

CORRECTED VERSION

STANDING COMMITTEE ON ECONOMY AND INFRASTRUCTURE

REFERENCES COMMITTEE

Subcommittee

Inquiry into primary health and aged-care services

Melbourne — 2 November 2011

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Associate Professor H. Britt, director,

Associate Professor G. Miller, medical director, Family Medicine Research Centre, University of Sydney.

The CHAIR — Thank you very much for coming. I understand you have come from Sydney on Qantas, so well done on being here.

Assoc. Prof. BRITT — We made it.

Mrs COOTE — Getting back is the trick.

The CHAIR — I have just a couple of formal bits and pieces to run through to start us off. I declare open the Legislative Council Economy and Infrastructure References Committee public hearing. Today's hearing is in relation to our inquiry into primary health and aged-care services, specifically the committee is examining the measurement, including budget measures, of primary health and aged-care services and outcomes.

I would like to welcome Professor Graeme Miller, medical director, and Associate Professor Helena Britt, director, from the Family Medicine Research Centre. I indicate to you that all evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Legislative Council standing orders. Therefore you are protected against any action for what you say here today but if you go outside and repeat the same comments they may not be protected by this privilege.

All evidence is being recorded. You will be provided with a proof version of the transcript within the next week. Transcripts will ultimately be made public and posted on the committee's website. We have allowed 5 to 10 minutes for you to make a presentation if you would like to start that way, and then the rest of the available time we will pepper you with lots of questions hopefully to assist us with our work. But if I could now ask you to begin by introducing yourself and if you could also provide a business mailing address so we can send transcripts on at the end.

Assoc. Prof. BRITT — Thank you, Ms Pulford, for the opportunity to come and discuss this matter. I am Associate Professor Helena Britt from the Family Medicine Research Centre at the University of Sydney. Our mailing address is level 7, 16–18 Wentworth Street, Parramatta, 2150. Graeme, you can introduce yourself.

Assoc. Prof. MILLER — I am Associate Professor Graeme Miller. I am the medical director of the Family Medicine Research Centre. My background is 25 years in general practice and another 15 years in general practice research. I am a full-time academic researcher at this point in my career. I have also been heavily involved in the development of e-health in general practice for the last 30 years or so as well.

Assoc. Prof. BRITT — My background is originally as a psychologist, although my doctorate is in general practice and I have been in general practice research since it began really — about 35 years too long. We are co-chief investigators of the BEACH program, which is a continuous study of GP activity in Australia that has been running since April 1998. We will first just summarise our comments by addressing items 1 to 4 in your terms of reference and we will then give a brief presentation on the BEACH program and summarise our plans for future programs, when we get them funded.

Firstly, item 1, whether Australia, like most other western countries, should mandate the provision of information on the reasons people receive primary care treatments — that is, epidemiological coding to the International Classification of Primary Care or similar. In fact very few countries mandate such data collection, and those that do, such as Norway, in some areas have found that such data is of very poor quality and is an unreliable measure of the nature of patient problems managed in primary care. To begin with, when they mandate they usually mandate the reason. Patients throughout the world usually have on average one and a half reasons. They may have four problems managed or six problems managed, so one is not going to work.

Further, mandating collection of diagnostic data into a central database would face strong public and professional obstacles based on issues of privacy for patients and health professionals. However, we agree with the proposal that all clinical data from primary care should, as you suggested, be coded and classified to the Australian and WHO recommended standard, the International Classification of Primary Care, and we work at an international level with that classification and on the committee of the World Organisation of Family Doctors.

We want to say that it is not necessary to mandate the collection of data or to collect all of the data from all of the GPs all of the time. It just does not work. But sampling techniques such as those we use in BEACH provide reliable measures of morbidity and its management.

The second item is whether Australia should mandate provision of waiting times and waiting lists for primary care services. Firstly, we do not have waiting lists in general practice. We have shown that a complex interaction of patient demographics, GP supply and regional distribution of the GPs in the population influences both the waiting times and absolute patient access. If you have a patient waiting time, you have no measure of those who just cannot even see a GP. Some GPs close their books to new patients in order to give adequate time to those who they already see. The collection of waiting times would not address these issues.

The third item is whether Australia should mandate the requirement for provision of information about outcome measures — that is, appropriate treatment for diabetes, appropriate treatment for asthma. This is a measure of process, not outcome. A review of the care given by GPs for the health priority areas was produced by the Family Medicine Research Centre in 2009. This report demonstrates changes in the provision of care to patients with diabetes, asthma and other national health priority areas over the 10 years from 1998 to 2008. I am sorry I could not supply 10 copies of the report — it was too many to carry — but I will be leaving you with a copy if anyone wants to specifically look at any of those diseases.

This report provides a useful source of data for policy decisions regarding all segments of the health system. Meaningful intermediate outcome measures such as HbA1c levels in patients with diabetes are part of audit programs which seek to improve the quality of care. That approach has been found to be far more effective than reporting outcomes on a public level. Also, it is not necessarily the best thing for every patient to get their HbA1c level to less than 7 — you may kill them, depending on what else is wrong with them.

The fourth one, whether conditions for which hospitalisations can be avoided, should be considered a surrogate for the adequacy of primary health care. BEACH data show that so-called primary-care sensitive conditions make up only a small proportion of problems dealt with in primary medical care. Avoidance of hospitalisations for these conditions can actually be counterproductive in terms of patient health, where clinical judgement may determine the appropriate venue for care.

A broad range of measures is needed to assess the adequacy of the primary health-care system. We have done quite a lot of research for the Victorian government over the years. We did a specific study of morbidity and treatment in general practice in 1999 for the Victorian government and included a comparison with earlier data that was a precursor to the BEACH program. An analysis of care provided by GPs was also included in our general practice report on states and territories — which we have just copied this summary off, but all these are available free of charge from the website.

We also did a study on the activities of GPs employed in community health centres in Victoria, also for the department. We did a study of the clinical activity of GP registrars in Melbourne 2008 for the Victorian Metropolitan Alliance, a regional GP training provider. So in fact we have probably done more in Victoria specifically than any other state. We are well placed to assist the government of Victoria with the provision of information on the activities of GPs in the state, or to facilitate development of better health services for the citizens of Victoria.

I would just like to go on to tell you a little bit about BEACH and then touch on what we are planning for the future.

Overheads shown.

Assoc. Prof. BRITT — What is BEACH? It is a continuous national study of GP activity operated by our centre. We are self-funded, not for profit. We do not have any infrastructure funding from the university or government. We began BEACH in April 1998, so we are now in our 14th year, and about 13 000 participating GPs have been recorded to date, which is about 8500 individuals. You can do it more than once, (be recruited) over the 14 years.

Data are now available for about 1.3 million encounters and are used by governments, industry, health planners, researchers and students; particularly by the commonwealth Department of Health and Ageing and

by the Department of Veterans' Affairs, both of which make a partial contribution to the cost of running the BEACH program.

The continuity of BEACH allows measure of change over time. It is a paper-based data collection system. You may wonder why. It is a national GP random sample drawn by the department from the Medicare claims data so that we can ensure that we are recruiting active GPs. We recruit about 1000 GPs per year, and about 85 of those are in Victoria per year. That is 20 per week, 50 weeks a year, and an ever-changing sample. We are not looking at one particular trained group of GPs; we are sampling everybody all the time.

Each GP completes information for 100 consecutive encounters, and we include all types of encounters, no matter who pays for them. We get national data on about 100 000 encounter records per annum. We collect information about the GP, such as age, sex, practice location, education et cetera; about the patient, their age, sex, postcode, whether they hold a health-care card, whether they are Aboriginal and/or Torres Strait Islander, and whether they are new patients to the practice.

About the encounter, we look at when, how they paid and the reasons for the visit by the patient — that is, why did they come, and they can give up to three reasons for coming. As to the problems managed, on the GP's view of the problem, which allows up to four per visit, the average is 1.5: there is an average of 1.5 reasons for coming and 1.5 problems managed. Then there is the management provided for the problem: all the managements including medications; there are other treatments, such as clinical, counselling and procedures; referrals to specialists and allied health professionals; and tests ordered. All the management is linked to the specific problem.

We classify the pharmaceutical data so we can group it at any level and look at the specific use of specific types of opioids — for example, what they are being given for. As to accessing the data, data are available to external organisations such as the Victorian government by ordering standard reports. You can say you want to know all about a problem and how it is managed, or about how drugs such as opioids are being used, or about a group of patients, such as people attending GPs in Victoria; so you can pull out Victoria.

You can get information from our annual reports — and I will definitely leave a copy — and we provide to people who support the BEACH program an interactive web server with secure access, so they can actually go in and ask questions themselves, such as how often a particular problem is managed in this area, or whatever. It is not set up specifically for Victoria, but it could be if you were supporting BEACH. We do 20 sub-studies a year of different topics. The supporting organisations provide the research question to us and then we build on that. I will not go into too much detail there.

We can also do tailored requests, so you can be looking at males aged 45 years and over and what is happening in Victoria with their care; children under the age of 5; specific topics like what is happening with GPs who are older and nearing retirement; by patient characteristics; or what has happened over time in Victoria.

We deliver, on a straightforward request, within one week of the request. If it is a very complex request, it can take a few weeks; so the best idea, if you are looking for information, is to ascertain if it has already been published. There are 30 books — there will be any minute — on our website, on the AIHW website, which can be downloaded. You can ascertain if you can get this information out of a standard report and which is the quickest and cheapest way to get it; if you need tailored analyses; or if you should become a participating purchaser/participating organisation and get access to the interactive web server. If you want to become a participating organisation, you get quarterly line data — in your case it would be Victoria versus all, or all other — and all weighted data. We strip the data that we supply so that it is not in any way identifiable, and you get access to the interactive web server, which we would create specifically for Victoria as well as Australia. You get 20 days work, which is quite a lot of analysis time, worth about \$440 000 a year in external sales — that is, to external organisations, because they have to pay an access fee as well. Somebody has got to pay for the fact that it is being collected. And you get copies of all the SAND reports, the reports about the sub-studies.

You have a SecurID to access the interactive web server. You get representation on the BEACH advisory board, which allows you to actually guide what happens in the coming years at BEACH, and it costs \$165 000 a year, including GST. It is excellent value if you use it. If it is not, you are better off to buy a report when you

need it. This is reliable data, and it is the only reliable data in Australia and it is probably the most reliable in the world and world renowned as such.

On two issues in Victoria — we just ran this quickly yesterday — the age distribution of the patients at your encounters compared with the national average, there is nothing terribly unusual there, although you are a bit higher in the older age groups and a bit lower in the younger age groups. That may have something to do with your population, which we would look into if we were doing this for you.

I did a quick run, because in the published paper that we have given here we found the major issue that stood out in Victoria was high levels of depression. Even after adjustment for your population, you had high levels of depression. And guess what? When we ran it again yesterday for the past five years — that data is at least five years old — you have got high levels of depression being managed in general practice and a high frequency of management of osteoarthritis. That is the type of thing you can identify and then look further, deeper into it.

We are supported by pharmaceutical companies. We have research agreements between the university and the Australian government's Department of Health and Ageing, and endorsed by the AMA and the RACGP. So on to questions.

The CHAIR — What was that GP data?

Assoc. Prof. BRITT — That was 200 to 220 GPs in Victoria per year.

Assoc. Prof. MILLER — In the five-year report it averaged 22.7 per cent of all the GPs in BEACH, which is almost precisely proportionate to your population of both GPs and people.

Assoc. Prof. BRITT — I knew when I said it, it was wrong.

Mrs COOTE — First of all, this is really interesting and thank you so much. Looking at the data collection across the country — we have had a number of people give us submissions and obviously there is a lot of duplication, as I am sure you would see here too — I would like to know from your point of view, and you have been in this long enough to know, when you say that if someone is going to use the data, then that is terrific and it is a great tool, or otherwise they should just buy the report, are people becoming better able to access this data; the people who engage with you, the GPs themselves, for example? What sorts of questions and what sort of information are they trying to take out of this?

Assoc. Prof. BRITT — I would say largely they use the published data. They use it to see how GPs are currently managing things, so that could be for educational purposes. If you are designing the education of your undergraduate medical students, you need to know what GPs are doing, because those graduates, many of them, will become GPs. Also, the specialist should know what GPs are doing anyway, I believe. They use it to test theories if they are applying for funds for research across the country or anywhere. They use it to work out how long and how much it is going to cost to actually do it. They will look at management of specific problems, such as the Productivity Commission uses it for measuring antibiotic prescribing for upper respiratory tract infection.

Mrs COOTE — In that case, I misunderstood you. I thought that when you were talking about the GPs themselves, the GPs themselves do not use this data?

Assoc. Prof. BRITT — Individually they do.

Assoc. Prof. MILLER — Individually they do. We publish a lot of data from BEACH which is used by the GPs. Previous to this, the *Australian Family Physician*, which is the monthly publication of the royal Australian college of GPs, and it is the major medical journal for GPs in this country, every month has a theme which might be mental health or something like that, and the first paper in it is always our analysis of the BEACH data for that theme.

We feed back to them what is happening in general practice in all of these aspects so that will be followed by other educational or research papers through the AFP, but that is one of the important ways that they use it. More importantly, I suppose, it is used also by organisations preparing guidelines or guidance or other things

for GPs, so it goes to GPs via other bodies like Kidney Australia or the Heart Foundation or Diabetes Australia.

Assoc. Prof. BRITT — Or the college.

Assoc. Prof. MILLER — Or the college will use our data for that and, as Helena said, also for training. The training curriculum standards developed by the college of GPs and vocational training for GPs is essentially based on our data as well.

Assoc. Prof. BRITT — And your two universities use it in planning their training too, both undergraduate and postgraduate.

Mrs COOTE — Is there anything prohibiting an individual GP from getting this data, apart from the cost?

Assoc. Prof. BRITT — In fact we do not charge GPs.

Assoc. Prof. MILLER — The published data is free — freely available on the web. All these reports can be downloaded at no cost.

Assoc. Prof. BRITT — But also GPs ring up about a specific topic that they are interested in. If they have been asked to speak about paediatrics to some group, they will ring up and say, ‘Where can I find something on this?’, and we will say, ‘We published a paper recently on it here. See if that is enough, otherwise come back to us’. And we will do some quick runs for them to give them some background information. We do not charge them. They give their time for nothing.

But the other useful thing from the GPs point of view is that we send an individual analysis of the GPs data, their 100 encounters, and compare that with last year’s — because we have not got this year’s yet — national average and with nine other unidentified GPs who recorded at about the same time, and they are told whether each of the other nine are male, female, what age group, whether they are rural or city et cetera. They like that. They have to fill in a questionnaire to show that they have looked through those results and they can assess what is different about them and why that would be. There is no right or wrong answer in general practice — there really is not, because the individuals, the patients, vary so much. The idea is to get GPs thinking why they are different, whether it is due to the fact that they are seeing more women, more young people, they are in a deprived area with huge levels of depression, or whatever. Then they comment on that and send it back.

Their reward for doing all this, which is an incredible amount of work, is to earn quality assurance points towards their continued professional recognition. A lot of them put some very interesting thoughts down about their prescribing and why that is so, so it is a good education on an individual level, anyway.

Mrs COOTE — Why is it a paper-based data collection process?

Assoc. Prof. BRITT — Where do you begin?

Mrs COOTE — Because they are GPs and you may not be able to read their writing might be a reason to actually go online.

Assoc. Prof. BRITT — We are good at that.

Assoc. Prof. MILLER — We have trained coders who have become very good at deciphering the medical blurb because they have things written freehand. It is all basically about the current state of electronic health records in general practice. We have been working in the area of developing standards for electronic health records in the coding, classifications data models and this sort of thing. We have been involved in major projects funded by the Department of Health and Ageing to develop standards. The problem is that there has been no real incentive or method to introduce or mandate standards in electronic health records. Therefore we have eight different EHRs currently being used, all using different data models and three different coding systems. Several of them are quite difficult to use. The level of data that gets put in by the GPs is extremely variable and certainly is less than they used to record on paper when they were putting it on paper — and certainly vastly less than they put on the BEACH forms that they do for us.

One of the traditions around general practice medical records has always been that they act as a sort of aide memoire for the GP's memory of a patient, rather than a comprehensive and complete record. Certainly the current electronic records are not either comprehensive or complete. We had a mandate from the AIHW, when we first started off this program 13 years ago, to move towards electronic data collection. We have been trying for 13 years and we now have a proposal up to move more definitively in that direction, which Helena might like to describe.

Assoc. Prof. BRITT — Yes, just to touch on it. It is called LongBEACH, because it is longitudinal data collection and patient based, so you are following a patient over time. It is GP recruited, so we recruit the practice and they recruit a certain number of patients in each age group to follow the pattern of the community. We have to first actually develop the software that sits beside their own software, pulls out some information, puts it in there, and then says, basically: well, doctor, what about the rest of it, please? It gives a very similar structure to what they are used to in a paper-based patient health summary and a BEACH form for the encounter data.

We have been short-listed by the NHMRC. We have been interviewed, but we are not a single disease-orientation and people like us to do research on a single disease.

Mrs COOTE — It is a most extraordinary indictment, in this age of data collection, to think that the data collection is not up to scratch, after all these years of using electronic data.

Assoc. Prof. MILLER — I suppose it is the way in which GPs work. They are very time poor. They do not have much time to put in data, so that the amount of data that is in electronic health records is still quite small because of the way in which they operate and the way in which they do this. I think it is part of the way in which the system operates. This is not uniquely Australian; this is a problem all around the world. At the moment we are working with the Canadians on a very similar sort of exercise of trying to collect data from general practitioners in Canada. The situation is virtually identical, except that they have only 20 per cent of the GPs with a computer on their desk and we have 98 per cent.

Assoc. Prof. BRITT — Ninety-eight per cent of our GPs have a computer on the desk. A couple of per cent do not actually touch it; a couple of per cent use it for email only. A large proportion use it only as my own GP does: to produce the script, to produce the pathology test order, and to produce referral letters where he actually enters the words. He has no morbidity data on there. In a lot of the other systems, they have some morbidity data and they have the prescribing data, but there is no linkage between the two. You cannot assume a person who is on an antidepressant has depression because we know that 25 per cent of them do not; antidepressants are also used for severe pain, not just for depression.

Mrs COOTE — What about the younger people coming through? They are really smart and they should be able to do this data collection. Are the new ones not getting better?

Assoc. Prof. MILLER — Yes, but the problem is that there are inherently problems with the software itself, of being able to record it, and the structure of the data models within the software. Australian medical software has been sort of stuck in a time warp for about 15 years and there has really not been much alteration to it.

Ms BROAD — Thank you for your presentation and for your description of the BEACH study of general practice activity and outcomes. I guess we would expect that you would be big advocates for a representative approach to studying general practice activity, given this study which I guess you are very proud of. Given that the Australian government, through the national health reforms, appears to be going down a road which is rather different, so that rather than relying on representative collection of data and analysis it is moving to collection of much more broadly based data and tackling some of these problems that I think Andrea was touching on, in terms of getting more data directly, what implications do you think that will have for the BEACH study?

Assoc. Prof. BRITT — I am not quite clear on it. Are you speaking of the PCEHR, the patient controlled electronic health record, or the — —

Assoc. Prof. MILLER — Medicare local data collections, or what? My interpretation of what the federal government is doing is not the same as yours.

Ms BROAD — Please go ahead.

Assoc. Prof. MILLER — In that the prime data source that the department is currently using is BEACH.

Assoc. Prof. BRITT — Together with Medicare.

Assoc. Prof. MILLER — Together with Medicare data and PBS data and some data like the national health survey, that sort of thing. I do not think that currently they believe they are going to get any sort of adequate data out of electronic health records. They are to a certain extent commissioning Medicare locals to try to collect data in some way or other, particularly around some of the indicators that they have developed, but a lot of this is going to be service level data; it is certainly not going to be at the level of patient morbidity and patient management.

The PCEHR, which is the main approach that they are taking at the moment in the development of electronic health records, is going to be a centralised repository of patients who opt into that system. That is going to be standardised within the repository but not in the EHRs from which it comes. NEHTA, who were responsible for this and who were responsible for the e-health transition as it were in the process of doing this, do not have a remit to do anything about the standards within GP electronic desktop systems. What they are doing is extracting some data, converting it into the SNOMED coding system, and sending it in terms of a summary into a central repository, but without changing the quality and quantity that is actually in the desktop EHR. At the moment there is a very large question about the number of patients who might participate and the number of GPs who might participate, because it is opt in for both of those. The other thing is that the government has specifically excluded the use of PCEHR data for secondary research or secondary analysis or secondary use for policy decisions. That has been explicitly excluded in the draft legislation they have been putting up.

Assoc. Prof. BRITT — Further, the patient can choose to leave bits out of the summary, so if you receive it as a clinician you do not know whether you have a complete record anyway.

Ms BROAD — As is currently the case?

Assoc. Prof. BRITT — Yes.

Ms BROAD — According to the information that has been researched for us, up until 30 June this year, the Australian Institute of Health and Welfare was a collaborating unit of the Family Medicine Research Centre.

Assoc. Prof. MILLER — The other way around.

Ms BROAD — Sorry. Yes, the other way around, and that is no longer the case?

Assoc. Prof. BRITT — That is correct.

Ms BROAD — Can you explain to us what has gone on there?

Assoc. Prof. BRITT — We approached the institute and had discussions about the fact, way back in 1997, that they are trying describe the health of the community and ignoring 85 per cent of us because we did not die, we did not have an accident and we did not go to hospital. So we developed this collaborative approach and got money from multiple sources — with broad agreement, of course, from the AIHW. There have been two changes of directors to the AIHW since Richard Madden had it at that time, and their approach has been somewhat different. They decided, which is part of our agreement, that you can choose to terminate the agreement if you wish, if you do not want to continue. I do think that it may have had something to do with their participation in BEACH, that they may have felt limited to put together any other competitive idea — do you know what I mean? It may have been limiting them in what they wanted to do, but certainly there has been nothing concrete that I have seen.

Assoc. Prof. MILLER — The other thing that appeared to influence them as well is that we were running this as a joint project, and this left them feeling that they had a contingent liability for the possibility of

significant losses occurring if the project did not attract sufficient funds. This appeared to be one of the factors in making the previous director of the AIHW, not the current director, cancel it. About a month before she left the agreement was wound up. As a result of that decision, we approached the Department of Health and Ageing, who had been part funding the program through the AIHW. The department opted to continue to fund us for a further three years, directly to the university rather than through the AIHW, so we ended up with continuing support from the department, which now comes directly instead of via the AIHW. We have an agreement. I would not say it is a collaborative agreement any longer, but we do have an agreement with the AIHW that defines how we both use BEACH data in the future — that is, data collected before 30 March this year, which was still collected under the AIHW Act. From then on it is solely collected by the university.

Ms BROAD — So at least for the next three years you think the funding is sorted?

Assoc. Prof. BRITT — Yes. The department funds only 20 per cent, so we also have to rely on the continued support of a range of pharmaceutical companies. Times are tight so we always have a question of whether we are employed next year on the BEACH program. We have managed to get through that for the last 13 years so I can see no reason why we should not for the next three. I do not really envisage anything else of any quality being established in that time. Even if we got funded tomorrow for LongBEACH, it is going to take time, even with the Medicare locals. We are talking to the Medicare locals and they are asking for assistance. It is a huge challenge for the Medicare locals to work out what in the world they are going to put forward to assess their needs and to assess their outcomes.

Mr RAMSAY — I have a couple of quick questions. You talked about the recruitment of GPs. Is there a willingness within the returnees to go through the process of filling out patient forms and is it onerous? There are three parts to the question, so just bear with me. The second part is that I am still unclear about how they skirt the privacy provisions on attaching name to management. I assume there is a relationship there, although there may not be. The third part is: can you make it state specific — that is, for Victoria to get Victorian data? Can you use the Victorian GPs in relation to Victorian management from that data collection?

Assoc. Prof. BRITT — Yes. I will start from the beginning, which was willingness. Lots of them are willing. They see the data output all the time. They are very supportive, but they are not always available. We get about a 30 per cent ‘Yes’ at any time over a year. A person who has been randomly sampled in one triennium — because we run on this quality assurance triennium — may refuse in the next triennium because they are heavily involved with some other study, local study or whatever. They say, ‘No, I just cannot do it’, and we say, ‘Thank you very much. We might speak to you again at the time’. It may be three or four years later that they are sampled again, and they say yes that time.

We carefully compare those who say yes with the total sample frame. Sometimes we find we have a slightly lesser proportion of the younger GPs, and we then use a statistical weighting to ensure it is all representative. We then compare the final sample of the encounters with the total encounters claimed from Medicare, and it is very nice indeed. Statistically it is beautiful, with a 30 per cent response rate. Yes, some of them find it extremely onerous, and they do sometimes go into panic. They are supposed to do 100 consecutive encounters. Sometimes they ring and say, ‘I cannot do this’ or ‘I have to stop; I have just had an emergency’ or ‘I have a full waiting room’. We say, ‘Stop, Doctor. Calm down. Get rid of all this, and start again this afternoon. The point is: do not be selective. That is the point of the continuity’.

With regard to the state-specific question, yes, we have a couple of hundred GPs per year in Victoria, and we can pull that data out, as we have in that state-based study, and do full reports on any aspect — that study is only a summary — of activity in Victoria by Victorian GPs, or you can look at Victorian patients if you prefer.

Assoc. Prof. MILLER — I will just pick up on that part of the question about it being onerous. One of the things about it from the GPs point of view is that for 100 consecutive consultations, which is about a week, yes, it is more work than they are normally doing. When they are practised at it, each consultation takes about 2 minutes extra, but the thing is that they are doing this for only one week every three years, if that, because we have a rolling sample with a three-year sample frame. That is why we have people who have done it five times who will come back and do it again, because it is a set piece that allows them the luxury of doing it in fairly high detail for that time. If they had to do the same thing on every patient 52 weeks a year, there is just no way

they could do it. This is why the sampling process works in comparison to trying to get people to do this sort of level of medical recording on every consultation they do every year.

The CHAIR — So in your view mandating data collection does not work?

Assoc. Prof. BRITT — No, it does not.

Assoc. Prof. MILLER — It works technically in that you can mandate as, say, we did originally with the immunisation register, when the doctors got paid \$18 a throw for recording the information and putting it into the central register. If you pay some money for them to do a specific task — and what they were having to record were essentially only three data items, not a fully comprehensive record — they will do it for that sort of exercise. But as soon as the money stopped, the rate of recording into the register promptly went down again. Frankly, I do not think the immunisation rate went down. I think what has happened is the recording has gone down, which is a different issue.

Assoc. Prof. BRITT — There is one group of people in a private organisation that has a financial agreement to decrease the cost of the hardware if the GPs supply certain data, but they only have to do anything with it when they prescribe. They use the computer for the prescription, and before they can leave the record they have to say what that drug was for. If they do not prescribe anything for that problem, they are not asked what that drug was for because there is no drug. The most common problem managed in that data collection is prescription. That is the problem.

The CHAIR — What proportion of consultations would result in a prescription?

Assoc. Prof. BRITT — The proportion would be about 60 per cent, but when they are asked for the problem managed they are supposed to put ‘hypertension’ or ‘diabetes’ and the most commonly recorded is ‘prescription’. That is what mandating does for you. Also, in New Zealand when they forced it the most common problem managed was ‘cardiovascular disease’, which was not really very helpful.

The CHAIR — Are there any similar surveys for allied health?

Assoc. Prof. BRITT — Not yet. We are working with Monash and Melbourne. Melbourne has just finished their first data collection on chiropractic care, which is very exciting and being presented next week in Canada. They are using our coding system and ICPC classification. They are very much based on the BEACH data collection system. I think that pilot is funded by somebody in the Victorian government. They have tried to get it up with physios as well, but they are having a little trouble with that, and I am not sure why. No, definitely not routinely. They would love to do it in Victoria, but the allied health services do not run on computers very much.

The CHAIR — Are any of the other state or territory health departments participating organisations that have that access to the data?

Assoc. Prof. BRITT — They are not currently participating organisations. We have certainly done external work for Queensland, New South Wales and South Australia, and Western Australia in the last couple of years, but they have been specific requests that they needed for a specific issue, rather than data collection overall — that is, data output on a regular basis where you can look at change. I think increased interest of late will change that.

Assoc. Prof. MILLER — Those will be mainly around public health issues rather than general practice issues. It is a matter of how much interest the state has in general practice and primary care. Victoria has, in that area, taken more interest than most other states, using the BEACH methods and BEACH data.

Assoc. Prof. BRITT — On the public health issues, we have 40 000 records a year of height and weight — that is, the patient BMI — smoking status and alcohol intake, for Australia. In your case, that would be one-fifth of those. That is a huge sample, much bigger than any of the health surveys that are being done, and that is going on all year.

Ms BROAD — Just one last question, also on the point about the requirement for provision of information about outcome measures. In your response, you explain the difference between measuring processes and

outcomes, so my question is: do you think that there are circumstances in which measuring processes such as the successful completion of a course of treatment could be an acceptable proxy for an outcome?

Assoc. Prof. BRITT — If you had a fair definition of ‘successful’.

Assoc. Prof. MILLER — This is a very difficult clinical question, I think, because of the variance in patients, the way in which you manage them, what the expected goals of treatment are for both patients and clinicians, and whether they are shared goals. You can look at goals, methods of getting there and outcomes in terms of predefined goals, but quite often these are fairly soft and not terribly amenable, on a population base, to the standard sort of indicators that people look at, which is unfortunate. You get surrogates for these — the HbA1c is probably the most typical one, showing what level of glucose control you have got — but you need other things of the same thing to interpret that.

Take the level of weight gain that might occur. Quite often if you have patients with diabetes and you are controlling their HbA1c very well with insulin, you also increase their weight and cardiovascular risk at the same time, so it is not easy to do. This is one of the reasons why we want to move into patient-based longitudinal data collection, where we can describe patterns of care and patterns of outcomes. The alternative is to use very broad outcome measures, as did Barbara Starfield looking at primary care internationally, and therefore you look at mortality rates or unexpected mortality rates as the end point, but that is a very blunt instrument for the system.

Assoc. Prof. BRITT — I missed one of Mr Ramsay’s questions.

Mr RAMSAY — You did, and I was going to ask it again, but I could not get a word in.

Assoc. Prof. BRITT — You asked about the leakage of patient identification. In BEACH we do not identify the patient at all, so we cannot link to MBS or PBS data or anything like that. The patient agrees that their data can be included, even though they are not identified. There is huge agreement about this and there is very little objection, because they cannot be identified. However, when we go to LongBEACH, the longitudinal study, it is going to have to be informed consent with approval for us to link their attendance data and their dietician data at the clinic et cetera with the MBS and PBS mortality statistics and hospital admissions. That is the sort of process outcome of care that you can then apply. There are, of course, also other outcome measures that you can encourage the GPs to use, but each of them takes time, and time is something that they are rather short of at the moment.

The CHAIR — Thank you. I think we are out of time for our session as well. On behalf of the committee, thank you very much for coming to Melbourne and for sharing some of your expertise and considerable experience in these matters to help us with our work on this inquiry.

Assoc. Prof. BRITT — Thank you, Ms Pulford. We would like to leave with you a pack of forms. You may like to look at a form to see what the GP is faced with.

Witnesses withdrew.