RACGP

Healthy Profession.
Healthy Australia.

10 December 2015

Indicator Review
Attn: Indicator Review Project Officer
National Health Performance Authority
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To whom it may concern

Thank you for the opportunity to comment on the indicators in the National Health Performance Authority's Performance and Accountability Framework (the Framework).

The RACGP is committed to supporting quality improvement in general practice. We are keen to work with the PHN's to improve quality at the local level and recognise that data is essential for and planning health services. However, we do have concerns that whilst the Framework was established in 2011, it is not clear what benefit has been derived from the Framework's indicators and how they have contributed to improved healthcare delivery and outcomes. This is crucial for the Framework's legitimacy and for professional buy in.

Extending the set of indicators until their value has been established is premature but we wish to make the following general points and observations:

1. The Framework appears to omit measures of access to community health - such as waiting times to receive an Aged Care Assessment Team review. This is an important step required by a patient before accessing a community nursing aged care package, respite admission to a residential aged care facility (RACF) or admission to a RACF. Similarly an indicator could be developed for the proportion of community living elderly that are receiving community nursing support. There may be wide variation across the country and consequently a wide variation in need for admission to RACF and emergency hospital admissions in the elderly.

2. The Framework indicators do not address potentially inappropriate care or unexplainable variations in services. Examples might include cataract surgery rates, knee arthroscopy rates for >50 year olds, psychotropic medication use in children and in RACF, colonoscopy rates. This could align with the work of the Atlas of Healthcare Variation. Many of the items demonstrate variations in access to care, particularly access to specialist's outpatient services for rural patients.

3. There appears to be an acceptance that data will not be available beyond aggregate Medicare data, patient surveys, BEACH activity data and deaths. It seems unreasonable in an age of electronic data that PBS and MBS and Hospital and Death certificate data cannot be linked at a patient level in a confidential way.

4. The Framework does not appear to report on access to out-patient specialist services. How long does it take, how much does it cost and how far does a patient travel to access a neurologist, psychiatrist, paediatrician, and cardiologist? This means there is no accountability built into the state or federal health system for reasonable access to these specialist services.

5. The Framework does not appear to report on access to evidence based rehabilitation services that have demonstrated efficacy at reducing secondary harm. Particularly cardiac rehabilitation, multi-disciplinary stroke rehabilitation and (with less evidence) pulmonary rehabilitation.

6. The Framework has only limited indicators reflecting out-of-pocket costs for healthcare and the extent to which this is a barrier to accessing necessary care. For GPs, much time is spent organising affordable care and compromising healthcare to fit a patient's budget. Often it comes down to an equation of suffer waiting lists versus cost of private services. Indicators should be developed for access to affordable dentistry, specialist outpatient care, palliative care and diagnostic services such as ultrasound and x-ray.

Specific to the existing set of indicators we make the following comments and observations:

7. Screening rates for bowel cancer needs a National database to collect privately provided faecal occult blood tests (FOBT) and the National Bowel Cancer screening program.

8. The adult immunisation record will allow influenza, pneumococcal and tetanus booster to be audited rather than just childhood immunisations.

9. Screening rates should include rates for eligible age groups to have absolute cardiovascular risk assessment.

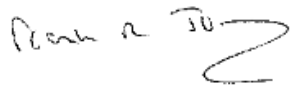
10. The Framework uses self-reported presence of a "long term medical condition" as a denominator for a number of primary care indicators. This is not a robust measure. Studies show a great discrepancy between medical conditions listed in administrative data (i.e. medical records) and patient self-reports. Other studies have demonstrated that prescribing or dispensing of long term medications is a more robust measure of the presence of significant long term medical conditions.

11. Quality of GP care can be assessed in a number of ways that are not considered in the Framework. The proportion of longer consultations has been shown to reflect the extent to which social and psychological impact of disease states are discussed and several related positive consultation outcomes.

12. Potential poor quality care can also be assessed by looking at the proportion of RACF patients prescribed antipsychotic medications or medications from the STOPP list of potentially inappropriate medications. Of course the 'best care' number will not be zero.

13. Indicator 40 about avoidable deaths in under 75 year olds seems difficult to define unless relying on the tiny proportion of coroners reports that trickle in 2-3 years after the event.

Yours sincerely



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