Inquiry into Primary Health and Aged Care

Final Report

Legislative Council

Economy and Infrastructure References Committee

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Inquiry into Primary Health and Aged Care

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Economy and Infrastructure References Committee

Committee Members

Ms Jaala Pulford – Chair
Member for Western Victoria Region

Mrs Andrea Coote – Deputy Chair
Member for Southern Metropolitan Region

Mr Greg Barber
Member for Northern Metropolitan Region

Ms Candy Broad
Member for Northern Victoria Region

Mr Damian Drum
Member for Northern Victoria Region

Mr Bernie Finn
Member for Western Metropolitan Region

Mr Simon Ramsay
Member for Western Victoria Region

Mr Adem Somyurek
Member for South Eastern Metropolitan Region

Committee Staff

Mr Robert McDonald – Secretary to the Committee

Ms Vicky Delgos – Research Officer

Mr Sean Marshall – Research Assistant

Address all correspondence to –

Economy and Infrastructure References Committee
Department of the Legislative Council
Parliament of Victoria
Spring Street
MELBOURNE VIC 3002

Telephone: (03) 8682 2817
Facsimile: (03) 9651 8799
Email: council@parliament.vic.gov.au
Web: www.parliament.vic.gov.au/standing-committee-on-economy-and-infrastructure

Chair's Foreword

I am pleased to present the first report of the Economy and Infrastructure References Committee. This is the first report from one of the Legislative Council Standing Committees, which were established under the Standing Orders of the Legislative Council in late 2010.

The Committee's Inquiry examined a variety of issues connected with the provision of primary care and aged care services in Victoria. Unfortunately, parts of the terms of reference were difficult to understand and numerous comments were made in submissions and at public hearings on the ambiguity of the language in the reference. This hindered the Committee's ability to take evidence as many of the submissions focused on the language used in the terms of reference rather than the issues at hand. Despite this, the Committee was determined to examine each issue raised in the reference, with a view to adding value where possible.

The first area of the Committee's inquiry was primary care. The primary care system is principally Commonwealth funded and is currently undergoing significant reform at a national level through the National Health Care Reform Agreement, Medicare Locals and the implementation of Personally Controlled Electronic Health Records. A number of the issues examined by the Committee are best addressed at a national level, however it is important that Victoria works with the Commonwealth Government to gain the best outcomes for Victorians.

The terms of reference required the Committee to examine whether the provision of certain information by primary care providers to governments should be mandated. There was strong opposition to mandatory data collection by a number of professional associations, and significant challenges would be faced in implementing such a system. The Committee examined a number of alternatives to the mandatory collection of data that may be more cost effective options of monitoring and evaluating primary care services.

The Committee also heard that there is a growing prevalence of diabetes and cardiovascular disease in the community. These health problems are causing significant stress already on the health care system, with their impact growing in future. It would be beneficial for the Department of Health to better target groups at risk of these health problems early to avoid hospitalisations and further medical intervention.

The second area of the Committee's inquiry was aged care. As aged care is regulated by the Commonwealth and principally funded by the Commonwealth, the Committee focussed on the role the State could play in improving aged care services. Access to primary care and aged care, particularly in remote and regional areas, were common themes throughout the Committee's investigations and more needs to be done to address these issues.

Regrettably, the work of the Committee has been hampered by a lack of resources. As no additional funding was provided by the Government for the Legislative Council Standing Committees, the Committee was initially advised there were insufficient funds to fully advertise its terms of reference and a full-time Research Officer was not made available to the Committee until October, six months after receiving the reference.

Under the Standing Orders, Committee meetings are scheduled to take place on Wednesday evenings and late parliamentary sittings have placed significant demands on Committee members. On four occasions the Committee met on a Wednesday evening despite the Council sitting past midnight on the Tuesday. WorkSafe Victoria has reported that long working hours and insufficient recovery time leads to a reduced ability to concentrate, make decisions, think analytically and communicate effectively. I urge the Government to consider the impact that its preferred sitting hours are having on the capacity for effective and orderly functioning of the Legislative Council Standing Committees, in the best interests of Victorians.

On behalf of the Committee, I would like to thank all the organisations that provided submissions to this Inquiry and to the organisations that provided evidence at the Committee's public hearing. The information provided was valuable and assisted the Committee greatly. As Chair of this Committee, I wish to thank my Committee members for their tireless work on this Inquiry and to the staff of the Secretariat for their research, writing and administrative assistance. While not legislatively required, I urge the Government to respond to the recommendations of this important Inquiry and look forward to seeing a response from the Government on the action it plans to take.

Finally, I note that the topic of the Committee's first inquiry, primary health and aged care, was not directly relevant to the Economy and Infrastructure References Committee's functions. Under the Standing Orders the Committee is responsible for inquiring into and reporting on any proposal, matter of thing concerned with agriculture, commerce, infrastructure, industry, major projects, public sector finances and transport. I urge the Government to ensure future references to the Committee are more appropriately aimed at the Committee's areas of responsibility.

JAALA PULFORD
CHAIR

Findings

Finding 1

Mandatory provision of information on the reasons people receive primary care treatments would face significant administrative, technical and logistical obstacles and is not recommended at this time.

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Finding 2

Survey-based data collection programs are a cost effective way of collecting information on the reasons for which people receive primary care treatments. However, there are limitations associated with the use of such survey techniques which need to be considered. In addition, sampling techniques do not provide a complete set of data, so cannot be used to analyse performance of individual service providers.

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Finding 3

Significant resources would be required to collect data on waiting times and waiting lists and, due the varied nature and resources available to primary health providers, such data cannot be easily compared between services. The Committee therefore does not recommend that waiting times and waiting lists for primary care services be mandated.

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Finding 4

The Committee supports improved measurement of primary health care outcomes, instead of the current focus on outputs. However, given the significant national reforms currently underway, in particular the establishment of the National Health Performance Authority and the roll out of Medicare Locals, the Committee awaits further details on the data collection and reporting roles of these bodies before making further comment.

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Finding 5

The Committee supports the initiative by the Victorian Department of Health to develop a health outcomes framework and clinical indicators for community health services, consistent with those being developed nationally, however notes that indicators and outcomes should be relevant and useful to Victoria.

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Finding 6

Due to the varied nature and resources of primary health providers, Australia should not mandate processes for "appropriate treatment" for patients in primary care settings.

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Finding 7

Data on conditions for which hospitalisations can be avoided should continue to be collected and used as an indicator of the adequacy of our primary health care system, however, this data must not be considered in isolation. A number of other issues, including socioeconomic factors and willingness to seek treatment, must also be taken into account when interpreting this data.

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Finding 8

Data on the provision of residential aged care and community care alternatives is currently collated and made available by the Commonwealth Government.

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Finding 9

The current aged care accreditation process is effective and has driven quality improvements in residential aged care facilities. Public reporting of accreditation assessments is useful for informing the consumers about the quality of services provided by individual providers.

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Finding 10

The Victorian Department of Health's:

- quantity indicators for ACAS do not provide a complete measure on the timeliness of assessments;
- quality measures for residential aged care services do not adequately measure the quality of service provision; and
- quality measure for HACC does not provide any information on the quality of the service received by HACC recipients.

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Finding 11

Data on avoidable hospitalisations could be used as one indicator of the quality of the care in residential aged care facilities, however, data must not be considered in isolation. A number of other issues, including access to primary care, clinical judgement, skill mix of staff and family pressure must also be taken into account when interpreting avoidable hospitalisation data.

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Recommendations

Recommendation 1

The Committee recommends the Victorian Government work with the Commonwealth Government, the National E-Health Transition Authority and professional associations to investigate how the Personally Controlled Electronic Health Records system can best capture and collate data on the reasons for which people receive primary care treatment, and ways in which the State can gain access to this data.

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Recommendation 2

The Committee recommends the Victorian Department of Health evaluate and analyse data currently publicly available through the BEACH program on reasons for GP-patient encounters. If more detailed or tailored data is required, the Committee recommends the Department utilise a survey-based data collection program to supplement existing information, or the Department could consider becoming a participating member of BEACH.

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Recommendation 3

The Committee recommends the Victorian Government work with the Commonwealth Government and professional associations to investigate the possibility of implementing national survey-based data collection programs, to capture data on the reasons why patients utilise community and allied health primary care providers.

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Recommendation 4

The Committee recommends that the Victorian Department of Health work with Medicare Locals and the Commonwealth Government to identify and address areas of need for primary care services, in particular in relation to after hours care and access to services in remote and regional areas.

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Recommendation 5

The Committee recommends that the Victorian Department of Health work with Medicare Locals to ensure that patients are aware of the different primary care services and treatment options available in their area to ensure the best health outcomes.

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Recommendation 6

The Committee recommends that further work be undertaken to examine the links between access to primary care and avoidable hospitalisations in order to better understand the data already collected and to better utilise the data to improve health outcomes and reduce any unnecessary burden on hospitals and emergency departments.

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Recommendation 7

The Committee recommends that the Victorian Department of Health take urgent action to address the rising prevalence of type 2 diabetes and cardiovascular disease by appropriately targeting groups at risk as early as possible to avoid hospitalisations and further medical intervention in future.

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Recommendation 8

The Committee recommends the Victorian Department of Health report publicly on the data currently collected against quality indicators for Public Sector Residential Aged Care Services, as foreshadowed in the 2007-08 Resource Manual.

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Recommendation 9

The Committee recommends the Victorian Department of Health analyse the data which has been collected through its Quality Indicators in Public Sector Residential Aged Care Services project to determine whether the collection of this data has led to improvements in the quality of care. The Committee further recommends that based on the findings of this review, the Department engage with the Commonwealth to determine whether the development of a quality assurance framework, requiring all residential aged care providers to report against published quality indicators (as recommended by the Productivity Commission), would be beneficial in informing consumers and achieving better health outcomes.

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Recommendation 10

The Victorian Department of Health should:

- include the average wait between client registration and ACAS assessment in its performance measures;
- include more meaningful measures on the quality of its residential care services; and
- as part of its 2012-13 Budget, put in place performance measures for the HACC program that adequately measure the quality of HACC services provided.

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Recommendation 11

The Committee recommends the Victorian Government make representations to the Commonwealth Government to encourage it to review the Medicare rebate for medical services provided by GPs visiting residential aged care facilities to ensure that it covers the cost of providing the service, as recommended by the Productivity Commission.

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Acronyms

AACC – Australian Aged Care Commission

ABS – Australian Bureau of Statistics

ACAP – Aged Care Assessment Program

ACAS – Aged Care Assessment Service

ACCMIS – Aged and Community Care Management Information System

ACCV – Aged and Community Care Victoria

ACFI – Aged Care Funding Instrument

ACPR – Aged Care Planning Region

ACSAA – Aged Care Standards and Accreditation Agency

ACSC – Ambulatory Care Sensitive Condition

ACSQH – Australian Commission on Safety and Quality in Healthcare

AIHW – Australian Institute of Health and Welfare

ANAO – Australian National Audit Office

ANF – Australian Nursing Federation

ARIA – Accessibility/Remoteness Index of Australia

BMI – Body Mass Index

CACP – Community Aged Care Package

CALD – Culturally and Linguistically Diverse

COPD – Chronic Obstructive Pulmonary Disease

DHPDS – Dental Health Program Data Set

EACH – Extended Aged Care at Home

EACH D – Extended Aged Care at Home Dementia

FMRC – Family Medicine Research Centre

GP – General Practitioner

HACC – Home and Community Care

NEHTA – National E-Health Transition Authority

NHPA – National Health Performance Authority

NHRA – National Health Reform Agenda

PBS – Pharmaceutical Benefits Scheme

PCEHR – Personally Controlled Electronic Health Record

PHIDU – Public Health Information Development Unit

PIP – Practice Incentives Program

PSRACs – Public Sector Residential Aged Care

QPI – Quality Prescribing Incentive

RACGP – Royal Australian College of General Practitioners

SEIFA – Socio-Economic Indexes for Areas

VAED – Victorian Admitted Episodes Dataset

WICC – WONCA International Classification Committee

WONCA – World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

1. Introduction

1.1 Terms of reference

On 5 April 2011, the Legislative Council agreed to the following resolution:

That this House requires the Economy and Infrastructure References Committee to inquire into, consider and report on the measurement, including budget measures, of primary health and aged care services and outcomes, and in particular whether —

(1) Australia, like most other western countries, should mandate the provision of information on the reasons people receive primary care treatments, that is, epidemiological coding according to the International Classification of Primary Care or similar;

(2) Australia should mandate the provision of waiting times and waiting lists for primary care services;

(3) Australia should mandate the requirement for provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in primary care settings, appropriate treatments for asthma in those settings and so on;

(4) conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of our primary health care system;

(5) actual rates of provision of residential aged care for each community should be provided, as opposed to bed ratios;

(6) comparable rates of community care alternatives should be provided for these communities;

(7) quality criteria for residential aged care across a community and for each individual setting should be more clearly available and provided; and

(8) potentially unnecessary or avoidable hospitalisations of patients in residential care should be used as a surrogate indicator for poor care in these settings.

and that the Committee present its final report to Parliament no later than 12 months after this reference is given to the Committee.

1.2 Inquiry Process

Upon receiving the terms of reference, the Committee sought briefings from relevant Departments on the issues raised in the reference. On 1 June 2011, the Minister for Health, Hon. David Davis, and Professor Chris Brook, Executive Director, Wellbeing, Integrated Care and Ageing, Department of Health, jointly briefed the Committee, followed by a briefing by Ms Penelope McKay, Director, Budget and Financial Management Division, Department of Treasury and Finance.

A discussion paper was prepared and on 9 July 2011, the Committee advertised its terms of reference in the *Herald Sun* newspaper calling for written submissions. The Committee also wrote to a number of key stakeholders throughout Australia inviting written submissions. Submissions were originally due to close on 19 August 2011, however the Committee later extended the period for submissions to 9 September 2011 to allow a number of organisations who had expressed interest in making a submission further time to finalise their responses. At the close of submissions, a total of 30 written submissions were received. A list of submissions is provided in Appendix A.

Following receipt of written submissions, the Committee sought expressions of interest to appear at a public hearing from the 30 organisations that had made a written submission. Five organisations expressed interest in attending a public hearing and a day of hearings was held on 2 November 2011. The hearings were designed to complement and expand on written submissions and to provide a balance of views and evidence relevant to the Committee's terms of reference. A full list of witnesses who appeared before the Committee is provided in Appendix B.

The Committee gratefully acknowledges the valuable contributions made by all submitters and public hearing witnesses.

1.3 Scope of the Committee's Inquiry

Throughout this Inquiry, the Committee has struggled to interpret the terms of reference it has been provided. The Committee found that the confusion was not limited to its members and similar comments were received from organisations making submissions and witnesses that appeared at its public hearings.

The Committee found that the Department of Health had re-worded these terms of reference in a background paper, stating that the Inquiry was considering the following:[1]

- Use of a consistent classification system across all primary health care services (eg International Classification of Primary Care)
- Mandating waiting times and waiting lists
- Mandating of outcome measures & other measures such as cycles of care
- Use of proxy measures such as avoidable hospitalisations.

The Committee considers that confusion over terms of reference has led to organisations, such as the Department of Health, re-wording the reference or making interpretations on what the terms of reference mean. This has led to difficulties for the Committee in collecting evidence from written submissions as well as witnesses in public hearings.

The Committee was also unsure of how budget measures relate to the overall Inquiry. As far as the Committee can determine, there are a small number of Victorian budget measures that provide primary health and aged care services to the community. The vast range of primary care initiatives examined and considered are Commonwealth funded, privately funded or a combination. In addition, none of these measure outcomes as Victoria's primary focus continues to be on outputs.

The first three terms of reference required the Committee to consider whether Australia should mandate the reasons why people receive primary care, the provision of waiting times and waiting lists and the requirement for provision of information about outcome measures. The Committee is of the view that, as a Committee of the Victorian Parliament, it is not in a position to dictate to the Commonwealth Government, what should be mandated across Australia. The Committee also received comments from the Australian Nursing Federation that it was unsure as to what was meant by mandating, and whether mandating the recording of treatment and outcomes would impose legislative penalties on its members who were already working in busy environments.

The Committee was also confused by the use of the word 'surrogate' in terms of reference 4 and 8. This issue was also raised with the Committee by the Australian Nursing Federation. To more easily deal with the terms of reference, it was decided to substitute the word 'surrogate' for 'indicator'.

The wording used in the terms of reference has hindered the Committee's ability to collect evidence. It has also meant that the Committee has had to interpret some terms of references as it saw fit. Future terms of reference would benefit from clearer wording, which clearly identified what information was sought.

[1] Department of Health, *Victorian Community Health Indicators Project – Background Paper*, 2011, p. 2.

2. Primary care in Victoria

2.1 Primary care

Primary care is the first entry point or first contact individuals have with the health care system. The aim of primary care is to provide appropriate treatment for medical conditions and to avoid hospitalisations or further secondary health care. An important feature of primary care is a people-centred approach. This is defined as an approach that:[2]

- focuses on an individual's health needs, rather than illness;
- builds a relationship between the individual and primary care professional;
- is comprehensive and regular, rather than sporadic, care; and
- individuals are partners in managing their health care, rather than purchasers of primary care.

It is thought that a people-centred approach offers more opportunities to prevent illness and death and provides individuals with better primary care, regardless of where individuals access this care. In Victoria, individuals access primary care via general practitioners, community health services, allied health practitioners and hospitals.

2.2 General practitioners

General practitioners (GPs) are medical practitioners that operate in local communities throughout metropolitan, regional and rural Victoria. The vast majority of GPs work from private rooms in general practices, however they also work in non-residential health facilities, acute care hospitals and in 24 hour clinics.[3]

The role of a GP is diverse. As a primary care practitioner, GPs provide advice on health promotion and prevention strategies, early intervention for medical issues and assists patients to manage chronic diseases to avoid hospitalisation or further medical intervention.[4]

The Royal Australian College of General Practitioners (RACGP) is the professional body for GPs. The RACGP's role is to provide support to GPs, GP registrars and medical students via education, training, research, ongoing professional development, and the development of guidelines and standards to ensure high quality health care. The RACGP also undertakes testing and registration of doctors to become registered GPs.

To register as a GP, following medical school and a one year internship, a doctor undertakes three years (full-time equivalent) of general practice training, which comprises of 12 months in a hospital, 18 months of general practice placements and six months of extended skills training. Following this training, a doctor must sit a range of exams and assessments to become a Fellow of the RACGP.[5] Attaining fellowship of the RACGP means that a GP can work independently and unsupervised in the Australian community.[6]

There are also ongoing professional development requirements to assist GPs to meet their personal and professional training needs.[7]

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2 Department of Health and Ageing, *Definitions of primary health care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/nphc-draftreportsupp-toc~nphc-draftreportsupp-ch3~nphc-draftreportsupp-ch3-def>, accessed 25 October 2011.

3 Australian Institute of Health and Welfare, *Medical labour force 2009 – Primary care practitioners*, Table 3.1, August 2011.

4 The Royal Australian College of General Practitioners, *What is General Practice*, <http://www.racgp.org.au/whatisgeneralpractice>, accessed 17 October 2011.

5 The Royal Australian College of General Practitioners, *The RACGP journey towards general practice,* p. 1.

6 The Royal Australian College of General Practitioners, *RACGP Specialist Pathways,* <http://www.racgp.org.au/assessment/pathways/specialistpathway>, accessed 18 October 2011.

7 The Royal Australian College of General Practitioners, *The RACGP journey towards general practice,* p. 1.

Services provided by GPs

The 2009 Australian Bureau of Statistics Patient Experience Survey found that 81 per cent of people over 15 years old visited a GP in the 12 months of the survey period. Of those that visit a GP, the survey found that approximately one in ten make 12 or more visits a year. These were most likely to be from the age groups 65 to 74 and those over 75 years of age.[8]

The Family Medicine Research Centre at the University of Sydney provided the Committee with data in its public submission. This data stated that:[9]

- approximately 83 per cent of Australians claimed at least one GP service through Medicare;
- of those 83 per cent, the average number of visits to a GP is 6.4 visits per person;
- between April 2009 and March 2010, there were 116.8 million GP service items claimed from Medicare at a cost of almost $5 billion.

Payment for GP services

GP services are paid for in three different ways:

- wholly through Medicare, via bulk billing services;
- payment is made by the individual, who claims a rebate from Medicare; or
- via other funders, such as Department of Veterans Affairs or workers' compensation bodies.

Payments made by other funders are not tracked, however the Family Medicine Research Centre estimates that there were approximately 5.5 million additional GP visits in 2009-10.[10]

2.3 Community health services

Community health services or community health centres are important to improve the health and wellbeing of Victorians. Community health services target people with poor health, or those at risk of developing health conditions in future and have a higher economic and social need for assistance.[11] However, community health services can only be accessed by residents of a community.[12]

The aim of community health services is to work with primary care providers to coordinate care, promote the prevention of lifestyle related health issues, develop programs to improve social and physical environments within the community and to assist individuals to actively participate in their own health care. There are around 100 community health services that operate from approximately 350 sites throughout Victoria.[13]

Community health services offer a range of services including primary care, and cater to these according to the need in their local area. These services include:[14]

- counselling and support services;
- health promotion activities;
- medical and nursing services;
- dental health; and
- allied health services (audiology, dietetics, exercise physiology, physiotherapy, podiatry, occupational therapy and speech therapy).

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8 Australian Bureau of Statistics, *Health Services: Use and Patient Experience*, March 2011, p. 4.
9 Family Medicine Research Centre, Submission No. 3, p. 1.
10 *Ibid.,* p. 1.
11 Department of Health, *Primary and Community Health*, <http://www.health.vic.gov.au/pch/>, accessed 19 October 2011.
12 Better Health Channel, *Community health centres*, <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Community_health_centres?open>, accessed 19 October 2011.
13 *Ibid*.
14 *Ibid*.

Other services that may be offered by community health services include aged care services, carer respite, maternal and child health programs, disability services and outreach services.[15]

Services provided

The numbers of services provided by community health services are counted in the number of hours spent with clients. For dental services, it is counted as the number of persons treated. The table below shows the actual results for 2009-10, along with the expected results for 2010-11 and the targets set for 2011-12.

Table 1: Services provided for primary, community and dental health

Element	2009-10 services provided	2010-11 services provided	2011-12 target services
Community health care (hours)	982,743	1,021,827	976,000
Small rural services (hours)	99,534	89,317	100,700
Dental services (patients)	314,700	331,208	332,150

Sources: Department of Health 2009-10 and 2010-11 Annual Reports and *Budget Paper No. 3 Service Delivery 2011-12*

Funding for community health services

Community health services are funded by the Victorian Department of Health. There are two types, those independently managed and those that are part of public hospitals, including rural hospitals. There are also nine Multipurpose Health Services in Victoria which are jointly funded by the State and Commonwealth Governments. In addition, there are also Women's Health Services, funded by the State through the Women's Health Program.[16]

Community health services charge fees for services provided. However, fees are based on an individual's ability to pay and fees can be waived if payment would cause difficulty.[17] Funding made available for primary, community and dental health in the 2011-12 State Budget is outlined in the table below:

Table 2: Funding for primary, community and dental health for the financial years 2011-12

Element	Actual expenditure 2010-11 (million)[18]	Funding 2011-12 (million)
Community health care	239.1	233.4
Small rural services	17.5	17.2
Dental services	172.2	167.1
Total	**426.8**	**417.7**

Source: Department of Health 2010-11 Annual Report and Budget Paper No. 3 Service Delivery 2011-12

15 *Ibid*.

16 Department of Health, *Community health directory*, <http://www.health.vic.gov.au/pch/commhealth/directory.htm>, accessed 19 October 2011.

17 Better Health Channel, *Community health centres*, <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Community_health_centres?open>, accessed 19 October 2011.

18 The original budget for 2010-11 was $413.3 million. Actual expenditure was higher than expected due to a range of financial issues.

2.4 Allied health

Allied health practitioners are tertiary-educated professionals trained in healthcare. The aim of allied health is to support individuals with the diagnosis and recovery of medical issues to improve quality of life through:[19]

- increasing an individual's mobility, ability to care for themselves and independence; and
- assisting individuals to manage chronic conditions and reduce the risks of complications following injury or illness.

Allied health practitioners include, but are not limited to, audiologists, psychologists, social workers, chiropractors, osteopaths, physiotherapists, dieticians, occupational therapists, medical radiation practitioners, pharmacists and podiatrists. The term allied health practitioner does not apply to doctors, surgeons, nurses or dentists.[20]

Allied health professionals work in a diverse range of settings, including schools, universities hospitals, community health services, medical clinics, aged-care facilities, local government agencies and in private clinics.[21]

The Australian Institute of Health and Welfare reported that there were 65,284 allied health workers in 2006. This figure increased almost 28 per cent from 2001.[22]

Proportion of services provided

Due to the dispersed nature of service provision in allied health and the range of allied health care professionals, it is not possible to quantify the number of services provided.

Funding for allied health

Allied health services are funded in a range of ways. As previously discussed, allied health accessed through community health services are funded by the State, but depending on a person's ability to pay, may attract a fee.

Some allied health services may be offered free of charge, for example through public hospitals, schools or universities. Otherwise, allied health services tend to be paid for by individuals. If an individual has private health insurance, they may claim a rebate.[23] Individuals can also access a rebate under Medicare for five visits to an allied health professional if they have a chronic condition or complex care need.[24]

2.5 Hospitals

In Victoria there are 19 public health services, 56 rural and regional public hospitals and seven multipurpose services. Each hospital has an emergency department, although the operating hours differ depending on the location.[25]

Emergency departments offer primary care, in particular for the treatment of medical emergencies. When patients arrive, they are assigned a triage category, which assigns a clinically recommended waiting time in which they should be seen. There are five triage categories, category 1 being

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19 Better Health Channel, *Allied health*, <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Allied_health?open>, accessed 20 October 2011.

20 *Ibid*.

21 *Ibid*.

22 Australian Institute of Health and Welfare, *Health workforce*, <http://www.aihw.gov.au/health-workforce>, accessed 20 October 2011.

23 Better Health Channel, *Allied health*, <http://www.betterhealth.vic.gov.au/bhcv2/bhcarticles.nsf/pages/Allied_health?open>, accessed 20 October 2011.

24 Department of Health and Ageing, *Allied Health Services Under Medicare – Fact Sheet*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-medicare-health_pro-gp-pdf-allied-cnt.htm>, accessed 21 October 2011.

25 Department of Health, *Health Service Governance*, <http://www.health.vic.gov.au/governance/>, accessed 18 October 2011.

resuscitation required and the patient should be seen immediately, through to category 5, non-urgent and the patient should be seen within two hours.[26]

Generally, patients in triage categories 1 to 3 are thought to require treatment in an emergency department, where as triage categories 4 and 5 are less urgent and care could be provided by a GP or other primary care provider. However, after hours and on weekends, access to GP services may not be available.[27]

At the present time, the Department of Health, via regular reporting from hospitals, monitors the number of presentations to emergency departments as well as the timeliness with which patients are treated. The information is also made publicly available via the *Victorian Health Services Performance Report*, released quarterly.

Proportion of services provided

The number of presentations to emergency departments during the period April 2010 to March 2011 was almost 1.48 million. The number of triage category 4 and 5 patients presenting to emergency departments was just over 760,000.[28] These patients create a significant amount of work for emergency departments in Victoria.

The Department of Health has established a number of programs to try and divert patients from seeking primary care in hospitals and provide alternative care, if appropriate. These include:

- Nurse-On-Call program – which provides expert health advice from a registered nurse. The service operates 24 hours a day, seven days a week.[29]
- Co-located After Hours General Practice Clinics are located within, near or adjacent to the emergency department of some public hospitals to divert less urgent patients from the emergency department.[30]
- Primary Contact Physiotherapists being introduced into some emergency departments to provide primary care to 'appropriately identified' patients following triage. This program was reviewed in 2010.[31]

Funding for hospitals

At present, funding for Victoria's public hospital system is provided by the State Government. The cost of public hospital funding in Victoria in 2010-11 was more than $8 billion. Funding to public hospitals is increasing each year, and between 1999-00 and 2010-11 funding has more than doubled.[32] The Department reports that the increase in cost is due to a number of factors, including:[33]

- the population growth experienced in Victoria;
- Victoria's ageing population;
- the increasing cost of care due to advancements made in medical technology;
- higher staff wages; and
- increased expectations from the community as to quality of care.

It is not possible to determine the amount of hospital funding that is used for the provision of primary care.

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26 Department of Health, *Emergency care*, <http://www.health.vic.gov.au/performance/emergency-care.htm>, accessed 18 October 2011.

27 *Ibid.*

28 Department of Health, *Victorian Health Services Performance Report March 2011 Quarter*, June 2011, pp. 16, 36, 39.

29 Department of Health, *Nurse-On-Call – 24 Hour Health Advice for All Victorians*, September 2010.

30 Department of Health, *New Models of Care*, <http://www.health.vic.gov.au/emergency/models.htm#primary>, accessed 18 October 2011.

31 Aspex Consulting, *Review of Primary Contact Physiotherapy Services*, August 2010, p. 1.

32 Department of Health, *Your hospitals: A report on Victoria's public hospitals July 2009 to June 2010*, September 2010, p. 2

33 *Ibid.*, p. 6

The National Health Care Agreement, signed between the State Government and the Commonwealth Government in August 2001, will see the Commonwealth provide up to 50 per cent of hospital growth funding. In return, States will provide a range of reforms.[34] This is discussed further in Chapter 3.

[34] Department of Health and Ageing, *What is national health reform?*, <http://www.yourhealth.gov.au/internet/ yourhealth/publishing.nsf/Content/reformQA01>, accessed 18 October 2011.

3. Recent reforms to improve primary care in Victoria

3.1 Recent reforms to improve primary care in Victoria

The Committee received its terms of reference for this Inquiry in April 2011. Subsequent to the terms of reference being received, a number of significant reforms to primary care in Victoria have commenced at the national level.

The most significant of these reforms was the National Health Care Reform Agreement signed by the Commonwealth, State and Territory governments in August 2011. In addition, a number of key programs are being rolled out by the Commonwealth Government that will change the way primary care is delivered and managed within Victoria, including Medicare Locals, Personally Controlled Electronic Health Records and the establishment of the National Health Performance Authority.

3.2 National Health Care Reform Agreement

The National Health Care Reform Agreement was finalised in August 2011 and is based on commitments made by Commonwealth, State and Territory governments in February 2011. The agreement aimed to clarify governance arrangements in relation to health care and recognises that the States are the managers of the public hospital system and the Commonwealth has full funding and program responsibility for aged care (except where otherwise agreed) and has lead responsibility for GP and primary care.[35]

Under the Agreement, the Commonwealth will be responsible for:[36]

(a) system management, policy and funding for GP and primary health care services;
(b) establishing Medicare Locals to promote coordinated GP and primary health care service delivery;
(c) working with each State on system-wide policy and state-wide planning for GP and primary health care; and
(d) promoting equitable and timely access to GP and primary health care services.

Whilst under the agreement, the Commonwealth takes a lead role in these areas, the Committee believes that it is important for Victoria to actively engage with the Commonwealth to ensure the best primary health outcomes are delivered for Victorians.

3.3 Medicare Locals

As noted above, a key program agreed to as part of the National Health Care Reform Agreement is Medicare Locals. Medicare Locals are primary health care organisations established to coordinate primary health care delivery and tackle local health care needs and service gaps. They will drive improvements in primary health care and ensure that services are better tailored to meet the needs of local communities.[37]

Following a review by the Commonwealth Government, the boundaries of Medicare Local regions have now been determined.[38] It is planned for 17 Medicare Locals to be established in Victoria, as part of an Australia-wide network of 62 Medicare Locals.[39] The first Medicare Locals commenced on 1 July 2011. Approximately 15 more Medicare Locals will commence in January 2012, with the

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35 Council of Australian Governments, *National Health Reform Agreement*, 2011, paragraph 1(f).
36 *Ibid*., paragraph 10.
37 Department of Health and Ageing, *Medicare Locals*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocals-lp-1>, accessed 17 November 2011.
38 Department of Health and Ageing, *Medicare Locals Boundaries Review*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/MediLocBound_Review>, accessed 17 November 2011.
39 Minister for Health and Ageing, Media Release — *Medicare Locals to Reform Primary Health Care in Victoria*, <http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr11-nr-nr121.htm>, accessed 17 November 2011.

remainder commencing from July 2012. The following four Medicare Locals commenced in Victoria on 1 July 2011:[40]

- Inner East Melbourne Medicare Local;
- Barwon Medicare Local;
- Inner North West Melbourne Medicare Local; and
- Northern Melbourne Medicare Local.

Medicare Locals will have a number of key roles in improving primary health care services for local communities. They will:[41]

- make it easier for patients to access the services they need, by linking local GPs, nursing and other health professionals, hospitals and aged care, and maintaining up to date local service directories;
- work closely with Local Hospital Networks to make sure that primary health care services and hospitals work well together for their patients;
- plan and support local after hours face-to-face GP services;
- identify where local communities are missing out on services they might need and coordinate services to address those gaps;
- support local primary care providers, such as GPs, practice nurses and allied health providers, to adopt and meet quality standards; and
- be accountable to local communities to make sure the services are effective and of high quality.

Guidelines have now been issued to Medicare Locals to assist them in fulfilling these roles. As part of this process, Medicare Locals are required to analyse local health data to be used as a baseline from which improvement in access to after hours primary care services can be measured.[42] As the initial stage of this process, the Australian General Practice Network has commissioned the creation of Medicare Local population health profiles. The profiles aim to assist Medicare Locals by collating existing health data and grouping it by Medicare Local region. The profiles have been produced by the Public Health Information Development Unit (PHIDU), University of Adelaide and include estimates of chronic disease and conditions in each area, and information on access to general practitioners.[43]

3.4 Personally Controlled Electronic Health Records

The Australian Institute of Health and Welfare undertook a review and evaluation of Australian information about primary health care in 2008. The key recommendations from that review were: [44]

- A minimum data set specification for GP–patient encounters should be defined, in consultation with all stakeholders, which builds on work already undertaken in this area.
- The options established as potential starting points for an electronic collection should be explored with all stakeholders to formulate an agreed approach for implementing collection of this minimum data set at the national level.
- Where existing collections provide useful data, they should continue to be supported during the transition period and, where appropriate, afterwards.

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40 *Ibid*.

41 Department of Health and Ageing, *Medicare Locals*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/medilocals-lp-1>, accessed 18 November 2011.

42 Department of Health and Ageing, *Medicare Locals: Guidelines for after hours primary care responsibilities until 30 June 2013*, p. 19, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/D7063D448828CC17CA2578CE001B313D/$File/MLAH%20Program%20Guidelines.pdf>, accessed 23 November 2011.

43 Australian General Practice Network, *Population Health Profiles*, <http://www.agpn.com.au/medicarelocaltransition/population-health>, accessed 17 November 2011.

44 Australian Institute of Health and Welfare, *Review and evaluation of Australian information about primary health care: a focus on general practice*, 2008, p. vii, <http://www.aihw.gov.au/publication-detail/?id=6442468192>, accessed 18 November 2011.

In the 2010-11 Budget, the Commonwealth Government committed $466.7 million over two years towards the development of a Personally Controlled Electronic Health Records (PCEHR) system for all Australians. The National E-Health Transition Authority (NEHTA) is in charge of developing the system, in collaboration with State and Territory governments with the aim that from July 2012, all Australians who choose to can register for a PCEHR.[45]

A PCEHR is a secure, electronic record of a patient's medical history, stored and shared in a network of connected systems. The PCEHR will bring key health information from a number of different systems together and present it in a single view. Information in a PCEHR will be able to be accessed by the patient and authorised healthcare providers and will enable healthcare providers to make informed decisions and improve treatment advice. Over time, patients will be able to contribute to their own information and add to the recorded information stored in their PCEHR.[46]

Whilst the system principally aims to provide better coordinated care at the individual patient level, one of the other significant stated benefits of the PCEHR system is better policy development as a result of the high quality data potentially available for use in research and planning.[47] The NEHTA Blueprint identifies data collection as a potential secondary use of information collected through the PCEHR system and notes that privacy laws already recognise a range of permitted secondary uses of health information.[48]

3.5 National Health Performance Authority

Legislation to establish the National Health Performance Authority (NHPA) was passed by the Federal Parliament in September 2011 and given Royal Assent on 14 October 2011. The main function of the NHPA is to monitor and report on the performance of the health bodies, including "*primary health care organisations*".[49]

Work is being undertaken currently to develop a national Performance and Accountability Framework. The new NHPA will report on the framework and develop and produce Hospital Performance Reports and Healthy Communities Reports (on primary health care performance) which will help Australians make more informed choices about their health services and help ensure the standard of care patients receive continues to improve. The framework will be used to improve performance across hospital, GP and primary health care services.[50]

3.6 Impact of recent reforms on primary health care in Victoria

National Health Reform will provide a boost in services and funding for primary care in Victoria through a range of new programs and increases in funding. Hospitals will receive an extra $4 billion to 2019-20 for additional investments, including treating primary care patients in emergency departments.[51]

However, National Health Reform has a strong focus on diverting primary care patients from emergency departments through the following initiatives:[52]

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45 National E-Health Transition Authority, *PCEHR Concept of Operations*, <http://www.nehta.gov.au/ehealth-implementation/pcehr-concept-of-operations>, accessed 17 November 2011.

46 National E-Health Transition Authority, *What is a PCEHR?*, <http://www.nehta.gov.au/ehealth-implementation/what-is-a-pcher>, accessed 17 November 2011.

47 National E-Health Transition Authority, *Benefits of a PCEHR*, <http://www.nehta.gov.au/ehealth-implementation/benefits-of-a-pcehr>, accessed 17 November 2011.

48 National E-Health Transition Authority, *NEHTA Blueprint Version 1.0*, p. 139.

49 National Health Reform Amendment (National Health Performance Authority) Bill 2011, clause 6.

50 Department of Health and Ageing, *Proper Funding—A New Funding Model*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/nhra-properfunding-fs#increased>, accessed 17 November 2011.

51 Department of Health, *National Health Reform* ,<www.health.vic.gov.au/healthreform/>, accessed 28 October 2011.

52 Commonwealth Government, *What is national health reform?*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/reformQA01,>, accessed 28 October 2011.

- an after hours telephone based GP service;
- the establishment of 17 Medicare Locals in Victoria, with four already established in June 2011. Medicare Locals will coordinate primary health care services in local communities; and
- continuing to establish 64 Super Clinics around Australia, which will provide extended primary care.

The Department of Health's website states that there will be system wide policy and State-wide planning for GP and primary health care services as a result of National Health Reform. In addition, Victoria can also expect to have access to Commonwealth data.[53]

[53] Department of Health, *National Health Reform,* <www.health.vic.gov.au/healthreform/>, accessed 28 October 2011.

4. Primary care data

4.1 Primary care data

The Committee was required to examine the adequacy of primary care data currently collected, and whether collection of certain additional data should be mandated.

The Committee notes that a comprehensive study of data currently collected in Australia in relation to primary care was undertaken by the Australian Institute of Health and Welfare (AIHW) in 2008. In its report, *Review and Evaluation of Australian information about primary health care: A focus on general practice,* AIHW has collated information on the dozens of programs currently operating within Australia to collect data relating to various aspects of primary care.[54]

Given this recent comprehensive study, rather than re-evaluate each of the programs covered by that report, the Committee has focussed on the four key questions relating to primary care outlined in paragraphs (1) to (4) of the terms of reference.

4.2 Reasons for which people receive primary care treatments

In paragraph (1) of its terms of reference, the Committee has been asked to consider —

> 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 according to the International Classification of Primary Care or similar.

In considering this issue, the Committee believes it is important to focus on whether data collected is reliable and suitable for the potential uses of the data, rather than whether the existing data set is complete. At the present time, the data available on primary care is dispersed across government, private providers and community groups. The Committee is mindful that an additional burden of collecting data should only be imposed on primary care providers if the data collected would be useful to those providers and/or the State in planning and delivering higher quality care outcomes for patients.

4.2.1 Data currently collected in relation to the reasons for which people receive primary care treatments

There is currently no comprehensive system in Victoria or Australia for collecting data on the reasons for which people receive primary care treatment. However, there are a number of existing programs that provide quality information on the reasons why patients visit GPs.

Bettering the Evaluation and Care of Health (BEACH) Program

The BEACH Program is run by the Family Medicine Research Centre (FMRC), based at the University of Sydney. Each year BEACH involves a random sample of approximately 1,000 GPs (200-220 are Victorian[55]) where each GP records details about 100 doctor-patient encounters of all types. The GP sample is a rolling (ever-changing) sample, with approximately 20 GPs participating in any one week, 50 weeks a year and each GP can be selected only once per quality assurance triennium (once every 3 years). The encounter information is recorded by the GPs on structured paper encounter forms and each GP participant also completes a questionnaire about themselves and their practice.[56]

Under the BEACH program, data on reasons for patients presenting to a GP is collected in accordance with ICPC-2 Plus coding. ICPC-2 is an internationally accepted classification system

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54 Australian Institute of Health and Welfare, *Review and evaluation of Australian information about primary health care: a focus on general practice*, 2008, <http://www.aihw.gov.au/publication-detail/?id=6442468192>, accessed 18 November 2011.

55 A/Prof. H. Britt, Family Medicine Research Centre, *Transcript of Evidence*, 2 November 2011, p. 24.

56 Family Medicine Research Centre, *Bettering the Evaluation and Care of Health*, <http://www.fmrc.org.au/beach.htm>, accessed 18 November 2011.

for primary care encounters developed by the WONCA[57] International Classification Committee (WICC), and was first published in 1987. A revision incorporating criteria and definitions was published in 1998 and has been accepted within the World Health Organization's Family of International Classifications.[58]

The BEACH database currently includes about 1.3 million GP-patient encounter records as at July 2011.[59] From the data collected, BEACH is able to provide a breakdown of the reasons for why patients sought care from a GP, for example:

Table 3: Problems managed at general practice encounters: April 2007 to March 2008
Distribution (%) of problem chapters for encounters with Victorian patients

Reason for encounter	Percent	95% LCL	95% UCL
Circulatory	12.15	11.38	12.91
General & unspecified	12.11	11.35	12.87
Musculoskeletal	11.55	10.77	12.33
Skin	11.29	10.59	11.99
Endocrine & metabolic	10.32	9.61	11.03
Psychological	9.17	8.53	9.81
Digestive	8.88	8.19	9.57
Female genital system	6.85	6.53	7.17
Neurological	4.24	3.68	4.80
Ear	2.53	2.36	2.71
Urology	2.47	2.27	2.67
Pregnancy & family planning	2.13	1.96	2.31
Eye	2.12	1.89	2.35
Blood	1.44	1.30	1.57
Male genital system	1.16	0.96	1.37
Social	1.06	0.94	1.19

Source: Public BEACH Data[60]; Note: LCL — Lower Confidence Limit and UCL — Upper Confidence Limit.

In its submission the FMRC commented:[61]

> BEACH has sufficient sample size to provide reliable annual data on GP clinical activity to the Victorian Government at marginal cost compared with a total new data collection program … The sample size is sufficient to give a representative picture of the activities of Victorian GPs, possibly even at a Medicare Local level.

Whilst the BEACH program is a random sample of general practitioners, rather than a comprehensive collection of data from every patient encounter, the FMRC believe that the quality of the data is still very high due to the statistical sampling techniques used by BEACH.

The main limitation on the BEACH Program is that it only surveys GPs, not other primary care providers such as allied health providers including pharmacists, physiotherapists and podiatrists. However, in evidence to the Committee, the FMRC stated a project similar to BEACH surveying

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57 World Organisation of Family Doctors, <http://www.globalfamilydoctor.com/>, accessed 18 November 2011.

58 World Health Organisation, *International Classification of Primary Care, Second edition (ICPC-2)* <http://www.who.int/classifications/icd/adaptations/icpc2/en/index.html>, accessed 18 November 2011.

59 Family Medicine Research Centre, *Bettering the Evaluation and Care of Health*, <http://www.fmrc.org.au/beach.htm>, accessed 18 November 2011.

60 Family Medicine Research Centre, *Public BEACH data*, <http://sydney.edu.au/medicine/fmrc/beach/data-reports/public/index.php>, accessed 18 November 2011.

61 Family Medicine Research Centre, Submission No. 3, p. 5.

chiropractors was currently being undertaken by Melbourne University, with the hope of including physiotherapists in future.[62]

FMRC stated that for minimal cost, the Victorian Department of Health could become a participating member of BEACH and have access to all the data collected.[63]

Study of GPs working in Community Health Services in Victoria

The FMRC also undertake tailored research for specific data needs. For example, in 2005, the Department of Human Services (which, through machinery of government changes in 2009 was split to create the Department of Health) commissioned the FMRC to undertake a study of GPs working in community health services in Victoria utilising the methods of the BEACH program. This research aimed to describe GP activity and profiles of patients attending Victorian community health services to assist both the Victorian Government and the management of the services to understand the unique clinical role and the characteristics of patients to whom GPs provide their services.[64]

Medicare data and Pharmaceutical Benefits Scheme Data

Medicare data and Pharmaceutical Benefits Scheme (PBS) data has limited use when attempting to determine the reasons for which people receive primary care treatments. Medicare data includes a Medicare item number, the amount of Medicare benefit applied, date of service and processing, provider number, recipient of the service and an indication of whether or not the item was provided in hospital. However, no information about the content of the consultation of the underlying medical condition is recorded.[65] Similarly, PBS data only collects information about the number of PBS subsidised drugs dispensed (approximately 80 per cent of prescription dispensed are subsidised by the PBS),[66] not the underlying condition for which they were dispensed. Whilst some condition specific data is available for targeted programs funded by Medicare, this data is collected for the purpose of making payments to GPs for services provided, and has limited benefits for research and analysis.

National health survey

The national health survey is conducted every three years by the Australian Bureau of Statistics. It is based on a questionnaire asked of 15,800 randomly selected households across Australia.[67] The data is therefore self-reported and not based on the assessment of a medical practitioner. The data is reported on a state by state basis and provides important information about the percentage of Victorians with certain long term conditions, such as arthritis, asthma, diabetes, heart diseases, cancer and mental disorders or illnesses. This data can be used for monitoring trends in certain conditions, and can assist the Department of Health in planning preventative health programs for Victoria.

Victorian Population Health Survey

The Victorian Population Health Survey has been conducted annually by the Health Intelligence Unit in the Department of Health since 1998.[68] Information is collected via computer assisted telephone interview on overall self-rated health status, level of psychological distress, body mass index (to determine weight status), the presence of chronic diseases, nutrition, physical activity, smoking and alcohol consumption. Information is also collected on participation in screening for bowel cancer, cervical cancer, breast cancer, high blood pressure, cholesterol and high blood

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62 A/Prof. H. Britt, Family Medicine Research Centre, *Transcript of Evidence*, 2 November 2011, p. 29.

63 *Ibid*., p. 23.

64 Family Medicine Research Centre, *Past commissioned research*, <http://sydney.edu.au/medicine/fmrc/research/commissioned/index.php>, accessed 18 November 2011.

65 Australian Institute of Health and Welfare, *Review and evaluation of Australian information about primary health care: a focus on general practice*, 2008, p. 21. <http://www.aihw.gov.au/publication-detail/?id=6442468192>, accessed 18 November 2011.

66 *Ibid*., p. 23.

67 Australian Bureau of Statistics, *National Health Survey: Summary of Results, 2007-2008 (Reissue)*, <http://abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4364.0Explanatory%20Notes12007-2008%20(Reissue)?OpenDocument>, accessed 18 November 2011.

68 Department of Health Victoria, *Victorian population health survey*, <http://www.health.vic.gov.au/healthstatus/survey/vphs.htm>, accessed 18 November 2011.

sugar in addition to community participation, levels of social support and connections with others. Interviews are conducted in the major non-English languages in Victoria to ensure people of culturally and linguistically diverse backgrounds are represented. Data is self-reported and participation is voluntary. The data is used to help the Department of Health monitor the health status of the Victorian population over time and to help ensure that public health programs are relevant and responsive to current and emerging health issues.[69]

4.2.2 Potential issues with mandating collection of data

A number of issues that would arise from the mandating of the collection of data on the reasons for which people receive primary care treatments were raised with the Committee through the submissions it received. These issues are discussed below.

Administrative burden

The majority of organisations that made submissions to the inquiry were concerned about the administrative burden that would be placed on primary care providers if the collection of data relating to the reasons for patient encounters was mandated. In particular the Australian Medical Association (Victoria) noted in its submission:[70]

> In the Australian context, a proposal to mandate collection of diagnostic data into a central database would face insurmountable public and professional obstacles based on issues of privacy and confidentiality of both patients and health professionals.

The Australian Nursing Federation (Victorian Branch) stated:[71]

> Should the concept as proposed be adopted, consideration must be given to how epidemiological coding could be applied and contextualised to the Victorian health care sector; ensure that it is fully funded so there is no additional cost burden to already finite services and the time it takes to input data is fully realised, resourced and funded.

The Australian Institute for Primary Care and Ageing noted similar issues:[72]

> In terms of identifying diagnoses or presenting conditions, the ICPC or ICDC take time to use and are too detailed for routine collection for every episode of care … It could be possible to apply a coding system to particular settings, clients, or MBS items; but the cost of collection would be high, and the need would have to be very clearly established.

The Committee agrees with these concerns and believes it is important that any data collection program should not unnecessarily increase the administrative burden on primary health care providers. An increase in administrative burden may adversely impact the number of patients primary health care providers are able to treat. Should a less detailed coding system be used, as suggested by the Australian Institute for Primary Care and Ageing, it would need to demonstrate that it could add value and provide information for improving primary care.

No improvement in quality of data

Data collection should only be mandated if it would result in higher quality data than currently available. As noted above, the BEACH program currently provides statistically reliable data on the reasons for primary care encounters through its ongoing survey. In its submission, the FMRC also commented:[73]

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69 Department of Health Victoria, *Victorian population health survey 2009 – information brochure*, <http://docs.health.vic.gov.au/docs/doc/0E699820F8372188CA2578670082611B/$FILE/vphs-brochure-2009.pdf>, accessed 18 November 2011.

70 Family Medicine Research Centre, Submission No. 3, p. 5.

71 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 3.

72 Australian Institute for Primary Care and Ageing, Submission No. 28, pp. 6-7.

73 Family Medicine Research Centre, Submission No. 3, p. 5.

> … very few countries mandate the provision of such data, and those that do, for example Norway, have found that the quality of such data is very poor and an unreliable measure of the nature of patient problems presenting to primary care.

GPs participating in the BEACH program must complete a form with numerous fields for each patient encounter. Given it takes approximately 2 minutes to complete such a form for every patient encounter, there is a risk that practitioners may take short cuts to save time, resulting in poorer quality data.

In its evidence, FMRC stated that certain pharmaceutical software had attempted to mandate a field for GPs to complete when prescribing medication, where the GP was required to list the underlying medical condition for which the medication was being prescribed. However, data extracted from the system showed the most common condition listed was "prescription", which is clearly not a medical condition, indicating GPs took short cuts or did not fully understand the software.[74] If reasons for encounter were mandated for each GP visit, for example by linking it to Medicare rebate claims, it is likely similar problems will be encountered. FMRC also stated that their experience shows there can often be 3 or 4 reasons for each GP-patient encounter, and a number of these may be missed if GPs have to complete data quickly, and only one reason may be captured.

Privately operated primary health providers

A number of submissions also stated it would not be possible for the Victorian Government to mandate data collection from privately operated and Commonwealth funded primary health providers. General Practice Victoria noted:[75]

> If Australia were to mandate the provision of information on the reasons people receive primary care treatments, and this was intended to happen across all general practice services rather than to be based on a sample, it would require major changes to the MBS and its legislation. The Commonwealth would need to change the system so that patients and doctors were obliged to report reasons as a condition of receiving MBS rebates ... These changes would apply only to the general practice private sector, because there is no system for data collection from private allied health, and no linked state or commonwealth payment. Although we do not have good evidence about allied health consultations, in the way we have for general practice (from BEACH data), we know that private allied health is a significant part of primary care.

Dental Health Services Victoria noted a similar issue:[76]

> In noting our support for the data collection, we also acknowledge the challenges that face Government (Federal and State) in establishing a collection platform. Dental care is provided predominantly in the private sector, and one of the major challenges is capturing private dental data to measure improvements in oral health of the whole community.

As allied health and dental health are significant providers of primary care, the Committee believes it would be useful to obtain better information on the use of these providers and the reasons for which patients use these providers. However, as there is currently no funding or reporting relationship between allied and dental health providers and the State or Commonwealth Government, collection of such data is not straightforward.

Implementing a program such as BEACH for such providers may be a more cost efficient approach, rather than mandatory reporting by all providers. As these practitioners are now regulated by national uniform regulations,[77] any attempt to mandate data collection would need to be implemented at a national level.

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74 A/Prof. H. Britt, Family Medicine Research Centre, *Transcript of Evidence*, 2 November 2011, p. 29.
75 General Practice Victoria, Submission No. 18, p. 4.
76 Dental Health Services Victoria, Submission No. 30, p. 2.
77 *Health Practitioner Regulation National Law (Victoria) Act 2009* which came into force on 1 July 2010.

National approach

Those organisations that supported greater collection of information relating to the reasons for which patients receive primary health care treatments cautioned the Committee against Victoria adopting its own system. Instead they advocated for a national system. In its submission, the Royal Australian College of General Practitioners commented:[78]

> The RACGP would be cautious to support the mandating of a specific coding system that would affect the current systems currently being utilised in various general practices until a true national standardised system is adopted.

The Australian Nursing Federation (Victorian Branch) stated:[79]

> The Australian government is preparing to establish a national data base in relation to people receiving primary health services and treatment in association with the implementation of the roll out of the national e-health initiative, therefore this move would seem to be a duplication of service provision and an unnecessary financial burden to the State. It would seem more appropriate the State based services ensure they are able to contribute to and access both State and National data.

The Australian Health Practitioner Regulation Agency stated:[80]

> It would be preferable for any proposal to impose additional data collection or reporting obligation on bodies within the [national registration and accreditation scheme] or practitioners or professions regulated by the scheme to be considered nationally, consistent with the national operation of the scheme itself. This would require consideration by all governments through the Australian Health Workforce Ministerial Council.

The Committee supports a national approach to data collection as it could provide legislative authority for data collection. The Committee also notes that Australian Health Ministers agreed on 5 August 2011 to establish a time limited Working Group to review opportunities to improve the effectiveness of health data reporting. Health Ministers noted future work will be undertaken with the new National Health Performance Authority.[81]

4.2.3 Alternatives to collecting data through a mandatory system

Given the challenges detailed above with implementing a system for mandatory provision of information on the reasons people receive primary care treatments, the Committee believes other avenues should be explored which could provide more comprehensive data in this area and which would be beneficial for planning and monitoring primary care. A number of alternatives for collecting data on why people receive primary care treatments are detailed below.

Electronic health records

Significant work has already been undertaken by the National E-Health Transition Authority (NEHTA) towards establishing a Personally Controlled Electronic Health Records (PCEHR) system for all Australians. A number of submissions identified the PCEHR system as a potential vehicle for the collection of more comprehensive patient encounter data. The Australian Nursing Federation (Victorian Branch) stated:[82]

> The Australian government is preparing to establish a national data base in relation to people receiving primary health services and treatment in association with the implementation of the roll out of the national e-health initiative, therefore this move would seem to be a duplication of service provision and an unnecessary financial

78 Royal Australian College of General Practitioners, Submission No. 14, p. 2.
79 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 3.
80 Australian Health Practitioner Regulation Agency, Submission No. 23, p. 1.
81 *Australian Health Ministers' Conference Communiqué, 5 August 2011*, <http://www.ahmac.gov.au/cms_documents/2011-Aug%205%20AHMC%20Communique.doc>, accessed 18 November 2011.
82 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 3.

> burden to the State. It would seem more appropriate the State based services ensure they are able to contribute to and access both State and National data.

The 2008 AIHW report, *Review and Evaluation of Australian information about primary health care: A focus on general practice*, examined the numerous data collection programs currently operating in Australia and made two key recommendations on this issue:[83]

- Minimum data set specification for GP–patient encounters should be defined, in consultation with all stakeholders, which builds on work already undertaken in this area.
- The options established as potential starting points for an electronic collection should be explored with all stakeholders to formulate an agreed approach for implementing collection of this minimum data set at the national level.

The NEHTA Blueprint identifies data collection as a potential secondary use of information collected through the PCEHR system and notes that privacy laws already recognise a range of permitted secondary uses of health information. The companion document to the exposure draft of the legislation to implement PCEHR further states:[84]

> The Draft Bill allows a consumer to consent to the collection, use and disclosure of information included in their PCEHR (see section 59). This takes into account occasions where a consumer has consented to have their information used and disclosed for research purposes. In this case the information is identifiable. Consistent with the current position under the Commonwealth Privacy Act, consent is not required if de-identified information is released for research purposes.

At the present time, there is confusion as to what information will be available to other organisations from the PCEHR system. The exposure draft of the Personally Controlled Electronic Health Records Bill is silent on the issue of whether data from PCEHR can be used for secondary purposes and the Australian Privacy Commissioner, in a submission on the draft Bill, has suggested that permitted secondary uses of data from PCEHR be prescribed in the enabling legislation to ensure that no confusion exists.[85] The Australian Nursing Federation (Victorian Branch) raised in its public hearing that there was still confusion around what information would be released from the PCEHR.[86]

At the present time, the Committee is unsure of whether there will be secondary uses for PCEHR data, and if there are, what these uses will be. The Committee agrees with the Australian Privacy Commissioner that secondary uses need to be prescribed in legislation to avoid confusion for users, the Government and bodies that may be potential secondary users of PCEHR data.

The Committee agrees with the recommendations made by AIHW in 2008 and believes that is it important that from the outset the PCEHR system be designed in a way to ensure the maximum benefit can be derived from the data collected. Collecting data indirectly through an e-health system would be more efficient than mandating the collection of data through other means, as primary health providers will not need to actively collect the data. “Reasons for encounter” are already listed as one of the priority clinical concepts in the development of the PCEHR system.[87] The Committee also believes it is important that any data collected be made available to State and local governments to assist them with the planning of services.

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83 Australian Institute of Health and Welfare, *Review and evaluation of Australian information about primary health care: a focus on general practice*, 2008, p. vii, <http://www.aihw.gov.au/publication-detail/?id=6442468192>, accessed 18 November 2011.

84 Department of Health and Ageing, *Exposure Draft - Personally Controlled Electronic Health Records Bill 2011 - Companion document*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-legals-pcehrbill2011-comp-toc>, accessed 18 November 2011.

85 Office of the Australian Information Commissioner, *Submission to the Department of Health and Ageing - Draft Concept of Operations: Relating to the introduction of a personally controlled electronic health record (PCEHR) system*, <http://www.oaic.gov.au/publications/submissions/2011-06%20Submission%20on%20PCEHR%20ConOps%20FINAL.html>, accessed 18 November 2011.

86 Mr M. Staaf, Australian Nursing Federation, *Transcript of Evidence*, 2 November 2011, p. 7.

87 National E-Health Transition Authority, *Detailed Clinical Models*, <http://www.nehta.gov.au/connecting-australia/terminology-and-information/detailed-clinical-models>, accessed 18 November 2011.

The Committee, however, acknowledges that there are a number of significant challenges in obtaining reliable data from an e-health system. In its evidence, FMRC stated that although 98 per cent of general practitioners have computers on their desks, very few use them to keep detailed patient history records, rather they are mainly used for administrative tasks such as printing prescriptions or writing referral letters.[88] Therefore a lot of data is never entered into an electronic system and consequently would not be captured in a report generated from the system. Furthermore, as PCEHRs are an opt-in system for both patients and general practitioners, it is unlikely data will be comprehensive in the near future.

However, the Committee believes capturing data indirectly through an electronic health records system should be a long term aspiration for the future. The Commonwealth and State Governments will need to work with the professional associations of primary care providers to determine how this could best be achieved.

Standardised classification systems

One issue raised by a number of submissions was the inability to connect data collected in different primary care settings. Currently, GPs and assorted allied health providers all have their own systems for classifying and coding reasons for patient encounters.

This issue has also been identified by NEHTA as part of its development of the PCEHR system.[89] Work has already been undertaken by the NEHTA to develop SNOMED CT-AU, which is now the preferred national clinical terminology for Australia and has been endorsed by the Australian, State and Territory governments.[90] Documentation on SNOMED CT-AU notes:[91]

> A clinical terminology can aid in providing health professionals with more easily accessible and complete information regarding medical history, illnesses, treatments, laboratory results, and similar facts. Standardised information can facilitate improved patient outcomes, clinical decision support, follow-up, and treatment. It can also facilitate analyses based on coded information from clinical IT systems.

Using a standardised terminology across all health sectors will make it easier to integrate health data from different providers into the PCEHR system. A project is also being undertaken to map ICPC-2, the internationally recognised classification system used by BEACH, to SNOMED CT-AU, allowing integration of data collected in the two classification systems.[92] The Committee believes a transition to a standardised classification system would provide great benefits in the future.

Additional surveys of primary care providers

As noted in the comments above, the BEACH program provides statistically reliable data on reasons for patients seeking treatment from GPs only, not other primary care providers. In its submission, the Australian Institute for Primary Care and Ageing suggested:[93]

> … that [the Department of Health] consider expanding the BEACH methodology to include community health and maternal and child health to provide a fuller picture of primary care services and reasons for seeking treatment.

In its report on *Australia's Health 2010*, the AIHW commented:[94]

> Although allied health care and specialist services are integral to the management of musculoskeletal conditions, little information about the use of these services is currently available.

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88 A/Prof. H. Britt, Family Medicine Research Centre, *Transcript of Evidence*, 2 November 2011, p. 26.

89 National E-Health Transition Authority, *NEHTA Blueprint Version 1.0*, p. 75.

90 National E-Health Transition Authority, *SNOMED CT-AU*, <http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-terminology/snomed-ct-au>, accessed 18 November 2011.

91 National Clinical Terminology and Information Service (NCTIS), SNOMED CT- AU FAQs, p. 5.

92 Wonca International Classification Committee (Miller, G), *Integrating SNOMED CT and ICPC-2 in GP EHRs*, <http://www.racgp.org.au/scriptcontent/nswwonca/04202010_Dr_Graeme_Miller.pdf>, accessed 23 November 2011.

93 General Practice Victoria, Submission No. 18, p. 5.

94 Australian Institute of Health and Welfare, *Australia's health 2010*, p. 190, <http://www.aihw.gov.au/publication-detail/?id=6442468376>, accessed 22 November 2011.

Until the full potential of the PCEHR has been explored, and issues of data quality examined, the Committee supports the continued collection of data from GPs through the BEACH program. Rather than mandating the collection of further data from GPs, the Victorian Department of Health should examine ways of gaining access to and analysing that data for planning purposes, as needed. Much of this data is already publicly reported, however, if regular data reports on patient encounters would be useful to the Department of Health, it should also consider becoming a participating member of BEACH in the future.

The Committee also believes there may be the opportunity to undertake further survey-based programs in other areas of primary care. As demonstrated by BEACH, such an approach can provide high quality data, but at a significantly reduced cost when compared to other options. If such a program were to be implemented, it would be preferable if it were undertaken at a national level, in consultation with the professional associations representing allied health and other primary care providers.

However, it is important to acknowledge that there are a range of limitations with survey-based approaches for data collection. The survey instrument used to collect information needs to be presented and written in a way that is clear to understand and ensures that participants complete all relevant aspects. If the instrument does not collect data that is accurate, the results of the survey will be flawed. In addition, all participants completing the survey instrument need to have a clear understanding what each question is asking them, and be using the same definitions when answering, for the information to be comparable.

There are also issues with sample sizes that are used when conducting surveys and ensuring that the sample size is representative of the population. In a large survey such as BEACH, while data may be statistically significant across Australia and at a State and Territory level, the data is less useful for picking up trends in areas, such as the prevalence of a disease.

In its public hearing, the Committee heard from Associate Professor Virginia Lewis that while survey-based research is useful, issues relating to the response rate must be taken into consideration. For example, with the BEACH program, there is a 30 per cent response rate from GPs participating in the survey, and there is weighting added to the overall results to account for the response rate. Professor Lewis went on to state:[95]

> 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 … 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.

The Committee concurs with this opinion, and is of the view that there are many benefits involved in undertaking survey-based research. It provides useful data, however it is important to keep in mind the limitations of this approach.

Finding 1

Mandatory provision of information on the reasons people receive primary care treatments would face significant administrative, technical and logistical obstacles and is not recommended at this time.

[95] A/Prof. V. Lewis, Australian Institute for Primary Care and Ageing, *Transcript of Evidence*, 2 November 2011, p. 34.

Finding 2

Survey based data collection programs are a cost effective way of collecting information on the reasons for which people receive primary care treatments. However, there are limitations associated with the use of such survey techniques which need to be considered. In addition, sampling techniques do not provide a complete set of data, so cannot be used to analyse performance of individual service providers.

Recommendation 1

The Committee recommends the Victorian Government work with the Commonwealth Government, the National E-Health Transition Authority and professional associations to investigate how the Personally Controlled Electronic Health Records system can best capture and collate data on the reasons for which people receive primary care treatment, and ways in which the State can gain access to this data.

Recommendation 2

The Committee recommends the Victorian Department of Health evaluate and analyse data currently publicly available through the BEACH program on reasons for GP-patient encounters. If more detailed or tailored data is required, the Committee recommends the Department utilise a survey-based data collection program to supplement existing information, or the Department could consider becoming a participating member of BEACH.

Recommendation 3

The Committee recommends the Victorian Government work with the Commonwealth Government and professional associations to investigate the possibility of implementing national survey-based data collection programs, to capture data on the reasons why patients utilise community and allied health primary care providers.

4.3 Waiting times and waiting lists

In paragraph (2) of its terms of reference, the Committee has been asked to consider —

> whether Australia should mandate the provision of waiting times and waiting lists for primary care services.

Data on waiting times and waiting lists is a potential measure of access to primary health care. The Committee believes it is important to ensure all Victorians can access primary health care in a timely manner when required. However, a number of factors can influence waiting times and waiting lists, therefore it is important to not consider this data in isolation.

4.3.1 Data currently collected relating to waiting times and waiting lists for primary care

As most primary health care providers are privately operated, there is currently no uniform system in place to collect data from primary health care providers relating to waiting times and waiting lists, unlike in the hospital system.

The best source of information on waiting times for GPs is the Australian Bureau of Statistics (ABS) Patient Experience survey, which asks the following questions relating to waiting times:[96]

> … have you waited longer than you felt was acceptable to get an appointment with a GP? [Yes or No]

[96] 7,124 households within Australia were surveyed in 2009 — Australian Bureau of Statistics, *Health Services: Patient Experiences in Australia, 2009*, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4839.0.55.001Explanatory%20Notes12009?OpenDocument>, accessed 18 November 2011.

> Has there been any time when you saw a GP for urgent medical care; [if so,] how long after you made an appointment were you seen by the GP?
>
> [respondents select from (a) within 4 hours; (b) longer than 4 hours but same day; (c) Next day; (d) 2 to 5 days; (e) 6 or more days]

This data is reported by the ABS and analysed by the Productivity Commission in its *Report on Government Services*. Based on the 2009 data, 16.2 per cent of Victorians felt they waited longer than was acceptable to get an appointment, 61.9 per cent of Victorians waited less than 4 hours to see a GP for an urgent medical appointment, 26.4 per cent waited between 4 and 24 hours, and 11.7 per cent waited more than 24 hours.[97] As with data relating to the reasons for primary health care treatment, this data relates only to GPs, not other primary care providers.

In the area of dental health, detailed statistics are maintained by the Department of Health on waiting times for publicly funded dental services,[98] which can be broken down to individual community dental clinics. However, publicly-funded dental services are only available to a limited number of Victorians, such as children or health care and pensioner concession card holders. For the majority of Victorians, dental care is paid for by the individual, and not government subsidised, and data on wait times for privately-funded dental services is not readily available.

4.3.2 Issues with mandating collection of data and difficulties in interpreting the data

Whilst comprehensive data on waiting times for primary care services is not currently available, a number of submissions queried whether the data would be valuable even if it were collected. The Australian Medical Association (Victoria) stated:[99]

> AMA Victoria has concerns in relation to the proposals to mandate the provision of waiting times and waiting lists for primary care services. It is not sufficiently clear what the benefits of collecting this data would be – Victorian doctors' experience tells us that patients do not report significantly long waiting times when they have an urgent need to access primary health care services. GPs and their practice staff can effectively triage patients and give them appointments according to need.
>
> However it is clear that doctors would have to bear the increased administrative burden posed by the collection of this information. GPs are scarce and under-resourced, and we need to ensure that any data collection does not create additional regulatory requirements for already stretched GPs. A GP's time is best spent caring for patients, not completing data collection forms.

The Royal Australian College of General Practitioners had similar concerns:[100]

> The RACGP does not support mandating the provision of waiting times and waiting lists for primary care services. The RACGP Standards for General Practice (4th edition) state that practices must have a flexible system for determining the order in which patients are seen, to accommodate patients' needs for urgent care, non urgent care, complex care, planned chronic disease management, preventative healthcare and longer consultations.
>
> By mandating the provision of waiting times it removes the flexibility that general practitioners require to be able to cater for individual patient needs. Furthermore, mandating waiting times does nothing to address workforce shortages and capacity issues. Like much of the health sector, there continues to be significant workforce shortages in general practice, especially in urban, regional, and rural areas of need. Penalising practices operating in areas of need, with large patient loads, would be counter-productive.

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97 Productivity Commission, *Report on Government Services 2011*, Table 11A.25.

98 Department of Health, *Dental care - time to treatment*, <http://serviceforip.webcentral.com.au/yourhospitals/dental.asp>, accessed 18 November 2011.

99 Australian Medical Association (Victoria), Submission No. 21, p. 2.

100 Royal Australian College of General Practitioners, Submission No. 14, p. 2.

Whilst waiting time targets are used to drive service improvement works in a hospital setting, these targets can be less productive in a primary care setting. The Victorian Healthcare Association commented:[101]

> Meeting static access targets such as waiting times and waiting lists should not be the predominant focus of health system performance.

The Australian Institute for Primary Care and Ageing noted:[102]

> The NHS (UK) has recently rescinded their PC waiting time target because of its impact on access generally…
>
> An additional relevant indicator that affects the patient experience of primary care is time spent waiting in services (in waiting rooms for example), but there are issues of validity and reliability with such measures. Patient-report is likely to be an overestimate or underestimate. Clinic reporting is likely to lead to underestimates. Using an observer is likely to be most accurate, but expensive, so is not feasible as a routine measure. Some evidence suggests that the quality of the waiting time is equally important as actual time spent waiting for subsequent doctor-consumer interaction.

The Committee is of the view that waiting times are a fairly blunt indicator of access to primary care. Furthermore, even if waiting times and waiting lists were mandated, collecting the data would pose difficulties due to the burden associated with collecting this data, and data is likely to be inconsistent and/or inaccurate.

4.3.3 Alternatives to collecting data through a mandatory system

Whilst the Committee believes there would be some value in more comprehensive data relating to waiting times, the key focus should be identifying areas of need and implementing programs to ensure timely and efficient access to care, not collecting data. Data collected on waiting times can assist in identifying areas of need and assist with the targeted provision of additional services. The Australian Institute for Primary Care and Ageing stated in their submission:[103]

> Availability of appointments … is important as an equity indicator as the evidence is that the distribution of GPs in Victoria does not meet community needs. This mismatch results in no [primary care] being available, or [primary care] having to be provided through alternative settings such as community health, small rural hospitals, or other outlets. Given the lack of control over where GPs open their practices at present, further data may be helpful to mount an argument for initiatives to encourage more equitable distribution (e.g., Quebec, Canada – where, in a system that does not allow consumer co-payments, a GP who opens a new practice in an already over-serviced area only receives 60 per cent of the MBS amount for services provided).

However, the Committee notes a number of strategies have recently been put in place at the Commonwealth level to identify areas of need and improve access to GPs. These programs have used a combination of existing data and community consultation to target funding and services.

<u>General Practice After Hours Program</u>

The General Practice After Hours Program was introduced in 2008-09 and aims to ensure that as many people as possible have access to quality after hours GP services when they need them. It does this by providing grants to help support the viability of services working in the after hours period, which is generally defined as before 8.00 am and after 6.00 pm weekdays; before 8.00 am and after 12.00 pm Saturday; and all day Sunday and public holidays. Funding provided targets areas of community need for after hours GP services and assists with the establishment of new after hours services, or the maintenance or extension of existing services.[104]

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101 Victorian Healthcare Association, Submission No. 26, p. 4.
102 Australian Institute for Primary Care and Ageing, Submission No. 28, p.7.
103 *Ibid*., p. 5.
104 Department of Health and Ageing, *General Practice After Hours Program*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/gpahp-lp>, accessed 18 November 2011.

Medicare Locals

The General Practice After Hours Program is progressively being replaced by Medicare Locals. As part of a stage one needs assessment and identification of priority gaps, Medical Locals are required to undertake a thorough assessment of the after hours primary care conditions within their regions. The section on analysing local health data in the *Medicare Locals Guidelines for after hours primary care responsibilities until 30 June 2013* states:[105]

> The Department will provide Medicare Locals with health-related data relevant to their region. This data will assist Medicare Locals in conducting their needs assessment and identifying specific areas of need within their region.
>
> Medicare Locals will also be required to gather other relevant quantitative and qualitative data throughout the needs assessment process. The quantitative data provided by the Department and that gathered by Medicare Locals will complement and support the qualitative data obtained. The data gathered by Medicare Locals should encompass all elements of the health (physical, social etc.) and health system (workforce, location etc.) characteristics of the Medicare Local region. This will provide a robust view of after hours primary care services and needs within the region. Medicare Locals will be expected to analyse this data as part of the needs assessment process.
>
> This data will also be used as a baseline from which improvement in access to after hours primary care services can be measured.

As part of the initial work, the Public Health Information Development Unit (PHIDU), located at The University of Adelaide, has developed Medicare Locals Population Health Profiles.[106] These baseline profiles provide some available data sets mapped to the new geographic boundaries for Medicare Locals.

As part of the 2010-11 Budget, the Commonwealth Government announced the 'Establishing Medicare Locals and Improving Access to After Hours Care' measure which includes the establishment of a national after hours GP telephone advice service and the introduction of new funding arrangements through Medicare Locals to support the provision of face-to-face after hours primary care services at the local level. There are also plans to establish a national health services directory, which will include information about after hours services, to assist consumers access services and also assist telephone-based nurses and GPs to direct people to after hours services in their region.[107]

After hours GP helpline

On 1 July 2011, the After hours GP Helpline commenced operation across Australia. The new service is Commonwealth funded and intended for people whose health condition cannot wait for treatment until regular general practice services are next available, cannot see their usual GP out of hours, or do not know where to access after hours care. Depending on their condition, the caller may be provided with self-care advice by the telephone-based GP, or may be referred to the most

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105 Department of Health and Ageing, *Medicare Locals: Guidelines for after hours primary care responsibilities until 30 June 2013*, p. 35, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/D7063D448828CC17CA2578CE001B313D/$File/MLAH%20Program%20Guidelines.pdf>, accessed 23 November 2011.

106 Australian General Practice Network, *Population Health*, <http://www.agpn.com.au/medicarelocaltransition/population-health>, accessed 23 November 2011.

107 Department of Health and Ageing, *Medicare Locals: Guidelines for after hours primary care responsibilities until 30 June 2013*, p. 35, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/D7063D448828CC17CA2578CE001B313D/$File/MLAH%20Program%20Guidelines.pdf>, accessed 23 November 2011.

appropriate health services in their local area.[108] In future, it is planned that this service will be integrated with Medicare Locals.[109]

Effectiveness of recently implemented programs

As Medicare Locals and the After hours GP helpline have only been recently implemented, it is not possible for the Committee to evaluate the effectiveness of these programs. The Committee, however, notes the data collection and evaluation role of Medicare Locals and that a needs assessment will be conducted at a local level, including direct consultation with primary care providers. The Committee believes this may prove an effective approach to identifying and addressing areas of need, without the increased burden of collecting and analysing waiting time and waiting list data from each primary care provider.

4.3.4 Other issues relating to access to primary care

The Committee also heard evidence that access to GPs in rural and regional areas was difficult. Some areas faced GP shortages, and existing GPs had a high patient load. In some regions, GPs did not accept new patients to ensure that they could continue to see their existing patient base. There are also some metropolitan areas of Melbourne that have a lower ratio of GPs to population. In these instances, individuals often travel to surrounding areas to seek primary care.

While in metropolitan Melbourne travelling to another suburb or area to access GP services is more possible and more likely, in rural and remote parts of Victoria it is not the case due to the transport distance and similar lack of availability of GPs in other towns. A range of other factors also impact the ability to access GP services. In some instances, the cost of attending a GP appointment can be prohibitive for some individuals and should there be a lack of bulk billing GPs in the area this will impact also on access to primary care.

The Australian Institute of Primary Care and Ageing also informed the Committee that from some of the evaluation work that they had undertaken there are general practices that will not accept patients with mental health issues because they can cause disruptions in the waiting room as well as require longer consultations.[110]

While there is currently no measure of how long patients wait to see GPs, mandating the provision of waiting times and waiting lists may not alleviate the problems associated with access to primary care. In addition, those individuals that could not get appointments due to GPs not accepting new patients would not be measured.

GP to patient ratios and the number of bulk billing GPs in different regions may be better measures access to GPs and help identify whether different communities have access to primary care. The Committee encourages further work to be undertaken to identify and address these issues, and notes that this is a key focus of Medicare Locals.

Finding 3

Significant resources would be required to collect data on waiting times and waiting lists and, due the varied nature and resources available to primary health providers, such data cannot be easily compared between services. The Committee therefore does not recommend that waiting times and waiting lists for primary care services be mandated.

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108 Department of Health and Ageing, *After hours GP Helpline*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/GPHelpline>, accessed 23 November 2011.

109 Department of Health and Ageing, *Medicare Locals: Guidelines for after hours primary care responsibilities until 30 June 2013*, p. 35, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/D7063D448828CC17CA2578CE001B313D/$File/MLAH%20Program%20Guidelines.pdf>, accessed 23 November 2011.

110 A/Prof. V. Lewis, Australian Institute for Primary Care and Ageing, *Transcript of Evidence*, 2 November 2011, p. 5.

Recommendation 4

The Committee recommends that the Victorian Department of Health work with Medicare Locals and the Commonwealth Government to identify and address areas of need for primary care services, in particular in relation to after hours care and access to services in remote and regional areas.

4.4 Outcome measures / appropriate treatment of conditions in primary care settings

In paragraph (3) of its terms of reference, the Committee has been asked to consider —

> whether Australia should mandate the requirement for provision of information about outcome measures, such as appropriate treatment for all patients with diabetes in primary care settings, appropriate treatments for asthma in those settings and so on.

4.4.1 Interpretation of this term of reference

The Committee and a number of organisations who made submissions to the Inquiry, have struggled to interpret this term of reference. In particular, the use of the word 'outcome' has caused confusion with both the Committee and with organisations making submissions.

An outcome is defined as the impact on a community that government contributes to, via the provision of outputs, which may be delivered by one or multiple government agencies.[111] For example, 'appropriate treatment for all patients with diabetes in primary care settings' would be an output. The intended outcome of providing additional services may be 'a healthier Victorian population'. The FMRC stated:[112]

> Appropriate treatment of diabetes [and] asthma is a measure of process not outcome.

The Australian Nursing Federation (Victorian Branch) stated:[113]

> The ANF (Victorian Branch) is not supportive of this proposal, as there is not a defined objective means to describe what is meant by the term "appropriate treatment". There may be many treatments deemed as appropriate but due to funding issues or accessibility are just not available. We are of the view that no health professional is in the business of initiating "inappropriate treatment".

Given the focus in the terms of reference on the "measurement, including budget measures, of primary health … outcomes" the Committee believes the key aspect of this term of reference, being the appropriate treatment of any type of chronic illness is an issue best dealt with by primary care providers as 'appropriate treatment' for each patient will differ. The central issue for government is how does it ensure that financial incentives offered to primary health care providers are achieving improved health outcomes for patients.

A secondary issue raised by this inquiry is whether particular process-based approaches to treatment of particular health conditions should be mandated in primary care settings. This issue is addressed later in this section.

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111 Victorian Auditor-General's Office, *Performance Reporting by Departments*, May 2010, p. 2.
112 Family Medicine Research Centre, Submission No. 3, p. 6.
113 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 4.

4.4.2 Difficulty measuring outcomes as opposed to outputs

Currently, Victorian Government funding to health service providers focuses on outputs, not outcomes. Part 3 of the Budget Papers specifies the major outputs or deliverables and provides the total cost of the output. For primary, community and dental health, the quantity and quality outputs specified by the Victorian Government are:[114]

- Better Health Channel visits;
- Number of referrals made using secure electronic referral systems;
- Primary Care Partnerships with reviewed and updated Strategic Plans;
- Service delivery hours in community health care;
- Standard Equivalent Value Units; and
- Agencies with an Integrated Health Promotion plan that meets the stipulated planning requirements.

For rural primary health, there are two quantity outputs:[115]

- Service delivery hours in community health care; and
- Standard Equivalent Value Units.

The Victorian Government Budget Papers measure these outputs, however there is no link between the output and improving the health of Victorians by providing information or primary care to the community.

The Commonwealth Government provides funding to GPs through Medicare rebates and is primarily based on a per consultation basis. It links to the outcome 'Access to government health and other payment and information services to the Australian public and providers through convenient and efficient service delivery.'[116] However, there is no link between Medicare payments and the quality or the outcome of the treatment provided.

The Australian Institute for Primary Care and Ageing stated in its submission:[117]

> Some kind of measure of "appropriate treatment" is desirable in areas where the government is directing large amounts of money, and where there is multiple activity; however, indicators such as the number of care plans made (claimed for) are too rough, and relate to health practitioner process or activity, not appropriateness, service quality, or consumer outcome.

The Committee agrees with the point made by the Australian Institute for Primary Care and Ageing, that having a care plan in place (output) does not link directly to quality of the care plan or ensure an appropriate outcome. The Committee supports better measurement of primary health outcomes, however notes that it is very difficult to measure outcomes, as opposed to outputs, in the primary health setting.

4.4.3 Programs currently in place to measure and improve primary care outcomes

Following the finalisation of the National Health Care reform agreement, the Commonwealth Government has established a number of statutory bodies focussed on improving health care within Australia. The Victorian Department of Health has also recently issued draft terms of reference for a Project Working Group to develop indicators to improve the quality and safety of care provided by State-funded primary health agencies.

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114 Victorian Government, *Budget Paper No. 3: Service Delivery 2011-12*, p. 205.
115 *Ibid*., p. 208.
116 Medicare Australia, *Annual Report 2010-11*, September 2011, p. 7.
117 Australian Institute for Primary Care and Ageing, Submission No. 28, pp. 7-8.

Australian Commission on Safety and Quality in Healthcare — Practice-level indicators of safety and quality for primary health care

The Australian Commission on Safety and Quality in Healthcare (ACSQH) is a Commonwealth statutory body which was established on 1 July 2011. Under the *National Health and Hospitals Network Act 2011,* the Commission is required to develop indicators relating to healthcare safety and quality. One of its initial projects is to develop practice-level indicators of safety and quality for primary health care. The aims of the project are to:[118]

- research the context for improving safety and quality in primary health care, and identify practice-level indicators currently in use;
- develop a candidate set of practice-level indicators of safety and quality for primary health care, in consultation with relevant individuals and organisations;
- obtain endorsement for the national set of practice-level indicators of safety and quality for primary health care;
- develop a specification for the national set of practice-level indicators of safety and quality.

The Commission recently released a consultation paper with a set of 34 candidate indicators, covering accessibility, appropriateness, acceptability/patient participation, effectiveness, coordination of care, continuity of care and safety.[119] Once finalised, the national set of practice-level indicators of safety and quality are designed for voluntary inclusion in quality improvement strategies at the local practice or service level. It is intended that primary health care services will choose a 'local bundle' of indicators from the national indicator set as a tool to assess and monitor the service's improvement in different dimensions of quality, and particular aspects of care, pathways or conditions.

Examples of the potential indicators in the consultation paper are:[120]

- Acceptability/patient participation — Satisfaction with patient experience — The proportion of regular patients who are very satisfied with specified elements of their patient experience within the previous 12 months (using a standard patient experience instrument).
- Effectiveness — Patient improvement — The proportion of regular patients whose condition has improved, measured using a validated tool or clinical guideline (for conditions where improvement is expected, e.g. diabetes, weight reduction, smoking cessation).
- Coordination of care — Referral process — The proportion of practice referrals that are issued in accordance with the practice's policy for referral processes (for appropriateness and timeliness).

The consultation paper also points out that practices can choose a certain set of indicators to assess the quality of care provided for patients with a particular condition, for example type 2 diabetes.

The Committee believes indicators such as these could be helpful to monitor the improvement of primary care within Victoria. However, the Committee notes that the model recommended by the Commission includes voluntary indicators and appropriate indicators are chosen that are relevant to the particular primary health service, rather than a standard set of indicators being imposed across all health services.

It is difficult to determine how many health services will use these indicators and it will be particularly difficult for rural and regional primary health services and metropolitan services that

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118 Australian Commission on Safety and Quality in Healthcare, *Practice-level indicators of safety and quality for primary health care: Consultation paper,* p. 6, <http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/FA18B96288243577CA25790A0006A72D/$File/consultation-paper-practice-level-indicators.pdf>, accessed 18 November 2011.

119 *Ibid.,* p. 20.

120 *Ibid.,* p. 20.

have a large patient load. Added to this is the financial and administrative burden that putting in place indicators and data collection methods would have in health services.

At this time, it is also unclear as to whether the information collected will be collated to allow reporting across Australia's primary health services and whether any collation would allow for data to be reported on at a local or state level. Given that indicators can be chosen by health services rather than having a standard set of indicators, it is also unclear of the quality and spread of data that would be collected.

The Committee supports this project being undertaken, and at this stage the direction appears promising, however, there are still a number of issues to be addressed.

Victorian Community Health Indicators Project

As part of the *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan*, the Department of Health is proposing to produce a Health Outcomes Framework for Victoria.[121]

> A comprehensive Health Outcomes Framework … that uses a set of indicators that reflect the quality of care delivered across all dimensions and domains is proposed, with a focus on measuring and improving patient health outcomes. Development and implementation of a Health Outcomes Framework will need to ensure there is minimal or no duplication of existing reporting requirements and that new requirements are not overly burdensome for providers.
>
> A Health Outcomes Framework would be used:
>
> — by the community, to gain an understanding of the overall performance of the metropolitan health care system, health status of the population and the care they can expect to receive
>
> — by government to report health sector performance and current priorities (which will change over time) to the community and as a means of accountability (to the community and parliament) and transparency
>
> — by health sector providers to review and monitor their performance and determine areas for improvement
>
> — by the department to monitor and evaluate health outcomes and inform resource allocation and improvement initiatives, such as those to be led through the Health Innovation and Reform Council.
>
> The Health Outcomes Framework would be developed in consultation with the sector and other key stakeholders.
>
> Indicators that comprise the Health Outcomes Framework should be developed to reflect high-quality health outcomes and work in concert with clinical guidelines and patient pathways.

As a step towards achieving this objective, the Victorian Department of Health is currently undertaking a review of health indicators in relation to Victorian community health services. A Project Advisory Group has been established and the draft terms of reference include the aim to develop a suite of clinical indicators that are:[122]

- common to all primary health services; b) and/or are relevant to services provided for clients with complex and /or chronic conditions; and/or c) are useful in evaluating the impact/outcome for particular cohorts/presenting health conditions;
- relevant to structure, process and outcome of primary health service;
- consistent with other indicators used or being developed nationally and in other jurisdictions for general practice and other primary health providers; and

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121 *Victorian Health Priorities Framework 2012-2022: Metropolitan Health Plan,* p. 64. <http://docs.health.vic.gov.au/docs/doc/Victorian-Health-Priorities-Framework-2012-2022:-Metropolitan-Health-Plan>, accessed 18 November 2011.

122 Department of Health, *Project Advisory Group — Victorian Community Health Indicators Project: Terms of Reference*, 2011, p. 2.

- used by agencies when reporting to clients and community on the quality and safety of their care (e.g. Quality of Care report).

The ACSQH is represented on the Project Advisory Group, along with a number of professional associations. The project is focussed on primary health providers, such as dental, allied health, counselling and nursing services, not GPs, as ACSQH project discussed above is focussed on GPs.[123]

The Committee is pleased to note that the Department is setting up an outcomes framework for community health services, rather than an outputs framework. The Committee supports the project being undertaken by the Department of Health. However, is of the view that any outcome set out for community health services should be appropriate, that is, relevant to the objectives of community health services, to offer free or reduced cost primary care to socially disadvantaged Victorians. The Committee also expects that any indicators set up should measure the outcomes that have been set for community health services.

The Committee considers that data collection methods will also need to be examined as part of this process, to ensure that they do not place a large cost onto community health services or impact the number of patients that health services can treat.

The Committee notes the Department is aiming to have consistency with national indicators and other jurisdictions. While consistency in indicators is important, it is more important that Victoria collects data that helps it to manage its primary health care system and ensure it receives data on whether its outcomes are being met. This will assist the Department in the longer term to better target funding and meet its objectives.

Dental Health Program Data Set (DHPDS)

In the area of dental health, a Dental Health Program Data Set (DHPDS) was released by the Department of Health in February 2011.[124] The data set is mandatory and must be used by all organisations funded by the Victorian Government who deliver public dental services. According to the DHPDS manual, the data will be used to fund, monitor and plan dental services to eligible clients.[125]

Whilst this program has been mandated for public dental health providers, as there is a funding and reporting relationship between the State Government and the providers, it does not apply to private dental service providers, who do not have a relationship with the State. Given there is currently no funding or reporting relationship, it would be difficult to mandate the provision of similar data from private providers.

Australian Bureau of Statistics Patient experience survey

The Australian Bureau of Statistics conducts an annual patient experiences survey. The survey is conducted through telephone interviews and aims to capture information about patient satisfaction with health services, including primary care. The data provides information on patient satisfaction for Victoria as a whole, but does not provide further breakdowns.

As noted above, patient satisfaction is one of the proposed practice-level indicators of safety and quality for primary health care. If such data was captured at the individual practice level, it would allow individual practices to identify areas for improvement.

In its evidence to the Committee, the Australian Psychological Society emphasised the need for patient experience to be taken into account when assessing the success of the primary care system. Current measures focus of the medical professionals view of appropriate treatment and

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123 Department of Health, *Victorian Community Health Indicators Project: Background Paper*, 2011, p. 7.

124 Department of Health Victoria, *Key policies: Dental health*, <http://www.health.vic.gov.au/dentistry/key-policies.htm>, accessed 22 November 2011.

125 Department of Health, *Dental Health Program Data Set Manual Version 1.0*, p. 7, <http://docs.health.vic.gov.au/docs/doc/CF1E1E28C3968180CA2578C30016A108/$FILE/Dental%20Health%20Program%20Data%20Set%20Manual%20v1.0.pdf>, accessed 22 November 2011.

are measured by the provider of the treatment.[126] Further development of methods to assess patient experience and the success of treatment from a patient perspective is encouraged.

National Health Performance Authority — Healthy Communities Reports

The newly established Medicare Locals will have a role in providing information about the quality of primary health services to the National Health Performance Authority:[127]

> The new National Health Performance Authority will produce regular Healthy Communities Reports. The reports will provide information about access to health services (including access to GP services and out of hours GP care), the quality of service delivery, funds management and patient outcomes and/or patient experience… Healthy Communities Reports will also provide information about each local area, allowing comparisons with Australian averages. Reporting on Medicare Locals will highlight chronic disease risk factors, community health and wellbeing requirements, and the quality of service delivery.

A draft National Health Reform Performance and Accountability Framework is currently being developed. It included draft indicators for Medicare Locals that include population health outcome measures, such as the incidence of selected conditions within each area. There are also planned performance indicators that include measures of patient experience.[128] The current focus of Medicare Locals is improvement of access to after hours primary care:

> A performance and evaluation framework for assessing the success of the after hours primary health care reform initiative, including the after hours GP helpline and the Medicare Local After Hours Program, is being developed. This framework will establish key evaluation questions and performance indicators against which the outputs and outcomes of the initiative will be measured.
>
> Medicare Locals will be expected to contribute to this evaluation. Medicare Locals will be required to monitor progress, and report as specified in their Funding Agreements. The Department will provide Medicare Locals with standardised reporting templates and tools. It is expected that service providers funded through Medicare Locals will be required to report to the Medicare Local on a regular basis. The Medicare Local will be required to undertake local performance monitoring and evaluation which establishes achievements against the Medicare Local After Hours Program Aim and Objectives. This will also enable the early detection and amelioration of any unintended consequences.[129]

The Committee notes, however, that at this stage it is unclear how Medicare Locals will collect this information.

Conclusion

The Committee believes there is value in moving from a performance model focused on outputs to a model that includes a greater focus on outcomes. However, it is important that the focus remains on improving the quality of care and health outcomes for patients, not just collecting data.

The Committee supports clear indicators being established to assist practices to measure and improve the quality of care. However, a number of submissions expressed concern about

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126 Mr. B. Li, Australian Psychological Society, *Transcript of Evidence*, 2 November 2011, p. 13.

127 Department of Health and Ageing , *Frequently asked questions about what National Health Reform means for Aboriginal and Torres Strait Islander peoples*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/atsi_faqs>, accessed 22 November 2011.

128 *National Health Reform: Draft Performance and Accountability Framework*, pp. 17-18.

129 Department of Health and Ageing, *Medicare Locals: Guidelines for after hours primary care responsibilities until 30 June 2013*, p. 35, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/content/D7063D448828CC17CA2578CE001B313D/$File/MLAH%20Program%20Guidelines.pdf>, accessed 23 November 2011.

attempting to collate that data centrally to allow reporting at a local, state or national level. The Royal Australian College of General Practitioners stated:[130]

> The RACGP supports the collection of data based on quality at the practice level where patient outcomes can be improved. However, the College would not support mandating the requirement for provision of information about outcome measures unless these markers can be shown to positively influence patient care. Further to this, the RACGP is unclear as to what outcomes this inquiry is looking to measure and how this data would be used.
>
> The RACGP Standards for General Practice (4th edition) state that quality improvement activities are an essential business activity, that need to be based on evidence produced by the practice's own data. Quality improvement activities allow practices to identify opportunities to make changes to the practice and its systems. that will both increase quality and safety for patients and improve patient outcomes.
>
> The College is also concerned as to how this data, if collected, will be used. The RACGP would be opposed to data being used for performance reporting of individual general practices and general practitioners.

The Family Medicine Research Centre noted in its submission:[131]

> Using measures within practices to improve quality of care has been shown to be more effective than reporting of outcomes on a public level.

Whilst noting these concerns, the Committee believes there would be some value in better reporting of outcomes at a local, state and national level. However, the Committee believes it is important to ensure that there is no duplication of effort in collecting and reporting information on this data.

Given that primary health care is mostly Commonwealth funded and the National Health Performance Authority only began operation on 1 July 2011, the Committee believes it would be prudent to wait until further detail about the data collection and the reporting role of Medicare Locals and the National Health Performance Authority is known before making further comment about how this could be best achieved.

As the Victorian Government directly funds community health services, it may be possible for the Victorian Department of Health to develop and implement outcome measures for these services. The Committee notes that terms of reference have been developed for Project Advisory Group to investigate a health outcomes framework. The Committee supports the statements in the terms of reference that such indicators should be consistent with those being developed nationally and relevant to the structure, process and outcome of the primary health service, however notes that indicators and outcomes should be relevant and useful to Victoria.

Finding 4

The Committee supports improved measurement of primary health care outcomes, instead of the current focus on outputs. However, given the significant national reforms currently underway, in particular the establishment of the National Health Performance Authority and the roll out of Medicare Locals, the Committee awaits further details on the data collection and reporting roles of these bodies before making further comment.

Finding 5

The Committee supports the initiative by the Victorian Department of Health to develop a health outcomes framework and clinical indicators for community health services, consistent with those being developed nationally, however notes that indicators and outcomes should be relevant and useful to Victoria.

130 Royal Australian College of General Practitioners, Submission No. 14, p. 2.
131 Family Medicine Research Centre, Submission No. 3, p. 6.

4.4.4 Appropriate treatment in primary care settings

The second related issue raised in paragraph (3) of the Committee's terms of reference, is mandating the provision of information about appropriate treatment of patients with particular conditions in primary care settings.

The Committee has interpreted this issue to be whether certain treatment processes should be prescribed or mandated for patients with certain conditions. That is primary health care providers would be required to follow particular steps to treat certain conditions, such as type 2 diabetes or asthma.

A number of submissions raised concerns about "mandating" treatments. The Australian Nursing Federation (Victorian Branch) stated:[132]

> In relation to the use of the term "mandate", it is not clear to us whether "mandate" is to mean legislated and therefore enforceable and be associated with penalties whether the mandate is breached, this requires further clarification.

They also commented:[133]

> There may be many treatments deemed as appropriate but due to funding issues or accessibility are just not available. We are of the view that no health professional is in the business of initiating "inappropriate treatment".

The Committee agrees that it would not be desirable to mandate treatment or to penalise medical practitioners for failing to follow a mandated treatment procedure. The Committee notes that each individual's circumstances need to be taken into account by medical practitioners when prescribing treatment. In addition, it should also be noted that medical practitioners are highly qualified professionals.

The Committee believes that there may be value in providing practitioners with recommended procedures to treat certain conditions, with incentives to follow those procedures. There are already a number of such programs are already in place. These programs are discussed below.

Practice Incentives Program

The Practice Incentives Program (PIP) is administered by Medicare and aims to encourage continuing improvements in general practice through financial incentives to support quality care, and improve access and health outcomes for patients. PIP incentives include:[134]

- Quality Prescribing Incentive (QPI);
- Diabetes Incentive;
- Cervical Screening Incentive;
- Asthma Incentive;
- Indigenous Health Incentive;
- eHealth Incentive;
- Practice Nurse Incentive;
- After Hours Incentive; and
- Teaching Incentive.

Under these programs, GPs are paid an additional payment if they follow certain prescribed treatments for particular conditions. For example, a GP is paid an additional $40 per year if they undertake the following within an annual cycle of care for a patient with diabetes:

- Assess diabetes control by measuring HbA1c;
- Ensure that a comprehensive eye examination is carried out;
- Measure weight and height and calculate Body Mass Index (BMI);
- Measure blood pressure;

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132 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 4.
133 *Ibid.,* p. 4.
134 Medicare Australia, *Practice Incentives Program (PIP)*, <http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp>, accessed 22 November 2011.

- Examine feet;
- Measure total cholesterol, triglycerides and HDL cholesterol;
- Test for microalbuminuria;
- Provide self-care education;
- Review diet;
- Review levels of physical activity;
- Check smoking status; and
- Review of medication.

Outcomes may be measured also as a patient completing an appropriate course of treatment, as determined on an individual basis by a medical professional. This will mean that the patient will have a higher chance of improving their health outcome. While there is a shared responsibility between individuals and medical professionals, programs such as the PIP put a financial incentive on ensuring that the patient completes the course of treatment.

This system of providing incentives to GPs or other medical professionals can be particularly important when dealing with more disadvantaged groups. The Committee heard during its hearing with the Australian Institute for Primary Care and Ageing that community health centres in Victoria struggle to get the same primary care outcomes as GPs because its client base tends to have more complex problems. It is also less likely that these patients will complete appropriate treatment regimes. It is in these instances that incentive payments to medical professionals such as GPs assist to ensure that patients complete appropriate treatment to achieve better health outcomes.[135]

Australian Primary Care Collaboratives Program

The aims of the Australian Primary Care Collaboratives Program are to improve clinical health outcomes, reduce lifestyle risk factors, maintain health for chronic and complex conditions and improve access to Australian general practice.[136] The program involves individual practices sharing information about how they have addressed certain issues, such as treating diabetes through a team approach involving practice nurses and dieticians or setting up a lung function clinic to improve management of people with chronic respiratory illnesses.[137] Other practices can learn from these shared experiences and implement similar initiatives in their practice if appropriate.

The Committee notes that different resources in different practices mean not all practices can take the same approach to treating all conditions. However, the Committee believes there is value in practices sharing information about initiatives and processes that have been successful and could potentially be used in other practices.

Medicare Locals

Although still in their initial stages, it is planned for Medicare Locals to have a role in coordinating treatment for patients with chronic diseases. Information on Medicare Locals states that:[138]

> Medicare Locals will be responsible for providing better integrated care, making it easier for patients to navigate the local health care system. The roles of these organisations could include:
>
> - facilitating allied health care and other support for people with chronic conditions;
> - working with local health care professionals to ensure services are integrated and patients can easily access the services they need; …

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135 A/Prof. V. Lewis, Australian Institute for Primary Care and Ageing, *Transcript of Evidence*, 2 November 2011, p. 35.

136 Department of Health and Ageing, *Australian Primary Care Collaboratives Program (APCCP)*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-pcd-programs-apccp-index.htm>, accessed 22 November 2011.

137 Australian Primary Care Collaboratives, *New care program improves outcomes for patients with diabetes*, <http://www.apcc.org.au/images/uploads/prospect_new_template150710.pdf>, accessed 22 November 2011.

138 Department of Health and Ageing, *Establishment of Medicare Locals and better access to after hours care*, <http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/factsheet-gp-01>, accessed 22 November 2011.

- delivering health promotion and preventive health programs to communities with identified risk factors (in cooperation with the Australian National Preventive Health Agency, once it is established) …

Medicare Locals will also help roll out the Australian Government's chronic disease package for diabetes patients by coordinating allied health services for those enrolled in the diabetes management program.

As the first Medicare Locals have only just been established, details of how these programs will work have not been finalised. The Committee notes however that Medicare Locals will be well placed to advise on the best treatment options for patients with chronic diseases based on the differing nature of the primary health providers in their local area.

In addition, Medicare Locals will be able to draw on significant amounts of data relating to treatment for patients with chronic diseases from their local area and across Australia to assist primary health care providers in providing the best health care for patients with chronic diseases.

Finding 6

Due to the varied nature and resources of primary health providers, Australia should not mandate processes for "appropriate treatment" for patients in primary care settings.

Recommendation 5

The Committee recommends that the Victorian Department of Health work with Medicare Locals to ensure that patients are aware of the different primary care services and treatment options available in their area to ensure the best health outcomes.

4.5 Conditions for which hospitalisations can be avoided

In paragraph (4) of its terms of reference, the Committee has been asked to consider —

Whether conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of our primary health care system.

The Committee believes that timely access to quality primary care treatment can prevent hospital admissions for certain conditions. However, the Committee believes the use of the word 'surrogate' is confusing and not appropriate. In its submission, the Australian Nursing Federation noted:[139]

The terminology used in relation to what is meant by "surrogate" is confusing. The Australian Concise Oxford Dictionary defines surrogate as, "A substitute, esp. for a person in a specific role of office". This definition in all its connotations usually refers to a person.

For the purposes of completing its Inquiry, the Committee has chosen to interpret the word 'surrogate' as being 'an indicator' for measuring the adequacy of the primary care system.

A number of submissions noted that avoidable hospitalisations are just one of many measures of the adequacy of the primary health care system, and cannot be viewed in isolation. The Victorian Healthcare Association stated in its submission:[140]

Many factors relating to the individual, environment, or the health service system, operating either in isolation or combination, may lead to avoidable hospital admissions. As a result, the VHA believes that it is problematic to consider avoidable hospitalisations solely as a surrogate for the adequacy of our primary health care system. It is important to keep in mind that there may be some instances where an ambulatory care sensitive condition [ACSC] is compounded by external factors.

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139 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 4.
140 Victorian Healthcare Association, Submission No. 26, p.5.

General Practice Victoria commented:[141]

> To an extent, there is already some recognition that conditions for which hospitalisations can be avoided is a surrogate for the adequacy of the primary health care system. We understand that the indicators to be set by the National Health Performance Authority will include readmission rates for selected conditions, to be collected by hospitals, and selected avoidable hospitalisations. But it is important for governments to work together to set the most useful indicators, and to provide the policy direction to ensure that their funded agencies and organisations work together to effect change. Simply asserting the conditions for which hospitalisations can be avoided should be considered a surrogate for the adequacy of the primary health care system could risk being seen as an oversimplified statement designed to continue "the blame game".

The Committee supports the collection of data on avoidable hospitalisations and notes that significant collection of this data already takes place. However, there are limitations on the data and it is important to ensure that this data is interpreted correctly and used in conjunction with other measures of access to primary care services, not used as the sole indicator.

4.5.1 Data currently collected on avoidable hospitalisations

The Department of Health requires every Victorian hospital to collect data on avoidable hospitalisations as part of the Victorian Admitted Episodes Dataset (VAED).[142]

Ambulatory care sensitive conditions

The Health Intelligence Unit of the Victorian Department of Health currently collates data on ACSCs from the VAED data provided by hospitals. ACSCs are those conditions for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in ambulatory setting such as primary care.[143]

The data collated records the number of people with an ACSC who were admitted to hospital. As data is collected at the hospital level, it can be broken down into region, local government area or primary care partnership region. Data is also coded by Socio-Economic Indexes for Areas (SEIFA) and the Accessibility/Remoteness Index of Australia (ARIA). The ACSC data collected for 2009-10 is presented in Table 4.

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141 General Practice Victoria, Submission No. 18, p. 8.

142 Department of Health, *Victorian Admitted Episodes Data Set (VAED)*, <http://www.health.vic.gov.au/hdss/vaed/>, accessed 22 November 2011.

143 Department of Health, *Ambulatory care sensitive conditions (ACSCs)*, <https://hns.dhs.vic.gov.au/3netapps/vhisspublicsite/ViewContent.aspx?TopicID=1&SubTopicID=10>, accessed 22 November 2011.

Table 4: Ambulatory care sensitive conditions for Victoria 2009-10

Condition	No. of admissions	Standardised Rate per 1,000 Persons	Lower limit of 95% CI	Upper limit of 95% CI	Average Bed days	Total Bed Days
Diabetes complications	63,185	11.42	11.33	11.51	8.11	512,458
Dental conditions	16,443	3.03	2.99	3.08	1.13	18,603
Chronic Obstructive Pulmonary Disease (COPD)	14,547	2.61	2.57	2.65	6.39	92,895
Pyelonephritis	14,126	2.55	2.51	2.59	4.17	58,970
Congestive cardiac failure	12,907	2.29	2.25	2.33	7.14	92,115
Asthma	9,836	1.80	1.77	1.84	2.04	20,062
Cellulitis	9,503	1.73	1.69	1.76	4.68	44,436
Iron deficiency anaemia	9,246	1.68	1.65	1.72	1.64	15,208
Angina	8,420	1.52	1.49	1.55	1.88	15,812
Convulsions and epilepsy	7,512	1.38	1.35	1.41	2.86	21,460
Ear, nose and throat infections	7,176	1.31	1.28	1.34	1.63	11,691
Dehydration and gastroenteritis	5,568	1.01	0.98	1.04	2.42	13,499
Influenza and pneumonia	2,635	0.48	0.46	0.50	8.73	22,999
Gangrene	1,932	0.35	0.33	0.36	14.61	28,224
Other vaccine-preventable conditions	1,383	0.25	0.24	0.27	4.91	6,795
Perforated/bleeding ulcer	1,373	0.25	0.23	0.26	6.84	9,393
Hypertension	1,322	0.24	0.23	0.25	2.94	3,889
Pelvic inflammatory disease	1,138	0.21	0.20	0.22	2.19	2,487
Nutritional deficiencies	49	0.01	0.01	0.01	14.55	713
Total ACSCs	180,858	32.77	32.63	32.92	5.12	926,257

Source: Ambulatory Care Sensitive Conditions Reports

The ACSC website states high rates of hospital admissions for ACSCs may provide indirect evidence of problems with patient access to primary healthcare, inadequate skills and resources, or disconnection with specialist services.[144]

Analyses from previous Victorian ACSCs studies have also identified significant differentials and inequalities in access to the primary health care system in Victoria.[145] The Commonwealth Department of Health and Ageing also reports on potentially preventable hospitalisations at a national level, based on data provided by the states. When analysing data by Indigenous status

144 Ibid.

145 Department of Health, *The Victorian Ambulatory Care Sensitive Conditions Study, 2001-02*, p. xiii, <http://docs.health.vic.gov.au/docs/doc/A595DDEB69465A78CA25787800832646/$FILE/acsc_finalreport.pdf>, accessed 22 November 2011.

and geographical areas, it identified that social disadvantage and remoteness are strongly associated with avoidable hospitalisations.

Table 5: Rate of selected potentially preventable hospitalisations (by indigenous status and remoteness) per 100,000 population 2008-09

Indigenous Australians	Other Australians	Major Cities	Very Remote
14,563.6	2,955.8	2,843.9	6,927.9

Source: Department of Health and Ageing, Annual Report 2010-11, p. 37.

National Heath Care Agreement

Under the National Heath Care Agreement which was finalised in August 2011, a range of performance benchmarks have been agreed to, one of which is:[146]

> By 2014-15, improve the provision of primary care and reduce the proportion of potentially preventable hospital admissions by 7.6 per cent over the 2006-07 baseline to 8.5 per cent of total hospital admissions.

This target, which has been agreed to by the Commonwealth Government and all State and Territory governments, illustrates that avoidable hospitalisations are already being used as a measure of the effectiveness of the primary health system.

It also means that the Victorian Department of Health will need to focus on this performance benchmark and reduce potentially preventable hospital admissions, as future funding for hospitals is tied to meeting this, as well as other performance benchmarks.

Potentially avoidable GP-type presentations to emergency departments

In its *Report on Government Services*, the Productivity Commission routinely examines potentially avoidable GP-type presentations to emergency departments, which is a different measure than ACSCs, as it includes those who were treated at a hospital emergency department, but not admitted to hospital. In 2009-10, there were 550,900 potentially avoidable GP-type presentations to emergency departments in Victoria.[147]

'GP-type presentations to emergency departments' are defined as those:

- allocated to triage category 4 or 5;
- not arriving by ambulance, with police or corrections;
- not admitted or referred to another hospital; and
- who did not die.

The Productivity Commission stated in its 2009-10 Report on Government Services: [148]

> A decrease in the proportion of presentations that are GP-type presentations can indicate better access to primary and community health care. A decrease can also indicate a reduction in reliance on emergency departments for the treatment of such conditions…
>
> One of several factors contributing to 'GP-type' presentations at emergency departments is perceived or actual lack of access to GP services. Other factors include proximity of emergency departments and trust for emergency department staff.

The table below is from the Department of Health's *Your Hospitals: July 2009 to June 2010* report. It shows that there were 586,790 GP-type presentations to emergency departments in Victoria. The Productivity Commission's report stated that 550,900 of these were potentially avoidable, which demonstrates that there are gaps in the provision of primary care in Victoria. The Department of Health's data shows that the number of GP-type presentations had reduced since 2008-09.

146 Council of Australian Governments, *National Healthcare Agreement 2011*, p. A-10.
147 Productivity Commission, *Report on Government Services 2011*, p. 11.35.
148 *Ibid*.

However, the table below shows that primary care treatment patients still make up a significant workload for emergency departments.

Table 6: Number of GP-type presentations to Victoria's emergency departments

Patient category	2008-09	2009-10
Category 4 PCT	462,162	424,581
Category 5 PCT	179,763	162,209
Total category 4/5 PCT	641,925	586,790
% of all emergency patients	47.4	42.0

Source: Department of Health, Your Hospitals July 2009-June 2010.

The Committee believes GP-type presentations to emergency departments should be considered along with avoidable hospitalisations when measuring the adequacy of primary health care. If patients are willing and able to access primary health care through other providers, such as after hours GP services, rather than attending an emergency department, this will assist to reduce the burden on hospital emergency departments and enable those departments to focus their resources on emergency situations. The data also provides the Department with information about the efficacy of its efforts to divert GP-type patients from emergency departments.

4.5.2 Interpretation of data currently collected on avoidable hospitalisations

Whilst data on avoidable hospitalisations is often used as a measure of the level of access to primary care, a number of different factors can influence avoidable hospitalisations. In the *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*[149] report, several factors other than access to primary care that can influence variation in ACSC admission rates were identified, including:

Disease prevalence

Systematic variations in disease prevalence can contribute to observed differentials in the rates of ACSCs. Prevalence of ACSCs can vary according to aetiology and progression characteristic of the disease, socioeconomic and environmental factors.

Propensity to seek primary health care

People can decline to seek primary health care due to various factors, such as geographic location, transport barriers, education, cultural, financial, and beliefs about the effectiveness of interventions. Patients who seek medical care later in the course of their disease may have missed the opportunity for their illness to be managed in the primary care setting.

Socioeconomic barriers to care

Access to care may be influenced by socioeconomic factors, such as race and poverty, which are important predictors of ACSC rates.

Hospital utilisation pattern

Thresholds, criteria and capacity for clinical admission may vary between providers and across geographic areas.

The report also noted a number of limitations that should be considered when assessing the value that ACSC admissions rates can bring to monitoring primary care:[150]

- The assessment of whether a condition or hospitalisation for a condition is sensitive to the provision of primary care and, therefore preventable, may often be

149 Department of Human Services, *Victorian Ambulatory Care Sensitive Conditions Study: Preliminary Analyses*, May 2001, p. 2.

150 *Ibid.,* p. 6.

subjective as well as evidence-based. As such, ACSC admission rates only suggest a degree of potential avoidability and point to possible areas of improvement.

- Factors other than access to primary care may influence hospitalisation rates and may be difficult to measure.
- There is a lack of information about variations in disease prevalence in small areas. This limits the ability to control for variability in ACSC rates that may be due to differential disease prevalence especially in the context of small area analysis.
- Although ACSCs have been used to evaluate the performance of the health system, their value in determining the impact of policy or interventions is not clear.

In its submission, General Practice Victoria noted that, in partnership with the University of Melbourne, it is currently developing a pilot proposal to link general practice with ACSC data as a way of testing the local evidence for links between reducing avoidable hospital admissions and primary care. The pilot is intended to provide a collaborative-type data set that the individual GP can use as a Quality Improvement tool and the Medicare Local can use as a local planning tool.[151] The Committee believes there is value in such initiatives which may help better understand the data and the link between primary care and avoidable hospitalisations.

4.5.3 Use of data on avoidable hospitalisations

The data on avoidable hospitalisations in Table 4 clearly identifies diabetes complications (512,458 bed days in 2009-10) and congestive cardiac failure (92,115 bed days in 2009-10) as significant causes of avoidable hospitalisations in Victoria. Further, data from the ABS National health survey also provides data on the prevalence of these health conditions in the community.

Whilst significant work is being undertaken to address these two conditions, the Committee believes more should be done to address these health problems, through a more concerted effort into preventative health

The Committee notes that the *Victorian Public Health and Wellbeing Plan 2011-15* contains a range of actions to improve the health and wellbeing of Victorians. These include:[152]

- building 'prevention infrastructure' and evidence that can support policy and practice;
- strengthening and maximising partnerships to improve prevention; and
- ensuring resources are available and interventions are tailored to reduce disparities in health outcomes.

In terms of cardiac disease and diabetes, there is already a large amount of data that shows these conditions are major causes of avoidable hospitalisations and are diseases which can be avoided. Evidence provided to the Committee by the Baker IDI Heart and Diabetes Institute highlighted that more could be done to identify persons who are at risk of type 2 diabetes and cardiovascular problems.[153]

The Committee considers that the Government, through a range of Departments should be putting a more concerted effort into using the data already available to develop health promotion plans and strategies that target groups that are at risk of diabetes and cardiovascular disease. Such action has the potential to significantly impact the rising costs of health expenditure at a primary and secondary health care level in future.

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151 General Practice Victoria, Submission No. 18, p. 8.

152 Department of Health, *Victorian Public Health and Wellbeing Plan 2011-15*, 2011, p. 31.

153 Prof. A. Dart, Baker IDI Heart and Diabetes Institute, *Transcript of Evidence*, 2 November 2011, p. 6.

Finding 7

Data on conditions for which hospitalisations can be avoided should continue to be collected and used as an indicator of the adequacy of our primary health care system, however, this data must not be considered in isolation. A number of other issues, including socioeconomic factors and willingness to seek treatment, must also be taken into account when interpreting this data.

Recommendation 6

The Committee recommends that further work be undertaken to examine the links between access to primary care and avoidable hospitalisations in order to better understand the data already collected and to better utilise the data to improve health outcomes and reduce any unnecessary burden on hospitals and emergency departments.

Recommendation 7

The Committee recommends that the Victorian Department of Health take urgent action to address the rising prevalence of type 2 diabetes and cardiovascular disease by appropriately targeting groups at risk as early as possible to avoid hospitalisations and further medical intervention in future.

5. Aged care in Victoria

5.1 Introduction

Australia's population is ageing due to an increase in life expectancy and lower fertility rates. Australia's ageing population is expected to significantly increase in the coming decades, which will impact Australia's labour force participation, skilled labour, the housing sector and the cost of health care.[154]

All states in Australia are experiencing growths in the number of elderly Australians. The number of elderly people grew 170.6 per cent in Australia between 1990 and 2010. Victoria experienced a significant growth of 6.3 per cent in the number of people aged 85 and over between July 2009 and June 2010.[155] This poses significant stresses on aged care services and means that more funding and aged care services will be required as our population ages.

The *Australia to 2050* report, produced by the Commonwealth Government estimates that in 2050:[156]

- Australia will have 2.7 workers for every person over 65 years of age;
- 2.5 million (or 8 per cent of) people will access aged care services; and
- almost 5 per cent of the Australian workforce will be employed in the delivery of aged care services.

5.2 Access to aged care

5.2.1 Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) was established by the Commonwealth Government in 1984[157] and is funded jointly by the Commonwealth, State and Territory Governments. The objective of the ACAP is to assess frail elderly people to ensure they can access to appropriate care. The ACAP aims to:[158]

- provide equitable access to all older people, including the Indigenous, culturally and linguistically diverse, those living in regional and remote areas, veterans and their spouses, widows, widowers, and people with dementia;
- provide service based on need;
- prevent or delay inappropriate admission to a residential aged facility by assisting frail elderly people to live in the community by facilitating access to services that meet an individual's needs;
- provide a comprehensive assessment that include a range of needs, including restorative, physical, medical, psychological, cultural and social needs; and
- involve the client, their carers and other service providers in assessing, planning and organising care.

The first step in accessing certain government funded aged care services, including admission into a residential aged care facility is via the ACAP. An assessment is undertaken by Aged Care Assessment Teams, or Aged Care Assessment Services (ACAS) in Victoria.[159] An assessment can

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154 Australian Bureau of Statistics, *Population by Age and Sex, Australian States and Territories*, 2010, p. 2.
155 *Ibid.,* p. 2.
156 Australian Government, *Australia to 2050: future challenges – the Intergenerational Report*, 2010, pp. 1-13.
157 Productivity Commission, *Report on Government Services 2011*, p. 13.4.
158 Lincoln Centre for Research on Ageing, *Aged Care Assessment Program Minimum Data Set Annual Report – Victoria 2009-2010*, November 2010, p. 1.
159 Department of Health and Ageing, *Being assessed for aged care*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/being+assessed-1>, accessed 31 October 2011.

be organised by a health care professional such as a doctor or nurse, or individuals can set up their own assessments.[160]

An ACAS team is made up of health workers who may include a nurse, doctor or allied health worker to assist in assessing an individual to determine what level of assistance they require.[161] With an individuals consent, the ACAS team may also talk to an individual's doctor about their medical history.[162]

At the assessment, the individual is asked about their daily living activities and the assistance that the individual requires to undertake each activity, as well as their health and any medical conditions they have, to assist the ACAS team to determine what kind of support is required. The ACAS team will then discuss with the individual whether an aged care home or more support at home is needed.[163]

At the end of the assessment, a letter is sent to the individual to tell them for which services they are eligible and have been approved. An Aged Care Client Record is also completed as this confirms that the individual is eligible for care.[164] The ACAS team also makes referrals to assist frail elderly people access the range of services they require.[165]

In Victoria in 2009-10, the median time elapsed between an Aged Care Assessment and admission into a Commonwealth funded nursing home was 42 days. Approximately 46 per cent of eligible elderly people had entered a residential aged care facility within one month of their assessment.[166]

5.2.2 Cost of the Aged Care Assessment Program

The Aged Care Assessment Program is jointly funded by the Commonwealth and State Government under a National Partnership. The Commonwealth Government budget papers show that $86.2 million has been budgeted for Aged Care Assessments in 2011-12.[167] From this, the Victorian Government will receive $18.7 million in 2011-12 for conducting Aged Care Assessments,[168] however the total output cost of Aged Care Assessments is expected to be $44.6 million.

5.2.3 Future changes to the Aged Care Assessment Program

As part of the National Health Reform Agreement, signed by the Commonwealth Government and the State and Territory Governments, the Commonwealth Government will be responsible for managing Australia's aged care system. The Department of Health and Ageing will be working with State and Territory Governments as well as Aged Care Assessment Teams to review service delivery and also to work towards implementing the agreements associated with National Health Reform.[169]

The targets associated with undertaking assessments have also changed, to improve timeliness. High priority clients should be assessed within 48 hours and clients not at immediate risk should be assessed in three to 14 days. The Commonwealth Government also states in its budget papers that it will be working with State and Territory Governments to improve the timeliness of assessments.[170]

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160 Department of Health and Ageing, *What's an assessment like?*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Whats%20an%20assessment%20like>, accessed 7 November 2011.

161 Department of Health and Ageing, *Am I eligible for an aged care home?,* <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Am+I+eligible?Open&etID=WCMEXT05-WCME-8ND8PX>, accessed 7 November 2011.

162 Department of Health and Ageing, *What's an assessment like?*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/Whats%20an%20assessment%20like>, accessed 7 November 2011.

163 *Ibid*.

164 *Ibid*.

165 Australian Government, *Portfolio Budget Papers – Departmental Outcomes*, May 2011, p. 169.

166 Productivity Commission, *Report on Government Services 2011,* Table 13A.66.

167 Australian Government, *Department of the Treasury Budget Statements*, May 2011, p. 44.

168 Victorian Government, *Budget Paper 5: Statement of Finances 2011-12*, p. 161.

169 Australian Government, *Portfolio Budget Papers – Departmental Outcomes*, May 2011, p. 169.

170 *Ibid.,* pp. 169-170.

5.3 Provision of aged care in Victoria

5.3.1 Residential aged care

The Commonwealth Government has primary responsibility for planning, funding and regulating aged care. State, Territory and local governments have roles in ensuring aged care centres comply with staffing and industrial awards and building and fire safety regulations.[171]

As at June 2010, there were 43,001 permanent residents in Victorian aged care facilities. Of these, 29,588 required high care and 13,413 required low care.[172] The cost of providing residential aged care in Victoria in 2009-10 was almost $1.9 billion of Commonwealth funding.[173]

The Victorian Government, while not a provider of funding for residential aged care beds, is a manager and owner of some 195 residential aged care facilities in Victoria,[174] which provide just under 6,000 beds, or about 12.7 per cent of beds in Victoria. Table 7 lists the ownership of aged care places in Victoria.

Table 7: Ownership of aged care places in Victoria

Type of facility	Percentage of aged care places provided
Religious	15.1 %
Private-for-profit	49.2 %
Community based	14 %
Charitable	7.4 %
State Government	12.7 %
Local Government	1.6 %

Source: Productivity Commission, *Report on Government Services 2011*.

In 2007, the Commonwealth Government set itself a target to increase the provision of funded aged care services to 113 places per 1000 people aged 70 years or over. The target of 113 places specifies that:[175]

- 44 places, or 39 per cent should be in residential high care;
- 44 places, or 39 per cent should be in residential low care; and
- 25 places, or 22 per cent should be in community care.

5.3.2 Other types of community care

For those not requiring care in an aged care facility, there are a range of community care options available to assist elderly Victorians to continue living in their home.

Following an Aged Care Assessment, an individual that does not qualify for residential aged care may be eligible for home care services and programs to ensure they have adequate support and can continue to live in their home. The Community Directed Care package has three sub-programs that support elderly people to live in their own homes:[176]

- Community Aged Care Packages;
- Extended Aged Care at Home; and
- Extended Aged Care at Home Dementia.

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171 Productivity Commission, *Report on Government Services 2011*, p.13.5.
172 *Ibid.,* p.13.14.
173 *Ibid.,* Table 13A.6.
174 Victorian Government, *The Victorian Government's role in residential aged care*, 2009, p. 5.
175 Productivity Commission, *Report on Government Services 2011*, pp. 13.6, 13.45.
176 Department of Health and Ageing, *Home-based care*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-comcprov-ccpindex.htm>, accessed 11 November 2011.

Fees are charged for these three sub-programs, with a pensioner on a full pension paying a maximum of $8.61 per day, however clients on higher incomes may be required to pay a higher rate, capped at 50 per cent of any income above the basic rate of a single pension.[177]

Community Aged Care Packages

The Community Aged Care Package (CACP) program offers a range of assistance from shopping, preparing meals and laundry to assistance with participating in social activities and temporary in-home respite care.[178]

The CACP program is funded by the Commonwealth Government. The program cost $508 million in 2009-10, of which Victorians received $131.8 million.[179]

Extended Aged Care at Home

The Extended Aged Care at Home (EACH) program provides a higher level of support to assist frail elderly people to continue living in their own home. The EACH program provides a range of services, which include registered-nursing care, allied health care, personal care, transport to appointments, social support and assistance with oxygen and/or enteral feeding.[180]

EACH is Commonwealth funded, with program costs of $206 million nationally in 2009-10, of which Victorians received $53.4 million.[181]

Extended Aged Care at Home Dementia

Extended Aged Care at Home Dementia (EACH D) helps carers of those with dementia with behavioural problems associated with their condition. These include 'shadowing' - following the primary carer and repetition of questions, 'sundowning' – agitation in the late afternoon or evening or other disturbances. The EACH D program also provides links to Dementia Behaviour Management Centres, allied health care, personal care, home help and continence management.[182]

The EACH D program is Commonwealth funded, with costs of almost $100 million in 2009-10, with approximately $25 million provided to Victorians.[183]

Home and Community Care

Home and Community Care (HACC) is an assistance program for frail elderly people and people with disabilities to provide assistance with daily tasks in their own homes. The HACC program aims to keep people at risk of entering residential aged care and those whose capacity for independent living is at risk in their homes as well as carers.[184] The type of assistance provided by HACC includes:[185]

- home care – cleaning, washing clothes, shopping and cooking;
- personal care – dressing, showering and eating;
- meals – delivering ready to eat or re-heating meals;

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177 *Ibid*.

178 Department of Health and Ageing, *Help staying at home*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/CACP-1>, accessed 14 November 2011.

179 Productivity Commission, *Report on Government Services 2011,* p.13.16.

180 Department of Health and Ageing, *Home-based care*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-commcare-comcprov-ccpindex.htm>, accessed 11 November 2011.

181 Productivity Commission, *Report on Government Services 2011,* p.13.16.

182 Department of Health and Ageing, *Extended Aged Care at Home Dementia*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/content/EACHD>, accessed 14 November 2011.

183 Productivity Commission, *Report on Government Services 2011,* p.13.16.

184 Department of Health, *HACC,* <http://www.health.vic.gov.au/hacc/hacc_victoria/funding.htm>, accessed 11 November 2011.

185 Department of Health, *HACC Program Brochure*, <http://www.health.vic.gov.au/hacc_victoria/brochure.htm>, accessed 11 November 2011.

- property maintenance – undertaking small tasks to improve safety, such as installing hand rails, checking smoke alarms and changing light globes;
- nursing – advice from a qualified nurse about ongoing health issues, such as diabetes or arthritis;
- volunteer co-ordination – regular visits from a trained volunteer to spend time with those who need it; and
- telelink – regular phone calls from individuals.

HACC also requires an assessment to be undertaken to determine the best services for an individual. They are called Living at Home Assessments, and a range of options to keep individuals living in their homes is explored.

HACC is jointly funded by the Commonwealth and State Government, with the Commonwealth providing 60 per cent of the budget. Local governments also contribute to HACC program resources and clients usually pay fees for the services received.[186]

In 2009-10, Victoria had just over 272,000 HACC clients, of which 65 per cent were aged 70 years or over.[187] In 2010-11, this number had grown to over 276,000. The Department of Health's annual report states that there were over 9.5 million HACC service delivery hours in 2010-11, at a cost of $558.9 million.[188]

5.4 Regulation of aged care

5.4.1 Aged care accreditation

The Commonwealth *Aged Care Act 1997* (the Act) sets out the framework for funding, regulation and accreditation of aged care services in Australia. The Act sets out 10 objectives for aged care, which include providing a high quality of care that meets the needs of individuals, encouraging diversity and responsiveness in aged care services and are available to those that need them.[189]

To deliver Commonwealth funded aged care services, an organisation must be approved by the Commonwealth Government as an approved provider. The organisation then has a number of places for care allocated to it. Each residential aged care facility also needs to be accredited to provide aged care services.[190]

The Commonwealth Department of Health and Ageing is responsible for ensuring residential aged care facilities are accredited. They contract this service to the Aged Care Standards and Accreditation Agency (ACSAA), a Commonwealth company, who has been undertaking the accreditation function since 1998.[191]

There are four accreditation standards and 44 outcomes against which aged care facilities are assessed. The four accreditation standards are:[192]

- Standard One – achievement of all standards;
- Standard Two – health and personal care needs;
- Standard Three – lifestyle; and
- Standard Four – Safe and comfortable environment that ensures quality of life.

ACSAA undertake accreditation of new homes before residents move in. Applications called 'commencing services' are submitted to ACSAA on how the new home will meet the accreditation

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186 Department of Health, *HACC,* <http://www.health.vic.gov.au/hacc/hacc_victoria/funding.htm>, accessed 11 November 2011.
187 Productivity Commission, *Report on Government Services 2011*, Table 13A.59.
188 Department of Health, *Annual Report 2010-11*, October 2011, p. 194.
189 Aged Care Act 1997 (Cth), Division 2, section 2-1.
190 Australian National Audit Office, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*, June 2011, pp. 16-17.
191 *Ibid.,* p. 17.
192 Department of Health and Ageing, *Accreditation*, <http://www.agedcareaustralia.gov.au/internet/agedcare/publishing.nsf/Content/Accreditation?Open&etID=WCMEXT05-WCME-8NM5FE>, accessed 15 November 2011.

standards. New homes can only be accredited for a maximum of 12 months, then they must apply for a further period of accreditation.[193]

Existing homes must apply for accreditation before their current accreditation expires. As part of the process, the aged care provider must submit an application for accreditation and notify residents or their representatives of the date in which ACSAA will be undertaking an accreditation audit, to allow residents or their representatives to meet with the assessors.[194]

The existing home must also provide a self-assessment document on how they meet the accreditation standards. This information is provided to ACSAA either at the time the application for assessment is made or at the site audit. The assessment team is usually made up of two assessors and an audit takes between two and four days to complete.[195]

Accreditation is given to an aged care facility for a period of up to three years. During this time, ACSAA will undertake spot checks of aged care facilities, with at least one being unannounced each year. The Australian National Audit Office (ANAO), in its report *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes* found that there was on average, 2.2 visits to each accredited home, or 6,119 visits in 2009-10.[196]

5.4.2 Recent reviews of aged care accreditation

There have been two recent reviews on the accreditation of aged care in Australia. The ANAO undertook an audit of the monitoring and compliance arrangements that support quality of care in aged care homes. The ANAO found that ACSAA had a case management approach and used risked-based decision making on timing visits to aged care facilities.[197]

Where breaches were found, the audit concluded that the Department of Health and Ageing had taken appropriate action, which was commensurate with the degree of non-compliance identified. The information used to make these compliance decisions by the Department of Health and Ageing is provided by ACSAA.[198]

The audit made three recommendations:[199]

- To ensure Approved Providers understand the service standards expected, the Department of Health and Ageing develop, in consultation with Approved Providers, a Service Charter and reports annually against it; and that the ACSAA report against their existing Service Charter.
- The Department of Health and Ageing develop a common risk profile for each accredited home and analyse this information.
- The Department of Health develop a KPI framework for the ACSAA, to allow stakeholders to assess the contributions made by ACSAA and the Department in improving the quality of aged care facilities.

The Productivity Commission also undertook a broad ranging examination of aged care. Part of this examined the quality assurance methods in place to ensure aged care meets a high standard. The Productivity Commission made one recommendation on this issue, that there should be quality indicators collected and reported at a provider level to help care recipients and their families make informed decisions about residential aged care facilities.[200] This issue is further examined in Chapter 6.

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193 Aged Care Standards and Accreditation Agency, *Annual Report 2010-11*, p. 16.
194 *Ibid*.
195 *Ibid*.
196 Australian National Audit Office, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*, June 2011, p. 21.
197 *Ibid*.
198 *Ibid.,* p. 23.
199 *Ibid.,* pp. 31-32.
200 Productivity Commission, *Caring for Older Australians*, June 2011, p. LXIII.

6. Aged care data

6.1 Aged care data and quality reporting

In its terms of reference, the Committee has been asked to examine several issues relating to the collection and dissemination of aged care data and quality reporting on aged care.

As aged care is principally federally funded, the majority of aged care data is currently collected nationally. The Committee also notes the Productivity Commission recently undertook an extensive investigation into aged care, which received 925 submissions and resulted in a report that was over 800 pages, *Caring for Older Australians*, released in August 2011. This report addressed a number of issues, including data collection and quality outcome reporting.

Given this recent and comprehensive national inquiry, rather than repeat work already undertaken by the Productivity Commission, the Committee has focussed on the four key issues relating to aged care outlined in paragraphs (5) to (8) of the terms of reference.

6.2 Actual rates of provision of aged care and community care alternatives

In paragraphs (5) and (6) of its terms of reference, the Committee has been asked to consider whether —

> actual rates of provision of residential aged care for each community should be provided, as opposed to bed ratios; and
>
> comparable rates of community care alternatives should be provided for these communities.

6.2.1 Data currently collected on residential aged care and community care places

The Committee and a number of submitters to the Inquiry were unclear as to why the Committee has been asked to investigate the provision of data on residential aged care places, as comprehensive data is already collected at a national level, and reported publicly by various Commonwealth agencies. In relation to community care, the State Government administers the Home and Community Care (HACC) program, and collects data which is both reported at a State level and provided to the Commonwealth Government for inclusion in reporting at a national level. The various sources of information on aged care and community care places are detailed below.

Aged Care Service List

At the end of each financial year, the Commonwealth Department of Health and Ageing publishes an Aged Care Service List on its website.[201] The list is very comprehensive and includes information on all aged care services subsidised by the Australian Government under the *Aged Care Act 1997*, including:

- residential aged care services (aged care homes);
- services that provide Community Aged Care Packages;
- services that provide Extended Aged Care at Home and Extended Aged Care at Home - Dementia packages;
- Transition Care services;
- Innovative Pool services;
- Multipurpose Services providing aged care; and
- services funded under the National Aboriginal and Torres Strait Islander Aged Care Strategy.

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[201] Department of Health and Ageing, *Data on approved service providers and aged care places*, <http://www.health.gov.au/internet/main/publishing.nsf/ Content/ageing-rescare-servlist-download.htm>, accessed 22 November 2011.

In relation to each individual service in the list, the information provided includes:

- the name and town/suburb of the service;
- the types of care provided:
  - Residential low-level care, residential high-level care;
  - Community Aged Care Packages;
  - Extended Aged Care at Home Packages;
  - Extended Aged Care at Home - Dementia Packages;
  - Multipurpose Service;
  - Transition Care; or
  - Aboriginal and Torres Strait Islander flexible care;
- the number of places in operation for each type of care;
- the name of the approved provider of the service in which the service is based;
- the Aged Care Planning Region of the service;
- the remoteness classification of the service;
- the organisation type, i.e. not for profit, for profit, local government or State Government; and
- Australian Government recurrent funding for the service for the financial year.

Spreadsheets are provided for the whole of Australia and by State. As the data is provided in a spreadsheet, it can be easily manipulated (such as being sorted by suburb or by postcode) which allows easy extraction of detailed information for particular areas.

Annual Stocktake of Aged Care Places

The Commonwealth Department of Health and Ageing publishes an annual stocktake of aged care places on its website.[202] This includes:

- total Operational Places by State/Territory;
- total Operational Places and Ratios at Aged Care Planning Region (ACPR);
- total Operational Places by Service Type;
- total Allocated Places by State/Territory;
- total Allocated Places and Ratios at ACPR;
- total Allocated Places by Service Type;
- comparison of Allocated and Operational Places and Ratios for Stocktakes from previous financial years; and
- total Offline Places by State/Territory.

The information is presented in tables and lists both actual number of care places provided, as well as aged care planning ratios. As stated in Chapter 5, the current planning framework for services provided under the Commonwealth *Aged Care Act 1997* aims to achieve and maintain a national provision level of 113 operational residential places and community aged care places per 1,000 of people aged 70 years and over. Within this overall target provision ratio, 44 of the total 113 places per 1,000 should be residential high care places, 44 should be residential low care places, and 25 places should be community care places (of which four will be Extended Aged Care at Home or Extended Aged Care at Home-Dementia packages).[203] Data published as at 30 June 2010 is in Tables 7 and 8 and is shown as the total number of places available in each region of Victoria as well as the ratio of places per 1,000 people aged 70 years or over.

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202 Department of Health and Ageing, *Links to the Stocktake of Aged Care Places for 2009-10*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-rescare-aac-stats-data-stocktake-2009-10.htm>, accessed 22 November 2011.

203 Department of Health and Ageing, *Planning for aged care services*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-aged-care-australia.htm~ageing-publicat-aged-care-australia-pt2~ageing-publicat-aged-care-australia-pt2-3>, accessed 22 November 2011.

Table 8: Total Operational Places at Aged Care Planning Region - 30 June 2010

	Residential Care			Community Care			Total
Aged care planning region	**High care**	**Low care**	**Total**	**High care**	**Low care**	**Total**	**Residential + community**
Barwon-South Western	1,959	2,111	**4,070**	172	895	**1,067**	**5,137**
Eastern Metro	4,159	5,234	**9,393**	348	2,085	**2,433**	**11,826**
Gippsland	1,121	1,525	**2,646**	137	643	**780**	**3,426**
Grampians	992	1,149	**2,141**	109	506	**615**	**2,756**
Hume	1,273	1,512	**2,785**	131	615	**746**	**3,531**
Loddon-Mallee	1,408	1,851	**3,259**	154	759	**913**	**4,172**
Northern Metro	3,224	3,334	**6,558**	276	1,669	**1,945**	**8,503**
Southern Metro	5,764	5,683	**11,447**	398	2,328	**2,726**	**14,173**
Western Metro	2,484	2,508	**4,992**	210	1,165	**1,375**	**5,137**

Source: *Annual Stocktake of Aged Care Places 2009-10*

Table 9: Total Operational Ratios at Aged Care Planning Region - 30 June 2010

	Residential Care			Community Care			Total
Aged care planning region	**High care**	**Low care**	**Total**	**High care**	**Low care**	**Total**	**Residential + Community (Planning Ratio)**
Barwon-South Western	44.0	47.4	**91.4**	3.9	20.1	**24.0**	**115.4**
Eastern Metro	38.4	48.3	**86.6**	3.2	19.2	**22.4**	**109.1**
Gippsland	34.5	47.0	**81.5**	4.2	19.8	**24.0**	**105.5**
Grampians	39.2	45.4	**84.7**	4.3	20.0	**24.3**	**109.0**
Hume	41.6	49.4	**91.0**	4.3	20.1	**24.4**	**115.4**
Loddon-Mallee	38.6	50.8	**89.4**	4.2	20.8	**25.0**	**114.5**
Northern Metro	42.3	43.7	**86.0**	3.6	21.9	**25.5**	**111.6**
Southern Metro	45.2	44.6	**89.8**	3.1	18.3	**21.4**	**111.2**
Western Metro	43.9	44.4	**88.3**	3.7	20.6	**24.3**	**112.6**

Source: *Annual Stocktake of Aged Care Places 2009-10*

Reports on the operation of the Aged Care Act 1997

The Federal Government produces annual reports on the operation of the Aged Care Act 1997.[204] These reports collate data on aged care and residential care places, and also analyse trends in the provision of these places over time. The reports also include data on the number of assessments undertaken by Aged Care Assessment Teams, calls to the Aged Care Information Line, funding provided to aged care providers, and a variety of other issues.

[204] Department of Health and Ageing, *Reports on the Operation of the Aged Care Act 1997*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-reports-acarep.htm>, accessed 22 November 2011.

Aged Care Australia website

The Commonwealth Department of Health and Ageing operates the Aged Care Australia website.[205] The website has a number of tools to assist people access aged care services, including an aged care home finder, a community care service finder and an Aged Care Assessment Team finder.

The aged care home finder allows users to search for residential aged care providers in their area (searching by suburb or provider name) and can also be filtered by level of care provided. Results on each provider are very detailed and include type of care provided (high care, low care, respite), number of places, accreditation status, style of accommodation, and other services provided. It also provides address and contact details for the provider. Users can also call the Aged Care Information Line for assistance.

Home and Community Care (HACC) Program Minimum Data Set Annual Bulletin

The Commonwealth Department of Health and Ageing produces the HACC Minimum Data Set Annual Bulletin.[206] The Bulletin reports on the number of HACC clients by State and Territory and includes statistics on age, sex, country of birth and Indigenous status and is compiled from data provided to the Commonwealth by the State and Territory health departments. The State/Territory departments are provided with the data by individual service operators in quarterly reports, which they are required to provide under their funding agreements.[207] Therefore the Victorian Department of Health currently has access to the data collected by individual service providers, and could undertake further analysis of Victorian HACC places if desired.

Aged Care Assessment Program (ACAP) - Minimum Data Set - Annual Report

Comprehensive data is currently collected on the activities of Aged Care Assessment Services. As with HACC, this data is provided directly to the Victorian Department of Health by the service providers themselves, and the Victorian ACAP Evaluation Unit in the Lincoln Centre for Research on Ageing collates an annual report on behalf of the Department. The annual report includes an analysis of:

- number of assessments undertaken;
- access to assessment (including measures of CALD and indigenous access);
- timeliness of assessment (waiting times for assessment in hospital and non-hospital settings);
- client characteristics (including age, accommodation setting and health conditions);
- support at assessment;
- recommendations (whether assessed to remain in community, or admission to residential aged care);
- range across teams (differences in timeliness of assessments and completed assessments between aged care assessment teams);
- care coordination; and
- data quality.

This analysis provides useful information on the performance of aged care assessment teams and changes in service delivery over time.

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205 Aged Care Australia, <http://agedcare.gov.au/>, accessed 22 November 2011.

206 Department of Health and Ageing, *HACC MDS Annual Bulletin*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-hacc-mds-annual-bulletin.htm>, accessed 22 November 2011.

207 Department of Health, *Data collection: Home and Community Care*, <http://www.health.vic.gov.au/hacc/data_collection/index.htm>, accessed 22 November 2011.

6.2.2 Use of data on aged care and community care places to plan for future need

As stated above, the Commonwealth *Aged Care Act 1997* aims to achieve and maintain a national provision level of 113 operational residential places and community aged care places per 1,000 of people aged 70 years and over. Each year data is used to allocate new aged care and community care places within each aged care planning region in order to meet this targe or maintain levels where demographics change. Applications for new aged care places are advertised each year through a competitive Aged Care Approvals Round. New places are allocated to the service providers who can best meet the identified care needs of the community. The allocation of places must take account of people with special needs who are defined in legislation as:[208]

- people from Aboriginal and Torres Strait Islander communities;
- people from non-English speaking backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged; and
- a veteran of the Australian Defence Force or of an allied defence force; or their spouse, widow or widower.

The tender documentation identifies particular local government areas and statistical local areas in which places are needed, and special needs groups that have unmet demand within these areas. Applications that best meet these criteria are then allocated places.[209]

6.2.3 Improving access to information on aged care and community care places

Given the data on aged and community care places is already collected and made available publicly by the Commonwealth Government, and well utilised for planning purposes, the Committee does not believe additional data collection at a State level is necessary. The State can already access this data and use it for planning or other purposes.

One issue raised in some submissions was that while this information is available, it is not well known by the public. The Australian Institute of Health and welfare commented in its submission:[210]

> Rates of provision (total operational places) are currently available by state and territory and by Aged Care Planning Region across Australian and published in table format on the DoHA website. The AIHW would support the improving of the presentation of this information to make it more visible and accessible to the general community.

The Committee notes that information relating to aged care places is currently available on various Commonwealth agency websites, however, not all elderly Victorians are aware these websites exist and many are not comfortable accessing information in this way. The Committee believes that further work could be done to better publicise the Aged Care Australia website, and the alternative of calling the Aged Care Information Line.

Finding 8

Data on the provision of residential aged care and community care alternatives is currently collated and made available by the Commonwealth Government.

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208 Department of Health and Ageing, *Planning for aged care services*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-aged-care-australia.htm~ageing-publicat-aged-care-australia-pt2~ageing-publicat-aged-care-australia-pt2-3#10>, accessed 22 November 2011.

209 Department of Health and Ageing, *2011 Aged Care Approvals Round Essential Guide,* <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-acar/$file/2011ACAR-EssentialGuide.pdf>, accessed 22 November 2011.

210 Australian Institute of Health and Welfare, Submission No. 19, p. 2.

6.3 Measuring quality and outcomes in residential aged care facilities

In paragraph (7) of its terms of reference, the Committee has been asked to consider —

> whether quality criteria for residential aged care across a community and for each individual setting should be more clearly available and provided.

The Committee has considered this paragraph of the terms of reference in context of the Committee's broader area of inquiry, being budget measures and the measurement of outcomes. Given aged care is Commonwealth funded and regulated, the Committee has first examined the adequacy of the current Commonwealth residential aged care accreditation process. The Committee has then considered whether additional data should be collected for measuring quality in residential aged care facilities and whether information on the quality of aged care should be better made available to the public. Finally, the Committee has examined current Victorian Government budget measures that relate to aged care.

6.3.1 Residential aged care accreditation

As discussed in Chapter 5, residential aged care facilities are currently assessed by the Aged Care Standards and Accreditation Agency (ACSAA) against 44 pass/fail accreditation standards, and if all standards are met, accreditation is granted. The effectiveness of the accreditation process was reviewed in 2007 in a report commissioned by the Department of Health and Ageing. The report found:[211]

> Generally, the level of quality in residential aged care was seen positively by stakeholders as having improved over the 10 years since accreditation was introduced…
>
> The introduction of accreditation was also found to have served a number of functions related to quality including to:
>
> - Remove under-performing homes from the sector;
> - Set a minimum standard for quality;
> - Raise the standards of quality across the sector;
> - Establish a degree of consistency across the sector; and
> - Develop a focus on continuous quality improvement and resident-focused care.

The Committee notes that the original accreditation process has seen significant improvement in residential aged care. Aged and Community Care Victoria noted in its submission:[212]

- in the 12 months to December 2000, 63.5% of facilities met all 44 outcomes
- in the 12 months to December 2009, 94.0% of facilities met all 44 outcomes
- in the 12 months to December 2010, 97.3% of facilities met all 44 outcomes.

The Department of Health and Ageing is currently undertaking an Accreditation Standards Review which is examining the current 44 criteria against which residential aged care facilities are assessed.[213] The Department has worked with a Technical Reference Group to develop 36 new expected performance statements, which aim to replace the existing 44 criteria. Consultation is

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211 Campbell Research & Consulting, *Evaluation of the Impact of Accreditation on the Delivery of Quality of Care and Quality of Life to Residents in Australian Government Subsidised Residential Aged Care Homes*, October 2007, p. x, <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-iar-final-report.htm>, accessed 23 November 2011.

212 Aged and Community Care Victoria, Submission No. 24, p. 6.

213 Department of Health and Ageing, *Draft Residential Aged Care Accreditation Standards*, <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-rescare-accreditation-standards-draft.htm>, accessed 3 November 2011.

being undertaken currently before the new statements are implemented. The proposed new statements are grouped under 3 standards:[214]

- ***Standard 1 - Living in the home***
  Residents' overall health and wellbeing is promoted and maintained. The home acknowledges, respects and promotes residents' individuality, equality and diversity. Residents are supported to maintain their personal, civic and legal rights, and are assisted to maintain and exercise choice and control of their own lives while respecting the rights and needs of others.

- ***Standard 2 - Personal and clinical care***
  Residents' physical, mental, spiritual, emotional and cognitive health needs are promoted. Optimal outcomes are achieved through the assessment and provision of individualised quality care and services. Services are based on practice informed by evidence in partnership with the resident (or their representative) and a healthcare team operating within their scope of practice.

- ***Standard 3 – Management of the home***
  The governance and management systems and practices of the home support and promote quality care and services, continuous improvement, open disclosure, and create a safe, stable environment for residents, staff and visitors.

In revising the Standards, there is an increased focus on the resident and encouraging the provision of resident-centred care, in line with other national and international health standards and practices. There has also been a focus on articulating more clearly the requirements of care under the *Aged Care Act 1997*, reducing duplication across the standards, and maintaining the present culture of continuous quality improvement.[215] The Committee believes the review of the accreditation standards is timely and the new statements will assist in continuing to improve the quality of residential aged care.

Public reporting on aged care quality

Accreditation reports on residential aged care facilities are currently published on the ASCAA website.[216] Reports can be searched by the name of the provider or by location. Not only do reports indicate the outcome of the assessment against each criteria (does comply or does not comply), they also include detailed written comments against each of the criteria, with most reports over 20 pages long. Aged and Community Care Victoria (ACCV) noted in its submission:[217]

> For consumers, reporting of quality of care measures needs to be provided in language and modes that are easily understandable and accessible, and enable them to make comparisons to assist them to make sound choices. Quality of care reporting also needs to be open and transparent, so that information relating to the type and nature of care consumers are seeking is available for all facilities and service providers.
>
> ACCV recognises that it is this kind of information that forms the basis of consumers and family members planning visits to a range of prospective providers to ascertain the quality, suitability, accessibility, cost, visiting arrangements and all other relevant information necessary in considering the placement of a parent or sibling in a residential aged care facility.

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214 Department of Health and Ageing, *Draft Revised Standards for Residential Aged Care*, <http://www.health.gov.au/internet/main/publishing.nsf/content/8D424DBDA7F8DB3DCA2578560083C355/$File/Draft%20Standards%20-%2022Mar11.pdf>, accessed 3 November 2011.

215 Department of Health and Ageing, *Draft Residential Aged Care Accreditation Standards*, <http://www.health.gov.au/internet/main/publishing.nsf/content/ageing-rescare-accreditation-standards-draft.htm>, accessed 3 November 2011.

216 Aged Care Standards and Accreditation Agency Pty Ltd, <http://www.accreditation.org.au/>, accessed 22 November 2011.

217 Aged and Community Care Victoria, Submission No. 24, p. 4.

> However, ACCV believes that sufficient information about quality of care already exists for consumers and providers. The implementation of a continuous improvement approach through the Aged Care Standards Accreditation Agency's (ACSAA) regular review and reporting cycle provides valuable trend data for individual facilities as well as the residential aged care system. The internet website of ACSAA provides a link to a search facility on its home page. The consumer or family member can enter the name of a facility to inquire its accreditation status, and the recommendations that stem from the most recent assessment by the agency against the expected outcomes of the accreditation standards.
>
> The reports available through the ACSAA website are very extensive and detailed, informing the consumer, potential consumer or family member of the conditions of the facility in question, recent improvements to the site and amenities, management practices and processes, continuous improvement, regulatory compliance, the facility's comments and complaints systems, and staff training and skill levels.

The Committee supports the continued provision of this information to the public, and better promotion of this service to ensure they are aware of this information.

Finding 9

The current aged care accreditation process is effective and has driven quality improvements in residential aged care facilities. Public reporting of accreditation assessments is useful for informing the consumers about the quality of services provided by individual providers.

6.3.2 Residential aged care quality indicators

The current accreditation process is based on individual assessments of residential aged care facilities by accreditation teams. There is no requirement for residential aged care providers to regularly provide data to the Commonwealth on their performance. The only mandatory reporting is currently in relation to adverse events, such as assaults and unreasonable use of force occurring within a facility.[218]

In its report on *Caring for Older Australians*, the Productivity Commission recommended setting up a new body, the Australian Aged Care Commission (AACC). The report examined whether introducing regular reporting from residential aged care providers to the Commonwealth Government against quality indicators would be beneficial. The report stated:[219]

> The Commission considers that a stronger emphasis on publicly reported performance information would help care recipients make more informed choices over services and improve transparency around how care dollars are spent. This will be particularly important in the context of the Commission's proposed entitlement system, which confers more control and choice of aged care services in the hands of older Australians…
>
> The Commission recommends that the quality assurance framework for aged care, and the accreditation role of the AACC be expanded to include collecting, collating and disseminating quality performance indicators. The indicators should make up a new Quality and Outcomes Data Set and should be aligned with the objectives of the aged care system (and where appropriate with health care indicators) and determined in consultation with care recipients, aged care providers, health professionals and peak bodies. Lessons from the development of other countries' LTC quality frameworks should also be drawn on in developing the Data Set.

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218 Department of Health and Ageing, *Compulsory Reporting Guidelines For Approved Providers of Residential Aged Care*, <http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-quality-guidelines-cr-ap.htm>, accessed 22 November 2011.

219 Productivity Commission, *Caring for Older Australians*, June 2011, p. 281.

The Committee agrees routine collection of data on the quality of services provided by residential aged care facilities could provide useful information, however notes there are a number of challenges to implementing such a system. Collecting additional data would require additional resources within aged care facilities and framing quality indicators against which useful data can be collected is difficult. In addition, there would need to be a robust framework for data collection to ensure high quality data. This would be difficult given the large number of aged care service providers.

Before such a system is implemented, it is important to clearly define the purposes for which the data will be used. The Productivity Commission pointed out in its report:[220]

> By collecting and publishing information on quality performance measures, care recipients would have better information on which to make choices about care and impose, as a consequence, a discipline on providers to deliver better quality care. As well, providers would be better positioned to benchmark their performance, understand variations in performance and identify best practice…
>
> Setting up and maintaining a dataset and making data available is also not without costs and these need to be weighed up against the potential improvements offered by any new data performance indicators. ACSAA supported the reporting of key indicators, suggesting that many providers already collect such information:
>
> > The introduction of a system whereby approved providers report key data to the Accreditation Agency has the potential to reshape the current visit-centric processes that are set out in the regulations. Such reporting could include corporate information and clinical and lifestyle indicators that would inform Accreditation Agency's case management. It is understood that most approved providers already collect such information for their own purposes.

In a separate section of its report, the Productivity Commission pointed out:[221]

> Beyond this, the Commission is proposing to strengthen the quality assurance framework by requiring that quality indicators be published to help care recipients and their families make informed choices about the quality of care and to enhance transparency and accountability around how funds are spent on care. The Commission is also suggesting that a facility publishes indicators staff qualifications and skills together with a profile of care recipients, as part of the proposed Quality and Outcomes Data Set.

The Committee supports this recommendation in principle, but believes further analysis needs to be undertaken to ensure this system would provide value for money. The existing accreditation has proved an effective way of monitoring performance and driving improvements within aged care facilities, so it is important to ensure any such framework would be similarly effective in further improving the quality of aged care.

Development of quality indicators

The Productivity Commission's report notes that much work has already been done towards developing potential quality indicators within the aged care setting.[222] In 2007, the Department of Health and Ageing commissioned a review of the accreditation process (the Campbell Report) which identified a number of potential indicators which could form part of a Resident-Centred Aged Care Quality Indicator Set. These indicators included areas of Resident Health Care, Interactions, Services, Personal and Environment. The report also examined possible sources of data from which these indicators could be measured.

Certain indicators identified in the report, such as statistics on falls, pressure ulcers, weight loss and depression can be measured objectively using clinical records, incident reporting forms and medication records. However, other indicators, such as measures of resident satisfaction with meals, their environment and their safety, can only be measured through resident experience

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220 *Ibid.,* p. 211.
221 *Ibid.,* p. 370.
222 *Ibid.,* pp. 216-17.

surveys, which may be subjective and potentially unreliable. This difficulty was raised by the AIHW in their submission:[223]

> The AIHW agrees that there is scope for improvement in reporting on quality criteria for residential aged care, underpinned by national standards across a range of measures. The AIHW acknowledges however that concepts such as quality of life are much more difficult to measure than clinical and system outcomes.

In evidence to the Committee the Australian Institute for Primary Care and Ageing also raised these challenges:[224]

> 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 … 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.

In evidence to the Committee, the Australian Psychological Society emphasised the importance of measuring quality of care from a resident perspective, not solely from the perspective of the care providers:[225]

> In an aged care setting it is very clinically effective, if I can call it that, to have the patients get up at 8 o'clock in the morning to have their showers and breakfast, have their lunch at midday, have their dinner at 5.00 p.m. and be in bed by 7.00 p.m. We know that not many elderly people have that routine in their lives. They may well prefer to get up late, stay up late and go to bed at 10 o'clock at night. When you are delivering the aged care service in a residential setting it is very effective to have everyone sticking to the same routine, but from a quality of life perspective that can make a patient feel depressed, isolated and totally bewildered by the new experience they have to go through. Not only are they transplanted into a totally foreign environment, they have to stick to a new routine and so forth. Their quality of life and their mental health suffers as a result of being in a nursing home.

In 2006, the Victorian Department of Health introduced a pilot program to collect data against certain indicators through its Quality Indicators in Public Sector Residential Aged Care Services project. The indicators were developed as a result of a detailed consultation process.[226] The indicators chosen include incidence of pressure ulcers, falls and use of physical restraints, residents on nine or more different medications, and unplanned weight loss. All these indicators are able to be measured objectively, so data collection is made easier. The Resource Manual issued in 2007-08 to assist aged care facilities in collecting and reporting data states:[227]

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223 Australian Institute of Health and Welfare, *Australia's health 2010*, p. 190, <http://www.aihw.gov.au/publication-detail/?id=6442468376>, accessed 22 November 2011.

224 Prof. Y. Wells, Australian Institute for Primary Care and Ageing, *Transcript of Evidence*, 2 November 2011, p. 36.

225 Mr. B. Li, Australian Psychological Society, *Transcript of Evidence*, 2 November 2011, p. 13.

226 Department of Health, *Public Sector Residential Aged Care Quality of Care Performance Indicator Project Report*, <http://www.health.vic.gov.au/agedcare/downloads/public_sector>, accessed 22 November 2011.

227 Department of Health, *Resource manual for Quality Indicators in Public Sector Residential Aged Care Services 2007-2008 version 1,* p. 3, <http://www.health.vic.gov.au/agedcare/downloads/psracs_resource_manual.pdf>, accessed 22 November 2011.

> For the first 12 months of the program, services collected and reported the required data for each indicator to DHS. DHS reported back to each service on the prevalence and/or incidence of each indicator for their service. Services were also provided with averaged data for all services and data over time. Services were able to use the data and the results to identify where:
>
> - Changes might need to be made to process or systems
> - Improvements were occurring as planned
> - Improvements were being sustained over time
> - Additional improvements might need to be implemented.
>
> Following this 12-month introduction period, there will be an increasing emphasis on public reporting and accountability. Services will have greater depth of data and benchmarking opportunities.

The Committee understands that data collected is used by the Department internally to provide averages across the system and then to benchmark each facility against the average. This information is then fed back to providers to assist them in assessing and improving their performance. To date, it does not appear as though public reporting on this data has occurred. The Committee is concerned this data is continuing to be collected, but may not be being used for its intended purpose. The Committee believes the Department of Health should review the data currently being collected and determine the best way to publicly report this data.

Recommendation 8

The Committee recommends the Victorian Department of Health report publicly on the data currently collected against quality indicators for Public Sector Residential Aged Care Services, as foreshadowed in the 2007-08 Resource Manual.

In March 2011, a report was produced by a consultant commissioned by the Department of Health which aimed to set reference ranges for these indicators.[228] The reference ranges set target rates and limit rates for each of the indictors. The target rate is an aspirational, realistic and achievable rate of performance, and the limit rate is a trigger for review and possible further action. Whilst the Committee believes there is value in such a program, statistics do not always give a true indication of the quality of care. Indeed, the consultant report itself noted:[229]

> The expert in polypharmacy at the expert roundtable was not aware of evidence supporting a specific number of medications influencing resident outcomes. Consequently they were not able to provide an evidence base to inform the reference range for this indicator…
>
> It is important to note that the purpose of this indicator is to provide a trigger point for services to investigate the prescription of nine or more medicines; however it does not speak to the necessity of these medicines. For many residents, more than nine medicines are appropriate and required.

The other performance indicators (incidence on pressure ulcers, falls, use of physical restraints and unplanned weight loss) overlap with areas currently assessed during the accreditation process. The current accreditation standards include:[230]

- **2.7 Medication management** - Residents' medication is managed safely and correctly.
- **2.11 Skin care** - Residents' skin integrity in consistent with their general health.

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228 Campbell Research & Consulting, *Development of Reference Ranges for Aged Care Quality Indicators*, March 2011.

229 *Ibid.,* pp. 24-5.

230 Aged Care Standards and Accreditation Agency Ltd, *Accreditation Standards*, http://www.accreditation.org.au/site/uploads/30985_AgedCare_ASENGLISHV1_3.pdf>, accessed 18 November 2011.

- **2.13 Behavioural management** - The needs of residents with challenging behaviours are managed effectively.

The Committee is of the view that whilst collecting data and setting targets can be useful, further analysis needs to be undertaken to ensure the quality indicators chosen and the data collected improves the quality of care, and does not duplicate information collected during the existing accreditation process. This process currently involves assessors meeting with residents and their families to gain their views on the quality of care, and regular resident experience surveys to collect data against resident satisfaction quality indicators may provide similar information. The Committee believes further analysis of whether the Quality Indicators in Public Sector Residential Aged Care Services project has led to quality improvements in those facilities would be useful in determining whether such a program should be implemented more broadly.

Recommendation 9

The Committee recommends the Victorian Department of Health analyse the data which has been collected through its Quality Indicators in Public Sector Residential Aged Care Services project to determine whether the collection of this data has led to improvements in the quality of care. The Committee further recommends that based on the findings of this review, the Department engage with the Commonwealth to determine whether the development of a quality assurance framework, requiring all residential aged care providers to report against published quality indicators (as recommended by the Productivity Commission), would be beneficial in informing consumers and achieving better health outcomes.

6.3.3 Victorian Government budget measures for aged care

Given this Inquiry's focus on budget measures and measuring outcomes, the Committee has also examined existing Victorian Government budget measures that relate to aged care. The Victorian Government, as part of its annual budget, sets performance measures for the delivery of residential aged care, aged care assessments and HACC Primary Health, Community Care and Support. The measures aim to assist the Department, Government, Parliament and the community to determine whether budget funding has achieved its intended purpose.

The Victorian Auditor-General undertook an audit titled *Performance Reporting by Departments* in 2010. The report assessed Departmental performance measures against three criteria:[231]

- Relevance – logical link between the measure, the agency's objective and the Government's intended outcomes.
- Appropriateness – there should be sufficient information to determine whether the agency has achieved its target and the target should be relevant.
- Fairly represent performance – the information must be able to be measured and information should be consistent, reliable and used for decision-making.

As part of the examination of budget measures for the area of aged care, the Committee examined the budget measures and the results reported by the Department of Health.

[231] Victorian Auditor-General's Office, *Performance Reporting by Departments*, May 2010, p. 19.

Residential aged care

For residential aged care, the Department has the following targets:

Table 10: Performance targets for residential aged care

Performance measure	2011-12 Target
Quantity	
Bed days in high care places	922,000
Bed days in low care places	388,000
Quality	
Residential care services certified and accredited	100%
Cost	
Total output cost	$323.2 million

Source: *Budget Paper No. 3: Service Delivery*, pp. 201-202.

The quantity of bed days in high care and low care is linked to the Department's objective of providing residential aged care to Victorians as is the cost of providing the service.

However, the Committee considers that quality of residential aged care is limited in only providing data on the number of homes certified and accredited. There would be value to expanding the quality indicators to provide more information – for example, by using the information the Department collects through its quality indicators from Public Sector Residential Aged Care Services – should the Department believe this provides useful information on the quality of aged care.

This would provide more relevant and appropriate information and assist the Parliament and community to determine the quality of residential aged care in Victoria, as the current indicator of certification and accreditation is a limited indicator of quality.

Aged Care Assessment

For aged care assessments, the Department has the following targets:

Table 11: Performance targets for aged care assessments

Performance measure	2011-12 Target
Quantity	
Aged Care Assessments	59,000
Timeliness	
Percentage of priority 1 and 2 clients assessed within the appropriate time – community based assessment	85 %
Percentage of priority 1 and 2 clients assessed within the appropriate time – hospital-based assessment	85 %
Cost	
Total output cost	$44.6 million

Source: *Budget Paper No. 3: Service Delivery*, p. 202.

While the quantity of Aged Care Assessments is easily measurable, it is a process that is not driven by the Department, rather it is a process where referrals are made to Aged Care Assessment Services. Therefore, this indicator may not be met.

The Department in 2011-12 changed its timeliness indicators. The timeliness indicators used previously were:[232]

> Average wait between client registration and ACAS assessment – community-based assessment

[232] Victorian Government, *Budget Paper No.3 Service Delivery 2011-12*, May 2011, p. 202.

Average wait between client registration and ACAS assessment – hospital-based assessment

In analysing the Department's past performance in its annual report for 2010-11, the average wait was 18 days for community-based assessments and 1.8 days for hospital-based assessments. The targets in place were 15 days and 2.5 days respectively.

The timeline for undertaking assessments has changed with the introduction of National Health Reform. The Commonwealth Government has changed the timelines for priority one community based ACAS assessments from 2.5 days to two days and for priority two assessments, from between three and 15 days to between three and 14 days. The Department has set its indicator for both community based and hospital based assessments to 85 per cent completed within the timeframe, consistent with the performance target set by the Commonwealth Department of Health and Ageing.

However, the Committee notes that in 2009-10 in Victoria 98.2 per cent of hospital-based assessments were completed within the target timeframe compared to 84.2 per cent for community based assessments.[233] Whilst a target of 85 per cent is appropriate for community based assessments, as this would represent a service improvement, a target of 85 per cent for hospital based assessments is very low when 98.2 per cent is currently being achieved, and is unlikely to drive service improvements.

The Committee also considers that the new budget measures implemented do not provide a complete picture. The Department's 2011-12 indicators would be best supplemented by the previous indicators on the average wait between registration and assessment. Only measuring the percentage of assessments undertaken in the appropriate timeframe could potentially create perverse incentives and allow some assessments to be delayed for long periods. The average waiting time also provides a better indication of how long the wait is between client registration and an ACAS assessment.

HACC Primary Health, Community Care and Support

For HACC Primary Health, Community Care and Support, the Department has the following performance measures:

Table 12: Performance measures for HACC Primary Health, Community Care and Support

Performance measure	2011-12 Target
Quantity	
Clients receiving Home and Community Care Services	295,000
Home and Community Care service delivery hours	10,355,000
Quality	
Eligible population receiving Home and Community Care services	30 %
Cost	
Total output cost	$608.3 million

Source: *Budget Paper No. 3: Service Delivery*, pp. 203-204.

The quantity of services provided is easily measurable, however, like ACAS assessments, it is not a measure that the Department can completely control. The quality indicator used by the Department, being the percentage of the eligible population receiving HACC services, is also not a measure that the Department can control.

In addition, this quality measure does not link to, or provide any information on, the quality of service provided by HACC to the community. The Committee considers that the Department should investigate ways to better measure the quality of HACC services provided. This is particularly

233 Department of Health and Ageing, *Aged Care Assessment Program Minimum Data Set Annual Report Victoria 2009–2010*, p. 90, <http://www.health.vic.gov.au/agedcare/downloads/pdf/acas_vic_report2009-10.pdf>, accessed 22 November 2011.

important, given the large financial investment made by the State in providing HACC services and the need for transparency.

Finding 10

The Victorian Department of Health's:

- quantity indicators for ACAS do not provide a complete measure on the timeliness of assessments;
- quality measures for residential aged care services do not adequately measure the quality of service provision; and
- quality measure for HACC does not provide any information on the quality of the service received by HACC recipients.

Recommendation 10

The Victorian Department of Health should:

- include the average wait between client registration and ACAS assessment in its performance measures;
- include more meaningful measures on the quality of its residential care services; and
- as part of its 2012-13 Budget, put in place performance measures for the HACC program that adequately measure the quality of HACC services provided.

6.4 Conditions for which hospitalisations can be avoided

In paragraph (8) of its terms of reference, the Committee has been asked to consider —

> whether potentially unnecessary or avoidable hospitalisations of patients in residential care should be used as a surrogate indicator for poor care in these settings.

As with paragraph (4) of the terms of reference, a number of submissions pointed out that the word 'surrogate' is not appropriate. In interpreting this issue, the Committee has focussed on whether avoidable hospitalisations should be used as an indicator of the quality of care provided by residential aged care providers.

6.4.1 Data currently collected on avoidable hospitalisations from residential aged care

As noted in Chapter 4, the Victorian Department of Health collects detailed data on avoidable hospitalisations through ambulatory care sensitive conditions (ACSCs) reports. Data on avoidable hospitalisations is collated from the Victorian Admitted Episodes Dataset (VAED) which is required to be collected for each patient admitted to a Victorian hospital.

One of the data fields collected in the VAED is admission source, which includes the category "Transfer from aged care residential facility". The VAED also includes a diagnosis code field, where at least one principal diagnosis and up to 40 ICD-10-AM codes reflecting injuries, disease conditions, patient characteristics and circumstances impacting this episode of care are recorded.[234] Certain ICD-10-AM codes have been identified as relating to ACSCs, which are those conditions for which hospitalisation is thought to be avoidable with the application of public health interventions and early disease management, usually delivered in ambulatory setting such as primary care.[235]

Based on this data already collected, it should be possible for reports to be produced from the VAED detailing the number of avoidable hospitalisations from residential aged care facilities, and this analysis would provide useful data. The Productivity Commission also currently collates and

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234 Department of Health, *VAED 21st Edition User Manual 2011-12*, <http://www.health.vic.gov.au/hdss/vaed/2011-12/manual/index.htm>, accessed 22 November 2011.

235 Department of Health, *Victorian Ambulatory Care Sensitive Conditions study*, <http://www.health.vic.gov.au/healthstatus/admin/acsc/index.htm>, accessed 22 November 2011.

analyses data on hospital admissions due to falls in residential aged care facilities in its annual *Report on Government Services*.

The main limitation on this data is that it is collected at the hospital level, and therefore can only be analysed by hospital. The data does not identify from which residential aged care facility a patient was transferred, and therefore reporting on the number of avoidable hospitalisations from individual residential aged care facilities, and making comparisons between them, is not currently possible.

Data currently published on avoidable hospitalisations can be analysed by age. An age breakdown of avoidable hospitalisations in Victoria in 2009-10 is in Table 13.

Table 13: Avoidable hospitalisations in Victoria 2009-10 by age

Age (years)	Number of Admissions	Standardised Rate per 1,000 Persons	Average Bed days	Total Bed Days
0-4	10,754	31.28	1.66	17,870
5-9	6,075	18.64	1.40	8,494
10-14	2,671	7.94	1.90	5,071
15-19	4,312	11.78	2.10	9,043
20-24	4,804	11.68	2.15	10,311
25-29	4,290	10.59	2.30	9,868
30-34	4,440	11.66	2.67	11,843
35-39	5,518	13.53	2.90	16,017
40-44	5,912	15.37	3.29	19,471
45-49	7,370	19.16	3.62	26,659
50-54	8,696	24.65	4.32	37,604
55-59	10,413	32.84	4.79	49,844
60-64	13,317	46.82	5.30	70,633
65-69	14,530	67.97	5.79	84,112
70-74	17,103	98.84	6.26	107,148
75-79	19,948	140.67	6.75	134,678
80-85	20,052	178.59	7.29	146,164
85+	20,653	209.77	7.82	161,427

Source: *Victorian Health Information Surveillance System: ACSC Reports*

This data clearly shows an increase in avoidable hospitalisations with age. However, Aged and Community Care Victoria noted in its submission this can be attributed to increased levels of frailty and complex care needs with older Victorians:[236]

> The average number of health conditions for people over 65 was 2.84, while more than half of those over 85 had an average of 4.85 health conditions, placing them in the profoundly disabled category. Those with depression as a co-morbidity had the highest number of health conditions, an average of 5.5. Many of these health conditions are long term and chronic, increasing the risk of necessary hospital admissions to address complex acute health needs that are best treated in hospital and not in an aged care setting.

The collection of data according to ACSC categories can also potentially be misleading, as the data is collected on conditions for which hospitalisation is thought to be avoidable, not a clinical

[236] Aged and Community Care Victoria, Submission No. 24, p. 6.

assessment of whether a particular presentation at hospital was avoidable in the individual circumstances. The Australian Medical Association (Victoria) stated in its submission:[237]

> There can be many reasons for hospitalisations and it is not always possible to definitively determine whether or not that hospitalisation was avoidable, even after lengthy investigation.

Whilst the Committee believes more should be done to reduce hospitalisations from residential aged care facilities, care needs to be taken when analysing this data.

6.4.2 Using admission to hospital from residential aged care facilities as a measure of the quality of care

The terms of reference require the Committee to examine whether avoidable hospitalisations can be used as a measure of poor care in the residential aged care setting. The Victorian Healthcare Association noted in its submission:[238]

> [W]hen RAC facilities are benchmarked, the VHA believes there are some indicators – such as higher prevalence rates of falls within a facility (there are guidelines designed to assist residential aged care facilities to develop and implement practices that reduce the falls experienced by those receiving care) or higher prevalence rates of acute admissions where health problems may be assessed as too difficult to manage – that can be used to demonstrate which RACs are not managing their residents adequately, which may indicate poor care in these settings.

However, a number of submissions expressed concern with attempting to use avoidable hospitalisations as a measure of the quality of care provided by a residential aged care facility, as a number of other factors influence whether a resident is transferred to a hospital that would not be taken into account if data on avoidable hospitalisation is considered in isolation. The AIHW noted:[239]

> The AIHW supports the collection of potentially unnecessary or avoidable hospitalisations in the residential care setting, and agrees this information could be used as a guide for quality of nursing care, although several other factors would require consideration if it is to be used as an indicator. Linkage of hospital and residential aged care data would be necessary to ensure accurate conclusions are drawn.

A number of these other factors that influence hospitalisations from residential aged care facilities are discussed below.

<u>Access to primary care</u>

The major factor contributing to avoidable hospitalisations from residential aged care facilities identified in submissions to the Committee was lack of access to primary care providers, such as GPs. Mercy Health stated in its submission:[240]

> Hospital admissions from the residential care sector is not an indicator of poor care but an indicator of inadequate access to General Practitioner and Registered Div 1 nurses. The failure to send a resident to hospital for medical assessment is poor care if the facility is unable to access a medical practitioner.

Aged and Community Care Victoria stated:[241]

> The evidence … demonstrates that potential or unavoidable emergency presentations and hospital admissions are appropriate for treatment of the health and care needs of residents and are not the result of poor care in residential aged care facilities and should not be used as indicators of poor care.

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237 Australian Medical Association (Victoria), Submission No. 21, p. 1.
238 Victorian Healthcare Association, Submission No. 26, p. 7.
239 Australian Institute of Health and Welfare, Submission No. 19, p. 2.
240 Mercy Health, Submission No. 13, p. 1.
241 Aged and Community Care Victoria, Submission No. 24, p. 6.

The Committee believes more needs to be done to improve access to primary care providers in residential aged care facilities. If these facilities were able to access GP services more readily, a number of hospitalisations could be avoided. In particular, there needs to be a greater incentive for GPs to visit facilities when needed. The Australian Medical Association (Victoria) noted in its submission:[242]

> Lessening red tape, rather than increasing it, is crucially important for our health care system — and especially for GPs working in aged care facilities. The administrative obligations on GPs in these facilities are considerably greater than for GPs in consulting practice. The regulatory requirements with which residential aged care facilities must comply mean that additional forms and paperwork must be completed by doctors.

The Productivity Commission have also examined this issue in their report on *Caring for Older Australians*. The Australian Medical Association (Victoria) further stated in its submission to that inquiry that:[243]

> It is well known that Medicare rebates are inadequate to cover the costs of providing medical care to residents in aged care homes, and do not reimburse the non face-to-face time required to provide that care. This is a significant deterrent to providing care, particularly for younger doctors who do not find providing medical services to aged care attractive in the current environment.

The Productivity Commission commented:[244]

> [O]lder Australians living in residential care should be able to access publicly-funded health services (including primary health services) in the same way as they would if they were living in the community. Also, if people cannot receive GP services they may end up in the emergency department of a hospital calling on resources in limited supply (and potentially limiting the ability of these departments to deal with other cases).
>
> But, if GPs are to deliver services in residential care and home settings, there must be adequate incentives to provide such services, that is, Medicare rebates must be sufficient to cover the cost to GPs (taking into account the alternative use of the GPs time) of providing this care.

The Productivity Commission then recommended:[245]

> The Medicare rebate for medical services provided by general practitioners visiting residential aged care facilities and people in their homes should be independently reviewed to ensure that it covers the cost of providing the service.

The Committee supports this recommendation and believes better access to GPs in residential aged care facilities will reduce the incidence of avoidable hospitalisations. The Committee encourages the Commonwealth Government to adopt the Commission's recommendation and to review the Medicare rebate to ensure GPs are adequately compensated for services provided at these facilities.

Clinical judgement and skill mix of staff in the residential aged care facility

Submissions to the Committee emphasised that decisions to transfer residents to hospital are made by qualified health professionals working in the facility, taking into account the resources and other options available at that particular facility. The Australian Nursing Federation (Victorian Branch) stated:[246]

> If a health professional (Nurse Practitioner, Advanced Practice Nurse, or Registered Nurse) has made a professional judgment to transfer a person to hospital, then it is

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242 Australian Medical Association (Victoria), Submission No. 21, p. 2.
243 Productivity Commission, *Caring for Older Australians*, June 2011, p. 221.
244 *Ibid.,* p. 223
245 *Ibid.,* p. 225.
246 Australian Nursing Federation (Victorian Branch), Submission No. 6, p. 7.

> not unnecessary, rather a decision made in light of the skill mix and support in the context of best care outcome for the person/patient/client that the decision is based on.

The Goulburn Valley Primary Care Partnership similarly stated:[247]

> Hospitalisation is not always a true reflection of poor care outcomes. In contrast it could be interpreted as an indicator of some services ensuring best outcomes for clients in an area of limited local services. Such an example of the 'one doctor town' requiring residential aged care residents to be transferred to the local hospital which enables the doctor to monitor the resident in an acute setting.

Submissions also highlighted that residential aged care facilities have limited resources, so transfer to hospital can often be required to ensure appropriate care. The Australian Institute for Primary Care and Ageing stated:[248]

> Rates of hospitalisation from residential aged care facilities are far too blunt an indicator. They do not take into account, for example, the level of disability of people being cared for or co-morbid conditions … Residential aged care is not well-funded to provide the level of medical care that hospitals can provide.

The Australian Medical Association (Victoria) commented:[249]

> We do not support the proposal that potentially unnecessary or avoidable hospitalisations of patients in residential care should be used as a surrogate indicator for poor care in those settings. Rather it is an indicator of both inefficient management practices and inadequate funding …
>
> [T]he proposal may mean that aged care facilities become reluctant to send patients to hospital if they think that this may be seen as an indication of poor care.

The Committee believes it is important to ensure residential aged care facilities are not discouraged from transferring patients to hospital if a hospital would be a more appropriate option for care. In facilities with limited resources and staff that may not have the expertise to deal with particular conditions, transfer of a resident to hospital may be required.

Family pressure

A further complicating factor when assessing avoidable hospitalisations is the role the family of a resident can play in pressuring staff to transfer the resident to hospital. Australian Institute for Primary Care and Ageing stated in its submission:[250]

> [F]amily pressure and the regulatory requirement to demonstrate appropriate duty of care may lead to residential aged care services sending residents to hospital.

This is particularly the case when a resident is nearing the end of their life, and the family believes their loved one would be better cared for in a hospital and the staff in the facility feel pressured to transfer a patient to hospital for fear of recrimination by the family. The Victorian Healthcare Association noted in its submission:[251]

> [E]nd of life care arrangements should enable multi-disciplinary care that enables people to complete their life within a PSRACs environment rather than an acute hospital setting. Improved communication and processes in regards to end of life care should result in fewer hospital admissions because residents (in partnership with their families and practitioners) are able to identify their preferred end of life location at an earlier stage.

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247 Goulburn Valley Primary Care Partnership, Submission No. 9, p. 3.
248 Australian Institute for Primary Care and Ageing, Submission No. 28, pp. 6-7.
249 Australian Medical Association (Victoria), Submission No. 21, p. 1.
250 Australian Institute for Primary Care and Ageing, Submission No. 28, p. 7.
251 Victorian Healthcare Association, Submission No. 26, p. 7.

The Committee agrees that better communication with families of residents could reduce avoidable hospitalisations by allowing residents to end their life in the residential aged care facility.

Finding 11

Data on avoidable hospitalisations could be used as one indicator of the quality of the care in residential aged care facilities, however, data must not be considered in isolation. A number of other issues, including access to primary care, clinical judgement, skill mix of staff and family pressure must also be taken into account when interpreting avoidable hospitalisation data.

Recommendation 11

The Committee recommends the Victorian Government make representations to the Commonwealth Government to encourage it to review the Medicare rebate for medical services provided by GPs visiting residential aged care facilities to ensure that it covers the cost of providing the service, as recommended by the Productivity Commission.

Appendix A:
List of Written Submissions Received

1. Baker IDI Heart and Diabetes Institute
2. Hobsons Bay City Council
3. Family Medicine Research Centre
4. Australian Psychological Society
5. Boroondara City Council
6. Australian Nursing Federation (Victorian Branch)
7. East Gippsland Primary Health Alliance
8. South East Healthy Communities Partnership
9. Goulburn Valley Primary Care Partnership
10. Cardinia Shire Council
11. Mitchell Shire Council
12. Campaspe Primary Care Partnership
13. Mercy Health
14. Royal Australian College of General Practitioners
15. Population Health Research Network
16. National Primary Health Care Partnership
17. Inner South Community Health Service
18. General Practice Victoria
19. Australian Institute of Health and Welfare
20. Municipal Association of Victoria
21. Australian Medical Association (Victoria)
22. Royal Victorian Eye and Ear Hospital
23. Australian Health Practitioner Regulation Agency
24. Aged and Community Care Victoria
25. Consumers Health Forum of Australia
26. Victorian Healthcare Association
27. Dental Hygienists Association of Australia - Victoria Branch
28. Australian Institute for Primary Care and Ageing
29. Cardio-Thoracic Surgery Clinical Information Service Queensland
30. Dental Health Services Victoria

Appendix B:
Schedule of Public Hearings

Wednesday, 2 November 2011

Baker IDI Heart and Diabetes Institute

- Professor Anthony Dart, Associate Director, Clinical

Australian Psychological Society

- Mr David Stokes, Senior Manager Professional Practice
- Mr Bo Li, Senior Policy Adviser Professional Practice

Family Medicine Research Centre

- Associate Professor Helena Britt, Director
- Associate Professor Graeme Miller, Medical Director

Australian Institute of Primary Care and Ageing

- Professor Yvonne Wells, Head, Lincoln Centre for Research on Ageing
- Associate Professor Virginia Lewis, Research and Evaluation

Australian Nursing Federation

- Mr Mark Staaf, Professional Officer
- Ms Trish O'Hara, Professional Officer

Appendix C: Summary of primary care data

Australia/Victoria data collection	Name of data set	Primary data collection point	How is it collected?	Who does the data go to?	Where is the data reported/published?	Ongoing/Non ongoing collection
Australia	Bettering the Evaluation and Care of Health (BEACH) program	Approximately 1000 GPs each year	Survey of 100 patients per GP	Family Medicine Research Centre	Report on GP Activity in Australia	Ongoing
Victoria	Study of GPs working in Community Health Services	GPs in Community Health Services	Survey of patients	Family Medicine Research Centre	Internal report by the Department of Health	Non-ongoing
Victoria	Community health centre data	Victoria's community health centres	Collection of the number of patient visits	Department of Health	Department of Health annual report	Ongoing
Australia	Medicare GP visit data	Claims made by individuals/GPs	Based on claims made	Medicare Australia	Medicare annual report, organisations can request Medicare data	Ongoing
Australia	Pharmaceutical Benefits Scheme	Pharmacies	Based on claims made of subsidised drugs dispensed	Department of Health and Ageing	Department of Health and Ageing annual report	Ongoing
Australia	National Health Survey	Telephone interview of participants	Survey of 15,800 Australians	Australian Bureau of Statistics	Australian Bureau of Statistics report	Ongoing (every 3 years)
Victoria	Victorian Population Health Survey	Telephone interview of participants	Survey of approximately 7,500 Victorians	Department of Health	Department of Health report on Victorian Population Health Survey	Ongoing (no reports available online since 2008)
Australia	Personally Controlled Electronic Health Record	Electronic data collection	Patient health records, of those that choose to opt in	Unsure at the current time	No current reporting	Ongoing
Australia	Patient Experience Survey	Telephone interview of participants	Survey done as part of Labour Force Survey	Australian Bureau of Statistics	Australian Bureau of Statistics report	Ongoing

Australia/Victoria data collection	Name of data set	Primary data collection point	How is it collected?	Who does the data go to?	Where is the data reported/published?	Ongoing/Non ongoing collection
Victoria	Dental Health Program Data Set	Public dental services	Recording treatment of all patients	Department of Health	Annual report, Victorian Health Services Performance report	Ongoing
Victoria	Victorian Admitted Episodes Dataset	Victorian hospitals, rehabilitation centres, extended care facilities and day procedure centres	Recording the information of all admitted patients	Department of Health	Victorian Health Services Report, annual report, special reports by the Department	Ongoing
Victoria	Victorian Emergency Minimum Dataset	Victorian hospital emergency departments	Recording the information of all emergency department presentations	Department of Health	Victorian Health Services Report, annual report, special reports by the Department	Ongoing

Appendix D: Summary of aged care data

Australia/Victoria data collection	Name of data set	Primary data collection point	How is it collected?	Who does the data go to?	Where is the data reported/published?	Ongoing/Non ongoing collection
Australia	Aged Care Funding Instrument	Residential aged care providers	Each provider claims reimbursement for each resident through Medicare Australia (services are allocated places so can only claim up to maximum number of residents)	Department of Health and Ageing	Aged Care Service List Annual Stocktake of Aged Care Places Reports on the operation of the Aged Care Act 1997	Ongoing
Victoria	Home and Community Care Minimum Data Set	HACC service providers	Quarterly reports submitted by each provider	Department of Health	Reported by Victorian Department of Health and Department of Health and Ageing	Ongoing
Australia	Planning ratios for aged care services	Population statistics from Australian Bureau of Statistics	Analysis of population statistics by region to determine number of aged care places needed	Department of Health and Ageing	Department of Health and Ageing information sheets/Aged Care Approvals Round Essential Guide	Ongoing
Victoria/Australia	Aged care assessments	Aged care assessment teams/services	Teams report the number of assessments undertaken	Victorian Department of Health and then to Department of Health and Ageing	Reported by Victorian Department of Health and Department of Health and Ageing	Ongoing

Australia/Victoria data collection	Name of data set	Primary data collection point	How is it collected?	Who does the data go to?	Where is the data reported/published?	Ongoing/Non ongoing collection
Australia	Consumer Directed Care Package	Aged care assessment teams and package service providers	Teams report the number of people assessed as eligible for each package. Service providers claim from Department for services delivered to eligible recipients	Department of Health and Ageing	Department of Health and Ageing annual report	Ongoing
Australia	Accreditation of Aged Care Services	The Aged Care Standards and Accreditation Agency	Assessment teams visit and assess each aged care facility	Department of Health and Ageing	Reported by ACSAA on its website and reported by the Department of Health and Ageing in its annual report	Ongoing
Victoria	Public Sector Residential Aged Care Services Quality Indicators	Public Sector Residential Aged Care Services	Quarterly reports on indicators submitted by each service	Department of Health	Not currently published	Ongoing