. CeHA is concerned about some specific aspects of the PCEHR concept of operations, particularly around:-

- the importance and governance of consumer entered data,
- the security, integrity and privacy of data
- the lost opportunity to support research and population health through harnessing de-identified data, and
- the usefulness of the PCEHR system

These and other concerns are discussed more fully in section 8, and also in Appendix 3 of this review.

### **The Implementation of the PCEHR system.**

Apart from governance issues, CeHA also has a number of other concerns about the implementation of the PCEHR system, including the role of the 'lead implementation sites'; the role of jurisdictions and community e-health activities; the importance of workforce and consumer literacy; the impact of PCEHR implementations on work practices; and use or otherwise of standards.

Implementation concerns are discussed more fully in sections 9 through 13.

## 1. PCEHR Context

*“The Commonwealth will make a landmark \$467 million investment over two years in the key components of an electronic health record system, so that all Australians have access to a personally controlled electronic health record (PCEHR) if they choose to. In order to fully realise the significant benefits of this Commonwealth investment, states and territories will also need to continue their planned or expected investments in core health information systems. States and territories will also need to provide the complementary investments to build their capacity in readiness for connection to this national system.”<sup>1</sup>*

Most Australian's probably believe that there should be a system of shared electronic health records in Australia. There is an underlying assumption that they could help improve healthcare, but many consumers believe that there are some important issues to be addressed, most notably around their usefulness, around privacy and access control, and around how the overall system will be financed, developed and managed, leading to a successful outcome.

The release of the PCEHR draft Concept of Operations is the first opportunity that the Australian community at large has had to contribute to the directions of e-health since the days of the HealthConnect Program more than six years ago. In that intervening period we have witnessed the establishment of the National e-Health Transition Authority (NEHTA); the 2007 Boston Consulting Group's review of that organisation; the 2008 National e-Health Strategy ( Deloitte report ); the report of the National Health and Hospitals Reform Commission; the ensuing National Health and Hospitals Network report *Delivering the Reforms*; and now, the PCEHR draft Concept of Operations. At last, the community has an opportunity to have a say, if only to comment on some aspects of this small, but important piece of the e-health jig-saw.

## 2. Governance

Consumers want any PCEHR development to be part of a well-articulated and well-accepted national e-health framework. Consumers are concerned to ensure that all e-health initiatives are founded on appropriate standards, present value for money, build on the lessons learned from local and overseas endeavours, are well managed, and are evaluated for their ability to improve the healthcare provided to all Australians. There is an urgent need to place the proposed PCEHR System in the overall e-health landscape; to acknowledge that e-health is necessary and should be part and parcel of a modern community; and to ensure that each e-health initiative is placed on a sound and sustainable footing.

Up until now, the track record on governance arrangements for the PCEHR and e-health more broadly has been too closed to the general community, particularly consumers. Consumers want and expect stakeholders to be engaged in a collaborative process that determines the best governance and management regime for each aspect and phase of e-health developments. Governance partners should include representatives of consumers, government, healthcare providers, and the health IT industry – the *four pillars*.

All of the above are recommendations that have been voiced many times over since the landmark 1997 report - *Health on line : report into health information management and telemedicine*<sup>2</sup> but more recently by Boston, the Booz & Co and the Deloitte reports, and all these parties concurred with the need for engagement as partners.

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1 [www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ImplementationPlan-Stream8](http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/ImplementationPlan-Stream8)

2 [www.aph.gov.au/house/committee/fca/tmreport.pdf](http://www.aph.gov.au/house/committee/fca/tmreport.pdf)

Furthermore, this was recently confirmed as policy by both Health Minister Roxon and Health Department Secretary Jane Halton at the Melbourne November 2010 "revolutionary" conference at which agreement with the 4 pillars model was confirmed.

### 3. How to establish the partnership.

The way to establish such a partnership, we suggest, needs to arise out of a dedicated 4-cornered roundtable, convened specifically to address this fundamental issue. All the parties need the opportunity to propose options, with ample time for due consideration leading to the drafting and forming of recommendations. CeHA and its associated bodies have made broad proposals over time. Appendix 1 of this submission contains draft organisation charts which are designed to apply specifically to the PCEHR and this Con-Ops proposal.

### 4. the business of e-health

E-Health needs to be run as a business, but not the business of health! It is the infrastructure required to enable the efficient and secure transport and interchange of data from clinician to clinician and on an organised basis with patients and clients.

Health and the interchange of the related data is very complex. It is often made to sound simple by comparing it with banks and their electronic money exchange transactions. This seems to arise from a common misunderstanding of the nature of the actual e-health networking business and the organisational component of the delivery of health services it is intended to deliver.

This misunderstanding was featured in the recent National Health & Hospitals Reform Commission report which stated: "Health is the same but lagging behind all other industries e.g. banks, in the introduction of its e-health IT functions." This assessment is now common, with this same repetitive exclamation about one's banking experience along with the unheeded warnings about the "break of rail gauge" and the priority of standards.

We hold that the analogy with banking is not correct and to follow it will not provide a practical business strategy. Our disagreement with this generally held view can be explained in the following terms:

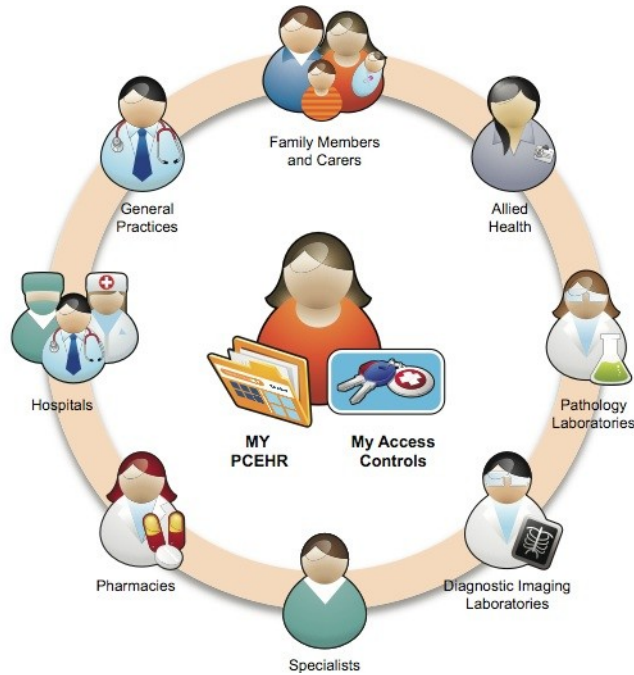
- It arises because the health industry varies from most other industries in at least one significant and pertinent aspect. Whilst most other industries operate their daily business on a "one-to-many" basis, health is one of the few that operate in a "many-to-many". This is because there is no one player or small coterie, which dominates a significant part of this very complex industry.
- This means that as a consequence, the oversight management of the network needs to provide coverage on an inclusive industry-wide basis.
- This would conglomerate all of the component sectors and operate with
- each of them jointly having a seat at the decision-making tables.
- This would enable their needs to be identified and incorporated
- progressively, with any (inevitable) mistakes made, able to be corrected
- quickly, with a full understanding of the requirements of the players.
- It also assembles a range of all relevant competencies within a practical advisory body. This would also create a situation of community wide participatory teamwork, collaboration and ownership.

These suggestions would give due recognition to the sound advice given in 2001 by the National Health Information Management Advisory Council in its *Health Online*<sup>3</sup> report, and not since disputed.

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3 [http://www.health.gov.au/internet/hconnect/publishing.nsf/content/7746b10691fa666cca257128007b7eaf/\\$file/actplan2.pdf](http://www.health.gov.au/internet/hconnect/publishing.nsf/content/7746b10691fa666cca257128007b7eaf/$file/actplan2.pdf)

According to Figure 1 of the PCEHR draft Concept of Operations, the consumer is portrayed at the centre of some disconnected ring of healthcare providers.



However, the actual business of e-health is about optimising a complex network of many to many relationships and information flows. CeHA proffers the following figure 1a as a more realistic alternative to illustrate the current business nature of e-health.

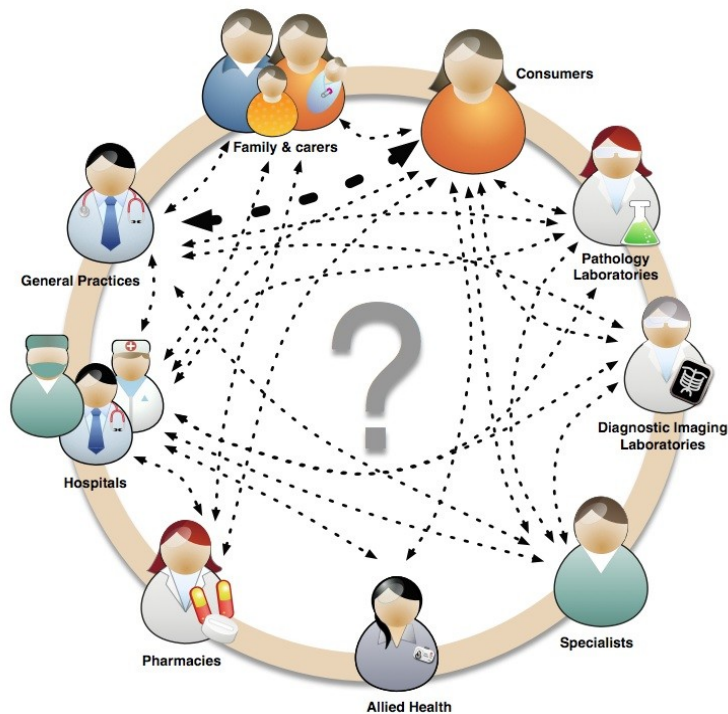


Figure 1a current governance of information flows

## 5. respecting the participants

The management of the e-health / telehealth network needs to be structured in accordance with the diverse needs of both the service providers and the consumers. The following are key requirements that need to be accommodated.

- All parties need to be at the same table at the same time
- All parties have equal status with informing the agenda, access to related information and 2 way discussion
- How does it need to be structured?
- How will it be funded?

The business comprises 2 principle players

- i. Suppliers of services
- ii. Customer /patient

IT interchange will need secondary suppliers of services to develop and operate the network.

AHMAC has endorsed the Deloitte recommendations. How is it intended that PCEHR implementations will comply?

Note: We understand that the transition role of NeHTA terminates on 30/6/2012 and PCEHR is due to commence operating on the very next day. It therefore seems appropriate that extensive restructure overall needs to be agreed by "the Principal Committee / AHMAC".

We suggest that it would be appropriate to incorporate the principle of whole of community engagement concurrently with this restructure, and providing for the direct inclusion of appropriate government agencies.

We further suggest that this initially be accomplished by the establishment of a PCEHR implementation advisory group and that this be a leading experience for the future when a more universal coverage of clinical treatments and consumers complete lifestyle needs will be introduced.

Recently, NEHTA held an ICT vendor forum, wherein many of the same issues that consumers have raised were also prominent amongst vendors, too. Eight significant issues were raised at that forum:

Key Issues raised by industry NEHTA Roundtable:-

1. **Scope:** should initially be restricted to limited functions that deliver quality benefits e.g. a summary health record.
2. **Sustainability and incentives:** A sustainable business model needs to be developed to support long term participation by all parties
3. **Progressive realisation of benefits:** Solutions need to highlight the progressive benefits of PCEHR building blocks.
4. **2012 timeframe:** Timeframe is unrealistic unless the focus is on targeted groups e.g. aged care, chronic illness, disabilities, etc.
5. **Patient control:** Further clarity is needed on what is meant by 'patient control'
6. **Governance:** Questions raised about whether legislation will be developed for the PCEHR, and the governance rôle of DoHA, Medicare, NEHTA, the states, territories and other government agencies.

7. **Scalability:** Lead implementation sites need to be scalable to support national implementation of PCEHR.
8. **Literacy & Communications:** Consumer and provider literacy program and a communication strategy are needed for uptake, together with an associated education and training program.

## 6. e-health as a viable and sustainable business

We believe that most activities involved in e-health need to be placed on a sound business footing, supported by a business case, and business plans aligned to the national strategy with cost / benefit analyses and identification of primary funding sources. Sustainability cannot be agreed whilst there is a total dependency on the uncertainty of nine jurisdictional annual budgets!

There is a need to clearly state what functionality the PCEHR system won't provide as well as what it will provide. It is important to clearly state who is expected to provide which components. The draft Con-Ops doesn't do that. There is no prioritisation of components suggested in the draft Con-Ops, nor even reference to how such a prioritisation might be developed, let alone deployed. Not all of the functionality outlined in the draft Con-Ops can be provided by July 2012. Some components may be too expensive, some not achievable for years. What are the timeframes for development, testing and deployment of the various components? Where are the links between the cost of a component and its potential benefits?

If the PCEHR is to contain information that will be used for clinical decisions, then the quality and safety of the system will need to be carefully assessed prior to deployment, and continually monitored thereafter.

## 7. strategic oversight of the PCEHR operation

The Department of Health & Ageing has divided the implementation of PCEHR system into at least these 4 areas of responsibility and sought private organisations (partners) to undertake these functions:-

- national infrastructure
- change and adoption
- benefits realisation
- external assurance advice

There appear to be no current options for how community involvement is to be incorporated into the design of these important functions. CeHA believes that the mechanism for community involvement in these needs to be determined as a matter of urgency.

## 8. PCEHR design and operation - content, functions, priorities

The draft Concept of Operations leaves many issues of concern to consumers either unaddressed or inadequately addressed. Consumers have already raised quite a number of these at the Consumer Forums organised by NEHTA, but have not found their way into the draft Concept of Operations. Some of the concerns include:-

- Integration of care plan data.
- The need to adopt a "keep it simple "(KIS) approach.

- How will allied health consultation summaries be added?
- Are non-government organisations that provide psychosocial health services considered to be part of the PCEHR system?
- What is the medico-legal status of consumer entered data?
- Consumers will need clear information about auditing, overall surveillance, sanctions for breaches, and complaints handling.
- How could the proposed complex access control mechanisms work in practice?
- The number and nature of repositories are ill-defined in the draft. CeHA believes that this aspect of the design needs further elaboration and that constraints are placed on where and how repository data is to be managed. We would be against any offshore cloud being used for this purpose.
- Will reports from specialists, pathology services etc to GP be available unfiltered, or only after health professional consent or can consumer elect if they want to receive direct or via GP/Specialist etc reports?

## 9. The importance of standards

A further key issue to be resolved with the agreement of all affected parties is that of standards at all levels.

We are aware that there is a range of views on this issue ranging from "it's all under control" to "totally inadequate". This is not a situation that satisfies the concerns of consumers. The ability to achieve interoperability must be an imperative at every stage and must apply to all operating levels e.g. technical networking, clinical servicing and inter-communication of data to and between all parties including consumers.

Consumers have not been adequately considered on this issue and we are led to believe that this may also apply to clinicians and even to software developers' interests.

We therefore propose that a specific, all parties roundtable be organised so that the issue of standards can be thoroughly and openly examined by all concerned and appropriate whole of community oversight can be established.

Everyone has expressed concern that we don't repeat "the break of rail gauge disaster" but we doubt that all of the actions needed to prevent this have been thoroughly and comprehensively examined by those experienced in such matters at the actual operating levels. As a result of numerous discussions, CeHA has reason to believe that standards and specifications are being developed and promoted without adequate testing, and without sufficient consideration of the operational constraints in which they need to be deployed.

In short, there appears to be such a gulf between what NEHTA is proposing in terms of standards, and what the operational community is able to support, that the rush to develop the PCEHR will likely compromise interoperability to such an extent that we will end up with a number of "break of rail gauge disasters"!

## 10. workforce and consumer preparedness

The PCEHR system will need an extensive training program for clinicians and consumers. The draft Concept of Operations implies a significant number of changes to current clinical workflow. This will



have a disruptive effect on the delivery of healthcare services that could jeopardise quality and safety. The identification and potential impacts of these changes have not been considered in the draft Concept of Operations. We believe they should at least be identified, and a mechanism for addressing them clearly articulated.

Likewise, for consumers, there needs to be a much clearer identification of the impact of individual PCEHR design considerations on the way consumers will interact with the system. The identification of these considerations should then lead to a plan of education and training for consumers.

## 11. “lead implementation sites”

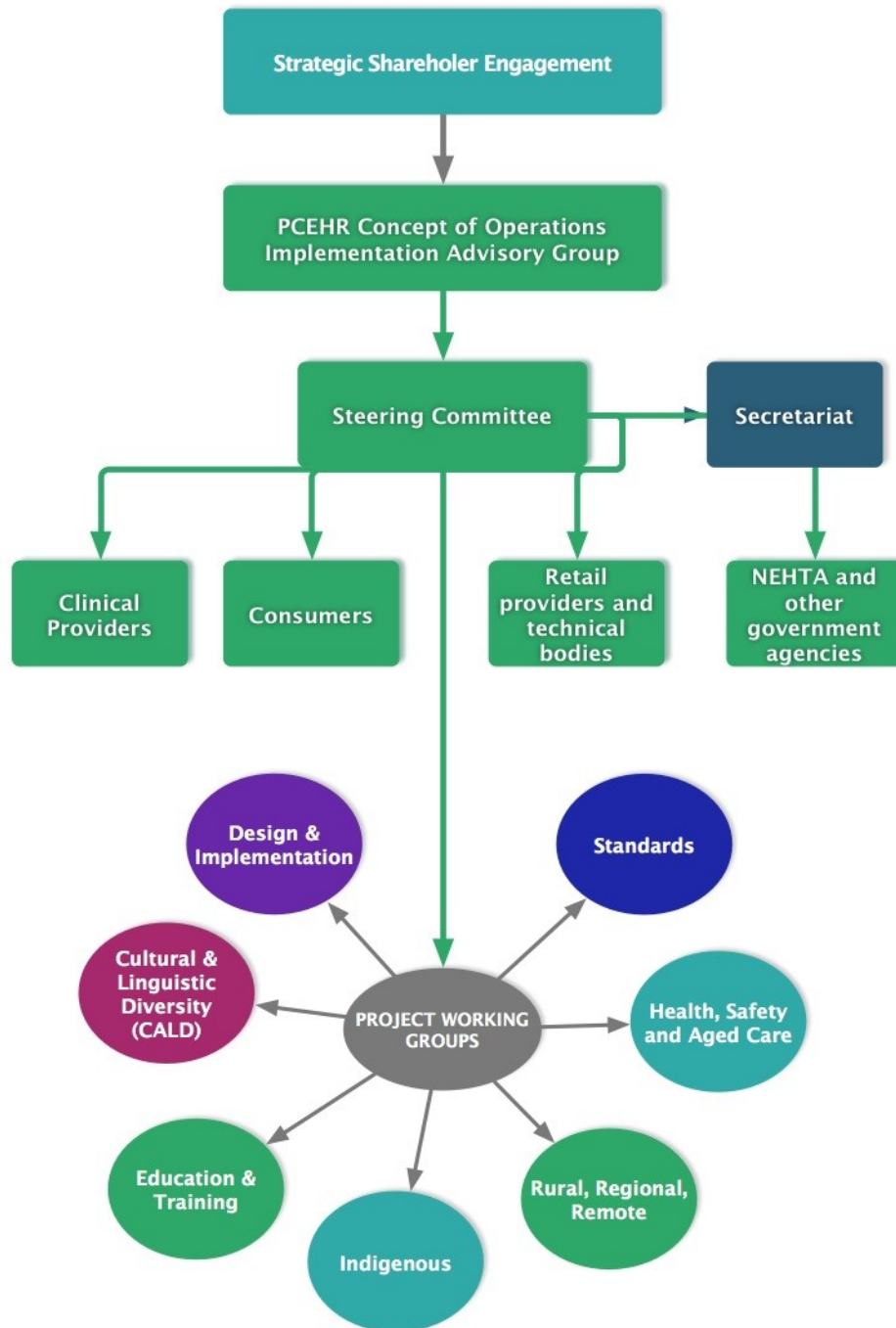
There is currently much confusion around the role of the “lead implementation sites” being funded by DoHA. It is important that community representatives are brought to the table to maximise opportunities arising out of this program. There needs to be a much clearer path for how these individual projects can converge with the PCEHR system implementation proper, rather than becoming isolated billabongs detached from the main flows of healthcare information. The criteria for choosing implementation sites should be agreed prior to the calling of tenders for those implementations. CeHA would favour, for instance, the choice of regional areas where the benefits of e-health are clear and where strong and simpler community networks can be harnessed for collaborative and cooperative development of targeted implementations.

## 12. complementary initiatives

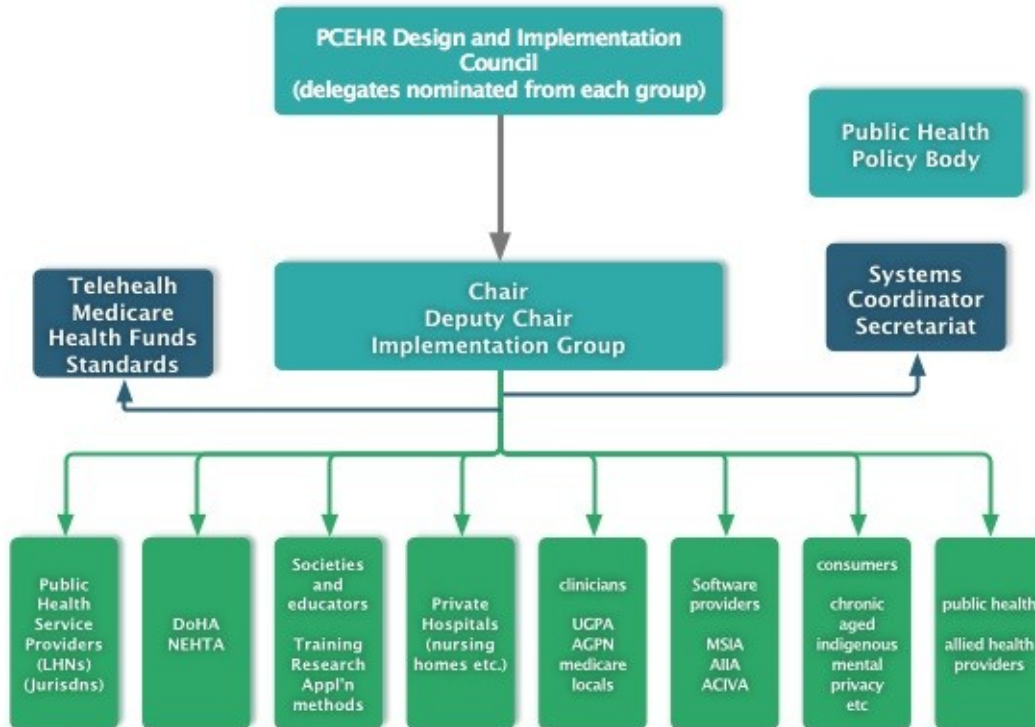
Consumers are interested in the possibilities which might be available through those associated projects that are not being directly funded by the commonwealth under the current \$467 million initiative announced in the May 2010 budget. For example, there are reportedly some 90 unsuccessful wave 2 applications by consortia wanting to participate as lead e-health sites. Consumers have had no visibility of these projects whatsoever. We don't know who the applicants were. We don't know what projects were being proposed. Surely there must be initiatives for value to consumers within some of these projects! What opportunities are there to harness the enthusiasm and technological capability embodied in these to help drive better outcomes for more consumers, not necessarily, nor only within the PCEHR system or its future progression but possibly also within the jurisdictions or community health?

## Appendix 1 – suggested governance models

A: Suggested interim governance model (refer also to our Figure 1a current governance of information flows and section 4. - the business of e-health)



A suggested longer term governance structure B:



## Appendix 2 - PCEHR – consumer aspirations and issues

Most Australian's believe that there should be a system of shared electronic health records in Australia. There is an underlying assumption that they could help improve healthcare, but many consumers believe that there are some important issues to be addressed, most notably around their usefulness and around privacy and access control. The following is an attempt to capture some consumers' aspirations as well as their concerns related to the proposed national system of Personally Controlled Electronic Health Records (PCEHR) announced in the May 2010 Commonwealth health budget. The aspirations and concerns have previously been conveyed to NEHTA through its Consumer Reference Forum.

### Consumers' Aspirations

#### A2-1 PCEHR Content and Functionality

The primary aim of the PCEHR must be to improve the healthcare of individual patients that choose to participate in the scheme. Consumers' requirements and expectations vary, so the system must support considerable diversity and be relevant to individuals conditions and needs. There is a particular need to support those consumers with chronic conditions and complex conditions (co-morbidities), where better sharing of information can reap substantial benefits.

Categories of content that might reasonably be expected to be supported include:-

- data relevant to emergency treatment
- important encounters
- important episodes
- medication history
- adverse reactions and allergies
- history of problems
- history of interventions
- history of tests
- history of test results
- immunisation history
- referrals and discharge summaries
- special alerts (e.g. epileptic, pacemaker, unstable diabetic, haemophiliac)

Additional functions that should be supported by the PCEHR system infrastructure:-

- care planning, particularly for chronic conditions
- appointments schedule / scheduling
- clinical content tailored to individuals' needs
- coupling to online knowledgebases
- special authorisation and access controls for specific conditions

#### A2-2 PCEHR access for healthcare providers

The PCEHR should aim to improve healthcare. This is best achieved through giving healthcare providers appropriate, controlled, but easy access to the EHR, through integration with their clinical systems. To be effective for clinicians, data quality is essential, and systems should ensure:-

- accuracy
- precision
- timeliness
- comprehensiveness

There is also a need to ensure adequate accessibility for rural and remote providers, who may currently only have narrowband connections.

### **A2-3 Facilitation of EHR Access by Healthcare Providers**

For patients that want it, the PCEHR should facilitate controlled and as-needed linkage to EHR data stored in healthcare provider's databases, in order for each relevant healthcare provider to view comprehensive longitudinal, i.e. lifetime, information for that patient. Examples include:-

- Capability of individual healthcare providers to gain access to all relevant information
- Support for trend processing – e.g. HbA1c levels; Prostate-Specific Antigen markers
- Controlled and protected access for research
- Support for location information – where in the world a condition or treatment occurred
- Special forms of aggregation – e.g. accumulated radiation dose from CT scans

### **A2-4 PCEHR Access for Patients**

Each consumers' own access to their PCEHR needs to reflect the diversity of consumers' wishes and abilities in such areas as willingness and capability to use online facilities, and attitudes to privacy and confidentiality.

Consumer access to the PCEHR:

- online, by themselves
- online, by agents such as carers and healthcare providers
- off-line, via download, or printing when visiting a healthcare provider
- full access, where appropriate mediated by a professional with appropriate qualifications

Consumer updating of the PCEHR:

- online, by themselves
- online, by agents such as carers and healthcare providers
- future support for online upload from home monitoring devices
- ability to have data amended or to have additional information associated with entries

### **A2-5 Support for Consumers**

The PCEHR must help consumers who want to be active in the management of their own health, particularly those with chronic conditions, in order to fill gaps in their care that currently make healthcare suboptimal for consumers.

- Help in the reduction of the incidence of unnecessary tests
- Save having to repeat basic information at each first encounter with a new provider
- Assistance to patients in weighing up the pros and cons of treatments being offered or advised, through the provision of links to appropriate information, such as:
  - medication instructions
  - interpretation of results

- known side-effects of tests and treatments
- typical outcomes of treatments
- Provision of links to assist in the assessment of costs, including out-of-pocket costs for diagnostic tests and treatments

## A2-6 Support for Diverse Categories of Consumers

The interests of consumers, and their needs from the PCEHR and e-health more generally, varies considerably depending on the particular category or categories that the individual patient belongs to.

The highest priority in the PCEHR's design should focus on patients with:

- chronic conditions
- complex conditions (comorbidities)
- high-dependency aged
- the aged more generally

Different considerations arise in respect of the following categories:

- acute conditions
- remote patients (and in many cases also rural patients)
- itinerants (which encompasses 'grey nomads', 'travelling salesmen', aboriginals living a traditional lifestyle, 'fruit-pickers', vagrants and 'street kids')
- families
- adolescents (i.e. people in transition from childhood to adulthood)
- those with culturally-sensitive conditions (which encompasses sexually-transmitted diseases, gynaecological conditions, and mental health; conditions of especial concern within particular ethnic, lingual and religious cultures; conditions of especial concern to particular individuals (whether rationally or otherwise) e.g. diabetes, leprosy, glandular fever, etc.)

## Consumers' Issues

### A2-7 Trust

The usefulness of a PCEHR system is critically dependent on the trust placed in the system and system management by its participants, be they consumers, healthcare providers, researchers, funders.

Examples of trust include:

- trust in the accuracy of information
- trust in the completeness of information
- trust in the currency of information
- trust that there are/will be appropriate privacy and security safeguards
- trust that the system will be used efficiently and effectively
- trust that the system will continue to evolve and improve
- trust that perceived deficiencies, inaccuracies, etc. will be addressed
- trust that information will not be misused
- trust in the reliability of access – can consumers and providers access when and where they need to?

Trust is hard to create, but easy to destroy. It is critical that stakeholders' issues be addressed from the

outset, and continue to be addressed throughout the life of the PCEHR.

## **A2-8 Information privacy, security, confidentiality**

Strict controls of the PCEHR are required to prevent unauthorised access by government agents, insurance companies, employers, etc. Yet these controls should not inhibit the “legitimate” access to information as determined by agreement between consumers and providers of the information.

## **A2-9 Support the diversity of consumer conditions and consumer accessibility constraints**

- Different conditions require different information to be stored in the PCEHR. A “standard” set of data will disenfranchise those with “non-standard” conditions.
- Some consumers want to be very active in managing their clinical information, others may not be.
- There is often a mismatch between clinicians' levels of trust in their patients' abilities to manage information and their patients' actual abilities.
- Consumers vary considerably in their health literacy. Will the PCEHR cater for this diversity?
- Some consumers are better able to manage their medical information than their healthcare providers.
- Some consumers will have and will continue to have considerable difficulty accessing and or controlling access to a PCEHR (e.g no internet connection, poor computer skills, mental impairment).
- How will child access be handled? Will parents control young childrens' access?
- How will children's private interests be secure from parents? Of particular concern to teenagers.
- How can the PCEHR best serve the interests of those not computer literate and those with poor accessibility options. We don't wish to exacerbate the digital divide. This particularly applies to the very ill and the elderly – those for whom a PCEHR should particularly aim to help.

## **A2-10 Mechanisms to make information available for research without compromising patient confidentiality**

Many, but not all consumers, are prepared and willing to provide information for medical research. Two mechanisms that could be managed under the PCEHR authorisation infrastructure are:-

- consent to use de-identified data
- establishment of a registry for donated information. Many Australians are prepared to donate organs or tissues for other individuals or for research. A similar, dedicated facility could be established for health information, provided that it supports an acceptable and workable regime of controls on how information is to be shared with research organisations.

## Appendix 3 – about CeHA

The Consumers e-Health Alliance (**CeHA**) is not formally incorporated at this stage, but its current partners comprise 14 leading chronic illnesses and conditions organisations along with some individual members. Refer Attachment for listing of CeHA Associates.

Peter Brown – Cancer Voices Australia - convenor.

### Steering Committee

Peter Brown Cancer Voices Australia

Russell McGowan Health Consumer Council - ACT

Anna Williamson (Leukaemia Foundation)

Kate Johnson (Kidney Health}

Eric Browne, carer (formerly involved with HealthConnect)

**CeHA** is a collective of consumer oriented organisations and people who have displayed active positive interest in the e- Health program. Our initial activities are to highlight the major blockages to effective implementation i.e. Ownership, Governance, Leadership and the community wide 4C's:-

Communication | Co-operation | Collaboration | Coordination.

**CeHA** seeks agreed standards at all levels and for all affected community sectors to be appropriately represented at the same table at the same time. CeHA provides the avenue for the tabling of ideas, concerns, needs, information on e-health in which development we have a common interest and which directly affects the individual lifestyles of every citizen including their individual health needs at all times.

This statement expresses the tenor of the concepts that are activating CeHA.

This submission is made on behalf of the CeHA Steering Committee.

### **CeHA ASSOCIATES**      as at 1/6/2011

Alzheimer's Australia	Health Consumer Council - WA
Arthritis Australia	Health Consumers of Rural and Remote Australia
Asthma Foundation	Kidney Health Australia
Australian Diabetes Council	Leukaemia Foundation of Australia
Australian Lung Foundation	National Heart Foundation
Cancer Council Australia	National Stroke Foundation
Cancer Voices Australia	PRA Mental Health Recovery
Cochrane Consumer Network	Private Mental Health Consumer Carer Network (Australia)
Health Consumer Council - ATC	Tasmanians with Disabilities
Health Consumer Council - Q'LD	The Country Women's Association of Australia

- END of CeHA SUBMISSION -