



Baker IDI Heart and Diabetes Institute

Submission for the Inquiry into Primary Health and Aged
Care Service Measures

July 2011

TO:

The Secretary
Legislative Council on Economy and Infrastructure Committee
Parliament House
Spring Street
Melbourne VIC 3002

Submission

Thank you very much for the opportunity to make a submission to this important enquiry. Whilst service measures in this area are not the core business of Baker IDI we cannot emphasise enough the importance of data collection related to treatment and quality of care as a way of informing policy and evaluating service provision. Research can be the prime driver of effective service provision and is most valuable if the data are available and analyzable from the point of view of continuity of care and the patient journey rather than episodes of care. As indicated in the call for submissions there are many data sets, but almost none can be used in conjunction with one another. This is both a pity and a waste of public resources and health data.

There are no current data of which we are aware that are capable of providing comprehensive and useful data on primary care episodes of care, let alone outcome data. There are some disease specific item numbers, but there are millions of consultations in Victoria each year about which we know nothing. What Medicare data is available is inaccurate due to the emphasis on data required for payment rather than health information. There has been some recent improvement but this would require some validation before it could be used. There is no current integration of MBS and PBS data so we may be able to get data on say the number of consultations and the item numbers but we have no idea what the consultation was about. If MBS and PBS data were integrated this may offer a better understanding of the reasons for consultation.

To date the major political barriers to data collection and integration of data has been on the basis of risks to privacy. In our view this is not a valid concern as there are well-established protocols for de-identification used elsewhere that can be applied here.

The e-health program may offer a solution, so long as each patient has a unique identifier and health record. The data entered into the health record still requires validation; but most important is the political will to allow data to be accessed. Ideally a centralized portal for access for research on de-identified data should be provided. In the absence of this, individuals should be able to specify that they agree to records being accessed for research purposes and consideration should be given to a system of research organization or researcher accreditation. I understand that this has been addressed in the UK National Health System so that clinical data can be used for research purposes.

In summary we support a comprehensive, valid and integrated census based health data set that is accessible for research and health planning.