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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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Professor Y. Wells, head, and

Associate Professor V. Lewis, director, research and evaluation, Lincoln Centre for Research on Ageing.

The CHAIR — Good afternoon and welcome. I will just run through some formal business to commence. We are today undertaking a hearing for the Legislative Council's Economy and Infrastructure References Committee. Our hearing relates to our inquiry, as you know, 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 welcome Professor Yvonne Wells, head of the Lincoln Centre for Research on Ageing, and Associate Professor Virginia Lewis, director of research and evaluation.

All evidence taken at this hearing is protected by parliamentary privilege as provided by the Constitution Act 1975 — and if you did this three weeks ago, this might be familiar to you — 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 proof versions of the transcript within the next week. Transcripts will ultimately be made public and posted on our committee's website.

We have allowed 5 to 10 minutes for a presentation to start, if you would like, and then the rest of the time for questions. For the Hansard record, please introduce yourself and also provide your business mailing address at the outset so we can send a copy of the transcript.

Prof. WELLS — Professor Yvonne Wells, AIPCA, La Trobe University, Victoria 3086.

Assoc. Prof. LEWIS — Virginia Lewis, all of the same.

Prof. WELLS — We thought we would start by trying to locate the centres where we work for you, because it seems a little confusing. Can I give you this handout?

The CHAIR — Yes.

Prof. WELLS — We do not have a formal presentation, because we thought that you probably had questions for us. We could make a few broad points about some of the issues that you are raising, but we wanted to start by letting you know where we sat in this organisation, since your original invitation was to Professor Rhonda Nay. Professor Rhonda Nay is the director of the AIPCA, so she is that box at the top. I am at the Lincoln Centre for Research on Ageing, which is one of the component centres of the AIPCA. I am the head of that centre.

Assoc. Prof. LEWIS — And I am the head of the centre that is CHSD on your diagram, which is on the far left. It stands for the Centre for Health Systems Development, and our particular area of interest is in primary care, the organisation of primary care and the development of primary health-care systems.

Prof. WELLS — Three of the centres within the AIPCA are concerned with ageing. Those are the Lincoln Centre for Research on Ageing; ACEBAC, which is the Australian Centre for Evidence Based Aged Care; and JRI, which is the John Richards Initiative and is located in Albury-Wodonga. You met Jeni Warburton. She is the head of JRI, whereas the other centres, which are to do with primary care — —

Assoc. Prof. LEWIS — They vary. The e-health unit is as it sounds: an e-health unit. Its work to date has primarily been in aged care, aged services and managing datasets. CHCP stands for Centre for Health Communication and Participation. Its orientation is around how you involve consumers in the development of health services and systems. QICSA on the end has actually moved out of AIPCA but used to be hosted within AIPCA. The health issues centre, which you may have heard of, is also associated with AIPCA, as is QIC, the Quality Improvement Council. As Yvonne said, the reason for saying that is that, in terms of developing our response to the inquiry, it was done by consulting across all the centres and getting feedback from all the centres. If at points you have questions which neither one of us is the source of, we may have to take them back and get clarification.

Prof. WELLS — I am here to speak on behalf of the three ageing centres.

Assoc. Prof. LEWIS — And my expertise is more in primary care.

Prof. WELLS — Sorry about that long-winded start.

The CHAIR — No, it is a helpful way to start.

Prof. WELLS — I suppose if we had some general points to make, one of them might be that, in terms of our response to the questions you posed, we were a little puzzled. That is because most of the data that you were talking about in the paper is actually commonwealth data rather than state data, so it is quite unclear to us what the purpose of the inquiry is and how we could help it, which is one of the reasons why we have not come with a formal presentation. The other reason is that we believe — I think we said this in our formal written submission to you — that data needs to be collected for a purpose and within a framework. Again, it was not clear to us in reading the paper that you put out for comment what that framework might be and what the purpose of collecting the data might be. Obviously data is really useful. Already a lot of data is out there that is not being fully used, and we can definitely see why the state might want to have a handle on those datasets. What the role of the state is in relation to the commonwealth is an issue, we think, actually. You would probably agree.

In coming here today, Virginia and I really are prepared to respond to any questions you might have to our written submission rather than making a formal presentation.

The CHAIR — Who would like to open the batting?

Mrs COOTE — We feel as if we are old friends here. We are.

Prof. WELLS — We are.

Mrs COOTE — An increasingly important issue, particularly with an ageing population, is that a lot of information that is out there is not actually being used effectively. Could you give me a handle on how much you believe is being collected in Victoria but is not being used effectively — information that is being collected but is not being translated into a usable commodity for policy purposes, data collection purposes and all that is needed? Could you give me some idea about how much we are looking at here?

Prof. WELLS — I can talk about the data in the aged-care sector, and then you might want to talk about anything in primary care or primary health. The main individual-level datasets that are collected in Victoria on people are the HACC minimum dataset and the Aged Care Assessment Program minimum dataset. Both of these datasets are collected already on every single client. E-health and Lincoln Centre together handle all of the Victorian data from the ACAP minimum dataset, which is collected quarterly. The data is collated at the centre. We report to the state Department of Health and to the commonwealth. The reports to the state are at the team level and are never released to the public. The reports to the commonwealth on a quarterly basis are never released. They are actually collated at the state level. We used to write a really large annual report every year, which was about 100 pages long, and the last one that was released was in 2006–07. Since then the commonwealth has taken over that whole process of collating data from all the states and they do not write those reports any longer.

While there is data that goes to the states, they do not easily have access to individual-level records, so they cannot easily carry out the analyses which they require. There are other datasets collected in Victoria that are even less accessible. I am speaking from experience here, because last year at the Lincoln Centre we did an evaluation of Direct2Care. With Direct2Care there are the two Access Points Demonstration projects that were set up. There was a national-level evaluation in Victoria after a state-level evaluation. Those two services also collect data on every single person who goes through. The data goes straight into a software system, the name of which I cannot remember, and that goes directly to the commonwealth.

We asked for copies of those datasets so that we could do some analysis. With Richard Rosewarne's assistance we set out specifications for the data that we wanted, individual-level datasets that we could analyse, a flat data file that we could merge with both the HACC and ACAP data, and we just never got anything usable. We got something that was a very dirty dataset, which took hours of cleaning, and which was very hard to understand. If we could not make sense of it, we cannot understand how anybody else could possibly have made sense of it, because it just was not data in a usable form. We know there are data out there that are usable. We know there are data out there that are not very usable. We know that there are data that could be used that are not being used.

Mrs COOTE — Can I just ask, on the HACC information that is collected, do you think the reason that the HACC information is not able to be accessed is that Victoria has such a different approach to HACC than any other state and therefore if it is collected by the commonwealth, it is not as relevant to them, because we are a different system?

Prof. WELLS — The state collates all of the HACC data, so it is in there in your Department of Health — the data for Victoria.

Prof. WELLS — It is the ACAP data that you do not get direct access to.

Mrs COOTE — And the primary care, Virginia?

Assoc. Prof. LEWIS — I do not think it is as bad as that sounds. In primary care there is a lot of data around, and I think it does get used. It gets used by different people for different purposes. I think the issue is more around whether there are ways to relate not necessarily in a sort of data-matching way but whether there are ways to relate the data to each other that have not been done or could be done better. There is also data that might be collected at local levels that would be quite helpful to aggregate up but perhaps does not have mechanisms in place to aggregate up.

There is some data — I am thinking through some of the service coordination tools and templates, but in fact that data does tend to get used. My impression certainly is that Victoria is quite good at using the data that it finds lying about and that it has access to in the primary care sort of space. I do not think there are the same issues. When we started looking at the documentation, we started from the point of view that they are actually not similar situations — the issues in primary care and those in aged-care services — and the indicators and measurement are not the same. They are very different. Hence the fact that we have different levels of understanding and experience in each of those spaces. I think the issues and difficulties around identifying or using the data are quite different in the two parts of the health system too.

Ms BROAD — I think possibly you were here when we had some discussions earlier during our previous presentation. I wonder if you would care to comment on the issues around relying on a representative dataset as opposed to, as your submission addresses, tackling these very big issues around collecting data across the board, getting different datasets to relate and pursuing these goals around better health outcomes with a framework around it that drives the design of it.

Assoc. Prof. LEWIS — I think that an approach like that, which is used for BEACH, is really useful, but it is useful for particular questions and not for most of the questions that have been identified as being of interest in this document. I think that the data that they get is helpful for saying what kinds of health issues are being seen and to some extent what that practitioner does. They do not get to outcomes for the client. I have concerns about the 30 per cent response rate, and I have concerns about the notion that the weighting that they introduce to account for the 30 per cent response rate is based on the age of the general practitioner and basically the amount they work — the number of sessions. I do not think that those are likely to be the actual biasing factors in the sample that they end up with.

As you know, the idea is that you get a random sample. If you end up with a low response rate, you have to think why is it those people and what is the factor that has actually determined their participation or not. It is more likely that the factor that determines their participation is something that is more about the quality of the GP, I suspect, so I have concerns about using that as a general indicator of the quality of our primary GP — primary medical care — system. I think that the actual bias in the sample that they end up with is a different sort of bias than just one that is related to age, location or the throughput they have or the number of hours they work. In terms of using it as a method to deal with some of those other questions, I think it would undermine the quality and the potential of that data to answer those questions. But I think what it does is really useful and important, and it is a really important dataset to have. It is just a matter of being aware that you cannot necessarily get all the answers from one dataset, methodology or approach.

Ms BROAD — Apart from measuring quality of care, if we go to the other issues around measuring outcomes and access — I think there were some others as well — and approaches to those based on what we have got?

Assoc. Prof. LEWIS — In primary care?

Ms BROAD — In primary care.

Assoc. Prof. LEWIS — In primary medical care with GPs — and there is that whole debate about what is primary care, primary health care, health care and so on.

The CHAIR — Yes, we did a bit of that this morning.

Ms BROAD — If we stick to GPs for the moment.

Assoc. Prof. LEWIS — That is right. Yes, it is a big issue and it is a hot topic. It is particularly a big issue in Victoria, because community health is a comprehensive, integrated primary health-care platform, and it is a platform that actually services the most vulnerable clients in Victoria. Yet if you applied most of those indicators that we are discussing on a very pure basis, they would come out looking not very good, because they take longer to deal with people and are much more complex. The chances that they will get the types of outcomes that my GP gets from me are really limited, because in fact the clients that they are dealing with have got so many different problems. Whether they will even actually stick with the treatment regime is dubious, so all of those sorts of factors become really highlighted in the community health sector in terms of their approach to primary health care and the kind of clients they deal with. I have wandered off the topic of the question. Sorry.

Prof. WELLS — That is all right. It is very interesting.

The CHAIR — No, that is very interesting.

Ms BROAD — Ways of tackling access and outcomes.

Mr RAMSAY — You sound like a politician.

Mrs COOTE — It is in the air, don't worry. It happens to everyone.

Assoc. Prof. LEWIS — As I think someone said, it is really difficult, obviously, which is why no-one has come up with a neat answer. Even at the national level where they are putting a lot of effort into this, the national council on safety and quality in primary care has come up with — and you would have seen them — their list of potential indicators. They include a wait time, and they include a wait time which tries to acknowledge the context by talking about locally determined targets and so on. That sort of allows you to say, 'Okay, we have got really hard people, so we will go for a different wait time to the GP in Brighton'. You think, 'That looks like fantastic data'; but in fact it is voluntary, and it is intended to be used as an internal quality improvement system. It is not actually going to generate data that you can pick up and use, even though it would be really interesting and useful.

That whole issue of, 'Can you get your hands on the data?' — and I do not understand them, but that will then introduce new applications of privacy and legal issues around whether you can or cannot get your hands on that data. Also, of course, as soon as you start taking data from people where it was originally intended for internal purposes, people start getting twitchy about the use to which it might be put. The idea that it might actually be used to compare services is justifiably nerve-racking for some people. I do not know how you actually do it.

I think the idea of having this sort of beautifully connected dataset that has unique identifiers and that can all be linked up is not possible. I think it is a matter of starting by building a framework which says, 'This is what we want Victoria's health system to look like, and this is how we think it should work', and just accepting that you can only answer bits of the question at a time and you can only build it in building blocks. By having a really clear framework about what you think it looks like or should look like, and what different parts of the system should look like and how they should work, you can test those bits with particular data that is valid and applicable at that point.

Ms BROAD — Can I just fast-track a follow-up to that, and then I will stop. If we imagine that we have got Medicare Locals in place, and we are actually able to ascertain that in some parts of Victoria we are seeing

much better outcomes than in others, and vice versa, and we want to do something about that, what should we be looking at in terms of those various measurements that we have talked about to enable us to do that, which is the whole point of the exercise really, at the end of the day?

Assoc. Prof. LEWIS — It is, and as we said, to get the outcome you actually need to know enough about the client to know whether the outcome was an achievable outcome and what the differences are. I was reading a paper the other day which looked at really enormous datasets about hospital separations. It looked at the hospital separations and outcomes for patients where they used the patients' socioeconomic status and the hospitals' geographic location demographic status and demonstrated that if you matched the client socioeconomic status across the different hospitals, going to a hospital in a poor area led to poorer outcomes than going to a hospital in a rich area. Why would that be so if in fact the health system is similar? What else is going on in that environment? That is where you start getting into the social model of health and why is it so.

The focus of JRI, one of our affiliated research centres, is on ageing in rural Victoria, because over and over the data tells us that we have poorer health and poorer health outcomes there. It might be the case that hospitals are a bit sparse in some places, but I do not think they are any worse. I do not know; the complexity of it makes it very difficult. I think in terms of what the purpose of the indicators is, I am interested in it from a primary care point of view and just knowing that there are enough basic primary medical care services available across the state, which is fairly basic mapping, and that enough of them offer bulk billing so that there is no out-of-pocket expense, that they can take new clients and that they will take new clients, because a lot of them will not take new clients or they will only take certain types of clients.

Those types of questions are not so complex, but it is fairly basic data that you could collect across Victoria which would help planning. Again, as you said, with Medicare Locals, we believe that part of their role will be to look for service gaps. What they do about it will be another matter.

The CHAIR — Primary health-care service providers in some areas, you said, are not open to new clients, and you also said they are not open to some types of new clients. Could you elaborate on that.

Assoc. Prof. LEWIS — Yes. In some of the evaluation work that we have done we have been told that there are general practices that will not take clients who have particular mental health conditions, for instance, because they may disrupt the waiting room and they can be difficult clients and take a lot longer to deal with. The 20-minute consult will turn into 30 minutes or 40 minutes. I am sure if you talk to the Disability Council of Victoria or any of those organisations, they would say that issues around equity of access come up anecdotally at least. I do not know what the data around this is. From my experience it is anecdotal, but as I say, I am sure there would be other organisations that may actually have some data about failure to receive service and so on.

Mr RAMSAY — I just have a quick one, if I may. Do you think there is a need to perhaps put the spotlight on residential aged-care providers in relation to performance measurements, and if so, how would they react to that? Is there a need, and if there is, what would their response be?

Prof. WELLS — There is already data collected on quality indicators and that is published, so that information is already in the public domain. Whether that adequately captures all aspects of quality is an issue with which the whole nation has been grappling for as long as I can remember. Yes, there could be additional indicators of quality. I am not quite sure how you would collect that data, though; maybe through resident satisfaction surveys or relative satisfaction surveys and that kind of thing. It would not be easy. It is not like going into somewhere and checking whether the fire extinguishers are in the right place and whether their case management records are good enough and they are following up on issues or that kind of thing. It is a different kind of quality.

Would people accept it? I think if it was fair, people probably would. It is the same issue that Ginny was talking about before, about people's perceptions of measurement. If people understand that the measurement process does not put them at a particular disadvantage, then often they do want to demonstrate that they are doing a really good job, trying really hard and doing the best for their residents that they can do given the resources that they have. If it is an additional burden of collecting data, then the answer is definitely no, because they already feel swamped by paperwork and they do not want any more, thank you very much. So it depends on how and for what purpose.

Assoc. Prof. LEWIS — I think that is right. I was thinking about this before when we were talking about the BEACH program data. One of you asked the question about what the response was and was it a burden for GPs to be collecting the data. One of the things is — and I know in some places in Victoria this has been done — if the point of it is just to collect the data, as evaluators we are frequently not welcomed into places because they think we are going to do something nasty. If the data is just being collected for the data, then people start saying, ‘Why do you want it? What are you going to do with it?’, and they might start gaming around it. But if in fact the data emerges from a process or a procedure that has been put in place to improve the care for clients, then it is more likely to be accepted and to be reasonable.

The sort of examples I am thinking of there are with the service coordination tools and templates that were introduced with the primary care partnership strategy and with the initial needs identification. That form is required in order to make referrals for services. So in effect you start getting a layer of good quality data about clients who are passing through the system, the nature of those clients and their needs at the point of a referral. It is not collected for data purposes — it is, but it is collected because the data helps the transfer of the client and an appropriate referral and so on. If you can then build in a system where you can extract that data so that you can watch it as it is being used, then that is more likely to be acceptable; it is probably better data, and nobody particularly minds because you are actually using it for a purpose which is around the care of the client. Maybe that is the answer to your question, too, Ms Broad, that if you can build it into the systems and processes and extract it, which is what some of the GP practice initiatives do too. They automatically extract the data from the GP’s electronic patient management — you know, some of the ABCD stuff, which is around chronic disease management? That is an automatic sort of data suck. That is probably more acceptable because it is for a different reason.

The CHAIR — Just to clarify that, are you referring to some of those recommended or agreed best practice for treatment of chronic illness initiatives?

Assoc. Prof. LEWIS — Yes, some of those, that is right, where they do clinical and case audits but in fact they do not have to do anything. I am trying to think of the one I saw recently where basically once the general practitioner has signed up to it the data gets pulled remotely, summarised and fed back to them, so they can see the trajectory and the client too can see the trajectory of their own care. That is clever, because it has a purpose around actually improving clinical practice, but of course it also gives you data. You are immediately going to hit equity issues and stuff about who is going to have a computer, which clients are going to sign up; all of that stuff will come into play.

Prof. WELLS — Just to take that back to aged care again, the data are already collected on the ACFI — aged-care funding instrument — on every single client in residential aged care regularly as well, so again there is a huge dataset already on everybody in residential aged care that is collected at the commonwealth level. I think those data get sent to the AIHW for collation. But those data are not about quality of care; they are about resident need. In fact there are perverse incentives in such measures because the residential aged-care providers are reimbursed on the basis of how needy people are, not on whether they manage to make people more independent or to do things for themselves in residential aged care. The incentives go the wrong way around. They are not as bad in ACFI as they were in the previous system, but they are still there. Depending on how you defined quality and outcomes for people in residential aged care, if you wanted to do something like that, then you would probably tack something onto the ACFI which demonstrated some kind of improvement or some kind of investment in the person rather than just their level of functioning. Do you know what I mean?

Mr RAMSAY — Yes. My question was not so much just about the fact of collecting data but actually trying to improve quality, or quality of investment to quality outcome, and that would be looking at the assessment process and then drilling down into the sort of measuring. The assessment process might not be appropriate. With the data collection we might find that we might have to reassess the assessment, if you like, and then move on to next step, which would be about measuring the quality of the residential aged care.

Prof. WELLS — Yes. I think that is done through the quality indicators. One of the things the assessors always do is look at people’s care plans. Then they look to see whether or not there is any evidence that people’s care plans have been acted upon, which is why of course there are now automated systems for doing all that kind of thing in residential aged care. The assessors get irritable if they can see some kind of issue arose and there is no record in the computer that something happened to act upon that issue. There are already in the

system potential points for making those kinds of assessments in a way; they are just not used in that way very much. Of course when the data are published from the accreditation system, it is pass/fail on all the standards. There is no sort of 9 out of 10 or 7 out of 10. It is very blunt.

Assoc. Prof. LEWIS — Which is a conscious decision, though, isn't it? It is a bit like child-care accreditation too: either you are or you aren't. It is that thing of whether or not you want to know the details because you want data or whether you accept that the process is such and is rigorous enough that you end up with three-year accreditation where it should be and not three-year accreditation where it should not be. There are two different purposes I think.

Mrs COOTE — Which almost leads us back to where we started, where you said in fact it is a very complex issue. A lot of this data is being collected by the commonwealth in any case. Can I ask each of you simply to state, if in Victoria we start to harness all of this information to get the sort of information that we want, which current body that is out there at the moment would be the best place to do that? Would it be the department? Would it be someone like BEACH? Who would be the best to do this? Which organisation would be best placed or already have a start on collecting a lot of this information that we are looking to muster?

Assoc. Prof. LEWIS — I would have thought the Department of Health for the primary care stuff, particularly because it has been an area of significant investment in Victoria for quite some time, whereas in some other states it has not been, so they are catching up. A lot of the stuff with the Medicare Locals and national health reform about picking up some of the learnings — horrible word, I know — has come out of Victoria. I think personally there is a lot of capacity and experience within the Department of Health. They could seek advice and help where they wanted it, but I think they have that overview.

Prof. WELLS — They have the overview and they have the expertise. They do not have access to all of the datasets. They do not have access to residential care datasets.

Mrs COOTE — That has been the discussion we have had here today, that someone has got the bulk of it, which is a good start and a place for a framework presumably, and obviously you would both agree it would be the Department of Health.

Assoc. Prof. LEWIS — I think so.

Prof. WELLS — Yes.

Ms BROAD — One last question that we have not touched on so far this afternoon. Our research notes remind us that one of the drivers for governments collecting health system data is to try to get to the question of efficient use of the funding that governments provide and try to establish whether value for money is being achieved. In seeking to measure and produce datasets to try to get to that question in primary care and aged-care settings, have you got a view about the best way to go about tackling that particular issue, which is from the point of view of governments rather than the consumers of health or aged-care services?

Assoc. Prof. LEWIS — In primary care I would have thought that the issue of the cost and so on is a commonwealth one. I think there is capacity to improve the value for money in primary care. There are system issues around using incentive payments for general practitioners as the only mechanism to get practice change. That is a problem from a finance and budget point of view if that is the only approach that there is. Also, I question the extent to which some of the outcomes that are intended from some of the investment are actually achieved. It is true to say that the indicators in that are often too clumsy so that if all it takes to get an additional payment is to claim for having done a particular assessment, then that is a problem because it is not what the quality of the assessment was. There is a lot of scope for the commonwealth to improve the way it assesses whether it is actually getting value for money in terms of its investment in primary care.

Prof. WELLS — I think that is probably true to say of most of the aged-care systems as well, though we are talking about a range — I suppose we are in primary care — systems, are we not? Home and community care, packaged care, residential care. Exercises that I have been involved in to look at, for example, the efficiency of the aged-care assessment program, by looking at the amount of money that was going in and the number of assessments that were coming out, did not seem to make a great deal of sense to me at the time, partly because other things affect the number of assessments that are done including obvious things like travel

times and other sources of income. Victoria always looked very strange when compared to the other states, for example, in terms of the aged-care assessment program because Victoria invested in it more than the other states and they did different kinds of assessments.

For example, in South Australia almost everyone that went through the ACAP went into residential care and that was not the case in Victoria — the assessments were more complex and people were directed to a range of other outcomes. The issue of efficiency requires you to state what the goals are of the particular thing that you are trying to measure. It comes back to where we started in a way, data for what purpose and within what framework, before you can really come to grips with efficiency.

I am sorry that is a very vague answer.

Ms BROAD — It is a complex question, so thank you.

Assoc. Prof. LEWIS — I will add one thing to the previous question about the best location for collecting information being and the Department of Health, and while I think that is true, it needs investment to be able to do what you ask of it. We have been involved in statewide evaluations of policy and initiatives that are intended to encourage system reform and they do not because the central investment in it to support change is too small. The location is right but it needs to have sufficient and the right resources to be able to then fulfil its potential as being the right location.

Mrs COOTE — The department will love that.

The CHAIR — We are out of time and we may even be out of questions. On behalf of the committee, I thank you for your time and for sharing your submissions with us today.

Witnesses withdrew.