A Potentially Preventable Hospitalisation Indicator for General Practice
Submission to the Consultation Paper
2 November 2018
OUR VISION
A healthy Australia, supported by the best possible healthcare system.

OUR MISSION
To conduct research, educate and influence the healthcare system to achieve better health outcomes, improved patient and provider experience, greater equity and sustainability.

OUR GUIDING PRINCIPLES
Healthcare in Australia should be:
Effective
Accessible
Equitable
Sustainable
Outcomes-focused.

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INTRODUCTION

The Australian Healthcare and Hospitals Association (AHHA) is pleased to provide this submission to the consultation into A Potentially Preventable Hospitalisation Indicator for General Practice.

WHO WE ARE

AHHA is Australia’s national peak body for public hospitals and health care providers. Our membership includes state health departments, Local Hospital Networks and public hospitals, community health services, Primary Health Networks and primary healthcare providers, aged care providers, universities, individual health professionals and academics. As such, we are uniquely placed to be an independent, national voice for universal high-quality healthcare to benefit the whole community.

OVERARCHING VIEW

AHHA supports the development of a potentially preventable hospitalisation indicator for general practice. This has the potential to improve health outcomes and system efficiency, as well as to assist in identifying areas of health inequality. This is particularly the case where the indicator is disaggregated in meaningful ways such as by age, Indigenous status, geography and socioeconomic status.

However, there are aspects of the proposed indicator that should be modified to better capture the extent to which the delivery of primary healthcare can be used to limit preventable hospitalisations. While the proposed indicator is focussed on general practice, there is a broader scope in which primary healthcare services are provided. This implies that an indicator of potentially preventable hospitalisations is required for primary care, with general practice then being a subset indicator.

AHHA is concerned with the proposal to remove from the indicator potentially preventable hospitalisations for people who are 75 years of age or over. This goes to the core of why the indicator is being developed and what it is to be used for. A potentially preventable hospitalisation is no less an issue for elderly patients than it is for younger cohorts of patients in terms of the patient healthcare leading up to such an event.

AHHA also believes that the development of a potentially preventable hospitalisation indicator for general practice should encompass palliative and rehabilitation healthcare. Further work is also required to consider inclusions addressing mental health and alcohol and drug use, and to consider prioritisation based on matters such as burden of disease and cost to the patient and the health system.
**Question 1: Definition of Potentially Preventable Hospitalisation**

AHHA agrees with the proposed definition of a potentially preventable hospitalisation. However, more clarity is required in the definition for the concept of ‘potential’.

Conceivably many hospitalisations occur notwithstanding the provision of appropriate care delivered by general practice teams. This could be due to unforeseeable degeneration in a patient’s condition or other environmental factors beyond the feasible control of general practice teams. Patient non-compliance is another confounding factor where a preventable hospitalisation could occur that is unrelated to the appropriateness of the preventive care and other health interventions provided by a general practice team.

Given the stated purpose of this indicator is for education, performance assessment, identification of targeted interventions for problem areas and for performance monitoring, the risk is that the focus of where system improvement should be best directed becomes obscured. This is further complicated by the longer-term view of potential preventability and the need for consistent provision of appropriate care and patient compliance to optimise health outcomes over this extended period.

While acknowledging the difficulties that these issues raise, the potentially preventable hospitalisation indicator for general practice needs to measure and summarise health outcomes in a manner that facilitates appropriately targeted responses.

**Question 2: Definition of General Practitioner Teams**

AHHA disagrees with the proposed definition of a general practitioner team, and instead proposes the title general practice team. In particular, we note the recognition of the value of multidisciplinary teams in providing responsive patient care and the variety of settings in which this may optimally be provided. This broader definition is also consistent with the longer-term view of potentially preventable hospitalisations adopted in the Consultation Paper, and with funding and care models currently being trialled or implemented, for example through the Health Care Homes program and as a result of the MBS Review.

**Question 3: Condition Exclusions and the Listed Conditions**

AHHA agrees with using the existing National Healthcare Agreement specification for potentially preventable hospitalisations as an interim measure for determining conditions that are in scope for the potentially preventable hospitalisation indicator for general practice. Further work is required, and should be progressed, to consider inclusions addressing mental health and alcohol and drug use, and to consider prioritisation based on matters such as burden of disease and cost to the patient and the health system.
However, AHHA considers it inappropriate to exclude palliative care and rehabilitation care types on the basis that they “require tertiary management” (Consultation Paper page vii).

There is significant policy work and government investment currently underway to shift palliative care from the hospital setting to the community and home care thus placing this care type increasingly within the domain of patient care provided by general practice teams. It is also understood that the Medicare Benefits Schedule Review is considering changes to improve the compensation to general practices for the provision of palliative care. Johnson et al (2018) explore issues relating to the provision of palliative care by general practices, and associated data and performance reporting capability in more detail, noting that data development is required. Notwithstanding the current paucity of available data, AHHA contends that contemporary policy settings and government funding provide a clear role for general practice in managing potentially preventable hospitalisations related to palliative care.

With respect to rehabilitation, a range of rehabilitation services are supported in the primary care sector, including with support to access these services through general practice. For example, very few primary joint replacement patients are considered inpatient rehabilitation candidates in public facilities, and in many cases, these patients will access services in the primary care sector, with the support of their general practitioner. While the market for provision of inpatient rehabilitation services is a business objective for some private hospital operators, Naylor et al (2017) provide evidence on the cost-benefit advantages of providing some rehabilitation care in the community rather than as an inpatient. AHHA contends that consideration should be given to the role general practice plays in managing potentially preventable hospitalisations in patients requiring rehabilitation services.

AHHA also considers that it is inappropriate to exclude or separate from the potentially preventable hospitalisations indicator people that are 75 years of age or over. This is further discussed in response to Consultation Paper Question 6 below.

**Question 4: Consistency Across the Proposed Indicator**

AHHA agrees with the proposed approach of vaccine-preventable conditions being assessed only on the basis of the reported principal diagnosis.

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Question 5: Inclusion of Duplicate Hospitalisations

AHHA agrees with the principle of excluding contiguous hospitalisations. However, as noted in the response to Consultation Paper Question 3, AHHA believes that it is inappropriate to exclude palliative care and rehabilitation care types from inclusion in the potentially preventable hospitalisation indicator for general practice.

Question 6: Patients 75–84 Years, 85 Years and Over

AHHA supports the supplementary reporting of potentially preventable hospitalisation indicators for general practice that controls for age. The growing prevalence of risk factors for chronic disease and the growing problem of multimorbidity, both at increasingly earlier ages, highlights the value of supplementary indicators of potentially preventable hospitalisations disaggregated across the age distribution.

However, AHHA does not support exclusion of people that are aged 75 years and over from the potentially preventable hospitalisations indicator for general practice.

AHHA is concerned that the Consultation Paper conflates the exclusion of people aged 75 and over from the proposed potentially preventable hospitalisations with avoidable mortality data. The health needs of patients related to potentially preventable hospitalisations do not cease at age 75, nor does the necessity for primary care services and providers to adapt to the needs of this cohort of patients.

The Consultation Paper states that, “the key change proposed in this new indicator is that it reflects the variety of prevention and management activities done by GPs, and how these occur across the lifespan of conditions” (page 6). The importance of this focus does not change as a person becomes older. While the Consultation Paper foreshadows a possible future “elderly-focussed specification”, ignoring such individuals in the initial specification of the performance indicator excludes a large segment of the population (1.64 million people as at June 2017) and a large portion of the patients presenting at general practice (17.6% of all Medicare Services in 2017–18).

As for any cohort of the population, managing an older individual’s care with effective primary care can prevent a condition progressing from chronic to acute and potentially requiring hospital care, which is the focus of the proposed general practice indicator. Furthermore, as noted on page 18 of the Consultation Paper, people aged 75 years and over are one of the two age groups of people most affected by vaccine-preventable conditions. Governments invest resources into health promotion efforts to encouraging older people to have the influenza and pneumococcal vaccines, so it would be an anomaly not to include this cohort of people in the proposed indicator.

The Consultation Paper notes that a third of potentially preventable hospitalisations are for people aged 75 and over. This is a significant portion of hospitalisations that are the target of providing better primary healthcare. AHHA considers that the justification of excluding these hospitalisations

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on the basis that “older patients often have a number of comorbidities which make it difficult to relate their hospitalisations to lack of access to appropriate general practice care and/or treatment” (Consultation Paper page 12) is at odds with the encounters general practices are already managing. For example, Harrison et al (2017) provide evidence that over half of general practitioner encounters were with patients that had two or more diagnosed chronic conditions, with more than a third having three or more diagnosed conditions, and that 30% of patients had complex multimorbidity.\(^5\) In noting the difficulty of treating patients with multimorbidity, Harrison and Siriwardena (2018, page 7) also note that any solution is, “likely to involve improved integration of the healthcare system and patient-centred care delivered by well-supported GPs”.\(^6\) These findings demonstrate the importance of keeping all patient cohorts in-scope for the proposed indicator.

The impact of excluding people aged 75 and over is shown on page 13 of the Consultation Paper where the range of conditions identified should for the most part be preventable, or at the very least managed within primary care. The statement that further substantial analysis and evaluation is required demonstrates that the consultation process has not been as comprehensive as should be expected for an indicator which may be adopted for performance reporting and system monitoring purposes.

The proposal to exclude people aged 75 years and over significantly reduces the baseline data for preventable hospitalisations, and for the purposes of performance reporting, removes many of the complex patients most in need of preventive healthcare with associated pressures across the health system. This has particular contemporary relevance with the growing role of primary care in keeping patients out of hospital and achieving more sustainable health funding.

AHHA also supports the production of an internationally comparable indicator of potentially preventable hospitalisations in general practice as a supplement to the more comprehensive indicator discussed in this submission.

**Question 7: Removal of Same-Day Hospitalisations**

AHHA does not agree with the exclusion of same day hospitalisations from the potentially preventable hospitalisation indicator for general practice. As more procedures are provided as same day admissions, there is increasing likelihood that these will include some that are potentially preventable and which the proposed indicator is intended to highlight.

While Hospital in the Home (HITH) care models may be a purposeful strategy to manage some patients outside of the hospital, some HITH admissions are potentially preventable, and should be considered for inclusion in the indicator. Examples include some patients with pneumonia, mild

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COPD exacerbations and infections such as skin wounds/cellulitis who require hospital services such as intravenous antibiotics but whose hospital admission may be potentially preventable.

AHHA supports the development of a potentially preventable hospitalisations indicator for avoidable general practice-type emergency department presentations. Because of the relative cost of providing emergency department healthcare in circumstances where the care could more appropriately be provided in the community, there would be value in measuring the extent to which this is occurring to enable appropriately targeted responses.

AHHA is less concerned about the exclusion of Hospital in the Home episodes of care as these represents a care strategy to manage patients outside of the hospital.

**Question 8: Exclusions and Other Conditions**

AHHA agrees with the proposed procedure exclusions. We agree that skin infections such as cellulitis should be in-scope for the potentially preventable hospitalisation indicators for general practice (note also our comments at Question 7 with respect to Hospital in the Home). Conditions such as scabies, otitis media, and complex otitis media (mastoiditis/petrositis) should also be included, particularly noting their relationship to acute rheumatic fever and rheumatic heart disease and the need for subsequent hospitalisations.

**Question 9: Population Groups in Greater Detail**

AHHA agrees that the potentially preventable hospitalisation indicators for general practice should be disaggregated by population cohorts such as age groups, Aboriginal and Torres Strait Islander status, illness type, remoteness and socioeconomic status, as this will provide useful insight into the care needs and health outcomes of these population groups. There would also be value in having a disaggregation of patients admitted to hospital from residential aged care for potentially preventable hospitalisations. However, as previously discussed, AHHA does not agree with removing segments of the population from the indicator based on age.

AHHA agrees with potentially adding conditions such as minor procedures. Some jurisdictions are already doing work in this area, as are some general practices. For example, Primary Health Care Limited is investing in urgent care facilities which will deal with these type of conditions, while some of the other larger corporate general practices and many regional/rural general practitioners already undertake minor procedures. The indicator needs to be adjusted to the changing way general practice business is being oriented - through both corporate practices, and through new funding models such as the Health Care Homes initiative. More consultation with large corporate general practice businesses in addition to the RACGP would assist in informing these considerations.

AHHA acknowledges that the current national indicator on potentially preventable hospitalisations does not account for prevalence, or the influence of factors not easily mitigated by the health system such as those associated with the social determinants of health. It also noted that variation is not only at the level of jurisdictions, but also occurs within jurisdictions between hospitals.

The current limitation on data being collected by separations and not by individuals is accurate when reported at the national level, but this varies across individual jurisdictions. For example, Queensland...
Health now uploads admitted patients’ data to My Health Record. In Victoria there has also been reporting and use of linked data across general practice and hospitals for at least the past four years.\(^7\) Also, as noted on page 21 of the Consultation Paper, work on the proposed indicator for general practice should anticipate the potential use of linked MBS/admitted patient data.

**Question 10: Polices, Programs and Long-term Trends**

AHHA agrees with the ongoing better use of linked data to inform further development of this indicator, and particularly the opportunities that may present through My Health Record.

**Question 11: Other Usages for the Proposed Specification**

Potentially preventable hospitalisations in private hospitals should also be in scope for this indicator, and AHHA encourages AIHW to undertake the necessary negotiations for these data to be made available. As around 40% of all hospitalisations are in private hospitals, excluding private hospitals from this indicator reduces its utility, particularly if it is to be used for performance reporting and to support future pay for performance objectives.

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\(^7\) Population Level Analysis and Reporting tool (POLAR) draws data from a range of sources including general practice, community health, public hospitals, ambulance, government, ABS and other population-based health areas. This is then used for local area population health analysis.