

## **Submission to the Senate Select Committee on Health inquiry into data linkage – December 2015**

Thank you for the invitation to make a submission to the Senate Select Committee on Health inquiry, addressing collection, linkage and access to health data, including identifying challenges and opportunities.

The Committee has previously received information on the functions of the National Health Performance Authority ('the Performance Authority'), as a Commonwealth funded, independent statutory authority. Of relevance to the Committee's current focus on health data, the Performance Authority produces reports on the performance of public and private hospitals and primary health care organisations, drawing on existing data that resides in more than 30 national health datasets. Access to these datasets is granted through a data plan, which is approved each year by all nine Australian health ministers. The Performance Authority's current Data Plan can be found at [www.nhpa.gov.au](http://www.nhpa.gov.au).

These health datasets have enabled the Performance Authority to release information on access to and utilisation of health care for hundreds of hospitals and local communities nationally. It has also enabled the Performance Authority to release information on measures of health and health outcomes across local communities nationally.

While this information sheds new light on health and health care in local areas, it cannot provide conclusive insights into the appropriateness or impact of varying levels of access to and use of health care, nor can it provide conclusive insights about the relationship between different parts of the health system. To do so requires data in different datasets to be linked at the level of an individual (but reported in such a way as to protect the privacy of the individual). This is the type of information that is necessary to truly understand the performance of health organisations, and consequences of local interventions or shifts in policy on the health of Australians and their subsequent need for services.

Where the Performance Authority has reported, it has been constrained in drawing conclusions about the results it has found. This is illustrated with a report the Performance Authority released on GP attendances which found that, while Australians visit a GP 5.6 times a year on average, one in eight Australians (12.5%) saw a GP at least 12 times in 2012–13, accounting for 41% of the \$16 billion Medicare paid in out-of-hospital benefits in that year. In some communities, about 8% of residents visited the GP 20 or more times in that year.

However, the siloed nature of current datasets means that if a particular area has a very high proportion of people who visit a GP often, we are unable to say, from that information alone, if that reflects well or poorly on the performance of the health system in that area. It could mean people are quite sick but are getting the access to health care they need. It could also mean something else such as poorly coordinated or insufficient community-based services such as community nursing or community care. We also do not know if these patients who see GPs or specialists much more

often than average, are less or more likely to attend an emergency department or be admitted to hospital. We cannot know that because we cannot follow individuals through the health system without linking data between the available datasets.

The Performance Authority has not been able to report on a number of performance indicators that are included in the COAG-agreed Performance and Accountability Framework. These indicators include in-hospital mortality and hospital readmissions (because of the inability to track individual patients being admitted to different hospitals in the course of their care) and community follow-up after discharge from hospital (because of the inability to track individual patients using information gathered by different health providers).

While some of the states can follow individuals over time and across different hospitals with their jurisdiction, they cannot easily measure community follow-up after discharge from hospital or determine what community-based interventions reduce rates of preventable hospitalisations, because they cannot easily link the hospital data they have access to with other data about GPs, specialists and aged care providers, because that data is held by the Commonwealth.

And the Performance Authority cannot do this at a national level. The value of the national datasets that are available to the Performance Authority is therefore diminished by our inability, for varying reasons, to link the data contained in different datasets. National reporting remains important because of the nature of Australia's health care system, with public hospitals and community health services being the responsibility of the states, primary medical care and specialist care the responsibility of the Commonwealth through MBS subsidies, and a raft of services provided in the private sector.

Much has been said over the years about improving the integration and coordination of care. The Performance and Accountability Framework identifies this as an area requiring further development of performance indicators that can measure these increasingly important aspects of care. Measuring and reporting on continuity of care will, by necessity, require linked data to follow patients as they receive care across time.

Australia collects much health data. However, without improved national consistency in collection and coding and linkage between different datasets, its full potential to inform public policy will remain unrealised.

For further information regarding this submission please contact Dr Diane Watson, Chief Executive Officer