LETTERS

Public reporting of hospital outcomes based on administrative data

574 Kerry Innes, Kirsten McKenzie, Sue Walker

574 Ian A Scott, Michael Ward

More than task substitution and transfer

575 Christopher D Hogan

Bill to ban reproduction of inmates with cancer proposed in New South Wales

575 John EJ Rasko

Public reporting of hospital outcomes based on administrative data

Kerry Innes, Kirsten McKenzie and Sue Walker

To the Editor: We recently read with concern the article by Scott and Ward on public reporting of hospital outcomes.[1] While we do not want to enter into the debate about whether the public release of hospital performance reports is beneficial or harmful, we would like to address some issues relating to the accuracy of administrative data. The authors stated that "data are *often* [our italics] inaccurate, incomplete, or provide insufficient clinical detail" and that the "accuracy of diagnosis coding is variable". They also mention the potential for "gaming" or "up-coding" by hospitals to make their institutions look better in public reports.

We believe the authors' argument regarding coding inaccuracies is flawed. One of the articles they cited was not about coding accuracy but about mortality differentials between metropolitan and non-metropolitan regions.[2] Another cited article quoted an example of a 100% miss rate for coding of dementia as a comorbidity that was based on only three cases.[3] As the authors later stress in their article, it is important that sample size be considered when interpreting data, to ensure that the effects of random error are minimised.

We agree with the authors' final point that distinguishing complications from presenting diagnoses (or comorbidities) is currently difficult using hospital coded data. However, the Victorian and Queensland hospital data collections now include an "alpha flag", which is a letter attached to each coded diagnosis to indicate whether the diagnosis was present on admission to hospital or whether it arose during the episode of care. Moves are underway to introduce a minimum national requirement to use the alpha flag as one method of identifying complications arising from medical or surgical care.

There are a number of national and state initiatives that aim to ensure the national morbidity data collection is as accurate as possible and that it provides data directly related to its purpose (and therefore not necessarily useful for other purposes). There is currently a national debate about the purpose of this collection.

It is clear that there are issues surrounding the capture and coding of hospital data that are not well understood by data users. Because of that misunderstanding, reports such as the one by Scott and Ward paint an unjustifiably bleak picture of the quality of the data.

Kerry Innes, Associate Director[1]
Kirsten McKenzie, Research Fellow[2]
Sue Walker, Associate Director[2]
1 National Centre for Classification in Health, University of Sydney, Sydney, NSW.
2 National Centre for Classification in Health, Queensland University of Technology, Brisbane, QLD.
k.mckenzie@qut.edu.au

1 Scott IA, Ward M. Public reporting of hospital outcomes based on administrative data: risks and opportunities. *Med J Aust* 2006; 184: 571-575.
2 Vu HD, Heller RF, Lim LL, et al. Mortality after acute myocardial infarction is lower in metropolitan regions than in non-metropolitan regions. *J Epidemiol Community Health* 2000; 54: 590-595.
3 Powell H, Lim LL, Heller RF. Accuracy of administrative data to assess comorbidity in patients with heart disease: an Australian perspective. *J Clin Epidemiol* 2001; 54: 687-693. ❑

Ian A Scott and Michael Ward

In reply: Innes and colleagues accuse us of overstating the potential inaccuracy of coded administrative data. They refer to state and national initiatives underway to ensure such accuracy, but offer no hard statistics that would reassure us that such data, in their current form, are as accurate as they need to be for purposes of quality monitoring and public disclosure. Until they do, we feel we have good reason to recommend caution in light of the few published Australian reports that are available (which we cited[1,2]), together with other research[3] and feedback from clinical directors, about significant error rates when coded diagnoses are audited by clinicians or compared with independent datasets maintained by clinicians (Professor David Johnson, Director of Nephrology, and Dr Paul Garrahy, Director of Cardiology, Princess Alexandra Hospital, personal communication).

In Queensland, formal regular audits on coding accuracy were initiated only in October 2005. They involve small numbers of randomly selected charts from each hospital and focus on specific coding issues identified for each hospital (Professor Stephen Duckett, Executive Director of Reform and Development, Queensland Health, personal communication). While we welcome (and were aware of) the introduction of "alpha flags" to distinguish in-hospital complications from pre-existing conditions, these remain a recent development (especially in Queensland), and others with considerable experience in their use express caution in interpreting results in the absence of rigorous validation.[4,5]

Ian A Scott, Director[1]
Michael Ward, Executive Director[2]
1 Department of Internal Medicine, Princess Alexandra Hospital, Brisbane, QLD.
2 Clinical Practice Improvement Centre, Queensland Health, Brisbane, QLD.
ian_scott@health.qld.gov.au

1 Vu HD, Heller RF, Lim LL, et al. Mortality after acute myocardial infarction is lower in metropolitan regions than in non-metropolitan regions. *J Epidemiol Community Health* 2000; 54: 590-595.
2 Powell H, Lim LL, Heller RF. Accuracy of administrative data to assess comorbidity in patients with heart disease: an Australian perspective. *J Clin Epidemiol* 2001; 54: 687-693.
3 Iezzoni LI. Assessing quality using administrative data. *Ann Intern Med* 1997; 127: 666-674.
4 Weingart SN, Iezzoni LI, Davis RB, et al. Use of administrative data to find substandard care: validation of the complications screening program. *Med Care* 2000; 38: 796-806.
5 Naessens JM, Huschka TR. Distinguishing hospital complications of care from pre-existing conditions. *Int J Qual Health Care* 2004; 16 Suppl 1: i27-i35. ❑

Correspondents

Please submit letters electronically via Editorial Manager at www.editorialmanager.com/mja/. Authors who cannot access the Editorial Manager submission system may submit letters by email to medjaust@ampco.com.au.

Letters must have no more than 400 words and 5 references. All letters are subject to editing for clarity and Journal style; proofs will not normally be supplied. There should be no more than 3 authors per letter, and each author should give one relevant position and affiliation for publication. Presentation of the reference list must follow the same guidelines as for manuscripts (see examples at www.nlm.nih.gov/bsd/uniform_requirements.html). In particular, only include material that has been published (or accepted for publication), and ensure that reference details are complete, including the names and initials of all authors for references with up to 4 authors, or of the first 3 authors then "et al" if there are more than 4.

More than task substitution and transfer

Christopher D Hogan

To the Editor: Your 3 July issue featured task substitution and task transfer. It is a principle of commercial organisation that if a task can be standardised, it can be delegated, automated or computerised, provided there is good central management, supervision and communication. However, I suspect that this is only a part of the new face of general practice, as we are being expected to undertake tasks for which my age cohort (I am 54) was neither trained nor prepared.

Practice administration is far more complex than ever before, and most of the clinical caseload has shifted from episodic care of infections and surgical conditions to the long-term systematic management of chronic cardiovascular, respiratory, musculoskeletal, endocrine, and other illnesses. Diabetes is a good example. Managing patients with diabetes requires high-level skills in practice management and protocol-driven chronic disease care.

I suggest that a basic and fundamental difference between doctors and allied health personnel is that allied health personnel are extremely comfortable with protocol-driven chronic management while doctors, especially of my age cohort, are more focused on detecting and dealing with difference, variation and abnormality in our patients' health. Rather than force all groups to do the same tasks, is it not better to build on their skills and interests in a logical and structured manner?

General practices are no longer only places where general practitioners work; they are evolving into teams of GPs, other doctors, administrators, allied health personnel and office and information technology staff, who work together in an integrated and coordinated way for the benefit of patients. This provides mutual support, flexibility of work hours and increased job satisfaction for all.

Our practice has been steadily working towards this for the past 20 years.

Christopher D Hogan, General Practitioner and Director
Research and Health Promotion Unit, Private Medical Practitioner's Rooms, Sunbury, VIC.
chris.hogan@racgp.org.au

Bill to ban reproduction of inmates with cancer proposed in New South Wales

John E J Rasko

To the Editor: A young man, a minor when sentenced in Sydney, was diagnosed with lymphoma soon after incarceration. Appropriate treatment was initiated, including pretreatment collection and storage of his semen. A local newspaper report that his sperm was collected and stored at taxpayers' expense prompted outrage in some sections of the community.

In response, the New South Wales Government drafted the *Corrective Services Legislation Amendment Bill 2006*, which would make it a crime for an individual imprisoned or awaiting sentencing for a "serious indictable offence", such as homicide, rape or terrorism to store "reproductive material" (semen or ova).[1]

It is routine (many would say mandatory) for men of reproductive age who are about to undergo therapy for cancer to be offered the option to store semen. Without this option, male cancer survivors might be unable to father their own offspring. There is no current routine technology for storing unfertilised ova.

In current practice for male prisoners, semen is stored before commencing treatment for cancers or similar conditions that may induce temporary or permanent infertility. This is the accepted standard of care, offered before such treatment to men who may not have completed their families. It is not current practice in NSW to store prisoners' semen in any other circumstances.

The proposed Bill will discriminate against prisoners in the quality and costs of their health care. Members of our community who require chemotherapy for cancer are offered collection and storage of their semen, provided free of charge by several public services in NSW. Under the proposed Bill, prisoners are required to pay storage fees during their imprisonment, even if their sperm were placed in storage before their incarceration. Discriminating against certain prisoners by demanding payment for other-

wise free services could be seen as a "cruel and unusual punishment".

The NSW Legislative Assembly passed the Bill on 25 May 2006. Medical, legal and human rights organisations, and individuals expressed concern to parliamentarians. In the Legislative Council on 7 June 2006, a majority vote referred the Bill to the General Purposes Standing Committee No. 3. This Committee has received submissions and will provide recommendations as to how the Bill should proceed.

If passed into law, the Bill would breach the principle of equivalence of health care for prisoners. The Australian Medical Association position statement on the *Health care of prisoners and detainees* states: "The duty of medical practitioners to treat all patients professionally with respect for their human dignity and privacy applies equally to the care of those detained in prison, whether convicted or on remand, irrespective of the reason for their incarceration."[2]

I argue that the Bill implies an intention to rid society of "criminal seed" and begins a move towards eugenics. If our society really accepts the idea that inmates of correctional facilities may one day return to a full and productive life, then it is unreasonable to deny them the possibility of having their own children because they developed a serious cancer. If this legislation is passed, a discriminatory practice of medicine according to convict status will be enshrined in NSW law.

John E J Rasko, Director, Cell and Molecular Therapies;[1] Head;[2] Professor[3]

1 Sydney Cancer Centre, Royal Prince Alfred Hospital, Sydney, NSW.

2 Gene and Stem Cell Therapy Program, Centenary Institute of Cancer Medicine and Cell Biology, Sydney, NSW.

3 Faculty of Medicine, University of Sydney, Sydney, NSW.

J.Rasko@Centenary.usyd.edu.au

1 Parliament of New South Wales. Correctional Services Legislation Amendment Bill 2006. http://www.parliament.nsw.gov.au/prod/parlment/NSWBills.nsf/0/044f50600fe72da2ca25717700329252/$FILE/b06-058-19-p01.pdf (accessed Sep 2006).

2 Australian Medical Association. AMA Position Statement. Health care of prisoners and detainees — 1998. http://www.ama.com.au/web.nsf/doc/SHED-5G4V6U (accessed Sep 2006). ❑

Read on the Web — eMJA

Most popular articles from 4/18 September issues

Doctors behaving badly?
www.mja.com.au/public/issues/185_06_180906/tat10926_fm.html

Prisons: mental health institutions of the 21st century?
www.mja.com.au/public/issues/185_06_180906/whi10502_fm.html

MJA Practice Essentials — Allergy 2. Anaphylaxis: diagnosis and management.
www.mja.com.au/public/issues/185_05_040906/bro10212_fm.html

"Meth mouth".
www.mja.com.au/public/issues/185_05_040906/she10494_fm.html

Clinical guidelines: what can we do to increase their use?
www.mja.com.au/public/issues/185_06_180906/gro10653_fm.html

Diabetes guidelines: easier to preach than to practise? A retrospective audit of outpatient management of type 1 and type 2 diabetes mellitus.
www.mja.com.au/public/issues/185_06_180906/bry11165_fm.html

Prevention and treatment of infant and childhood vitamin D deficiency in Australia and New Zealand: a consensus statement.
www.mja.com.au/public/issues/185_05_040906/mun10153_fm.html

Organ donation: a chance for Australia to do better.
www.mja.com.au/public/issues/185_05_040906/mat10528_fm.html

***Trans* fats in Australian fast foods.**
www.mja.com.au/public/issues/185_05_040906/letters_040906_fm-1.html

Optimising communication between consumers and clinicians.
www.mja.com.au/public/issues/185_05_040906/gree10342_fm.html

MJA The Medical Journal of Australia

Editor
Martin Van Der Weyden, MD, FRACP, FRCPA
Deputy Editors
Bronwyn Gaut, MBBS, DCH, DA
Ruth Armstrong, BMed
Ann Gregory, MBBS, GradCertPopHealth
Tanya Grassi, MBBS(Hons), BSc(Vet)(Hons)
Manager, Communications Development
Craig Bingham, BA(Hons), DipEd
Senior Assistant Editor
Helen Randall, BSc, DipOT
Assistant Editors
Elsina Meyer, BSc
Kerrie Lawson, BSc(Hons), PhD, MASM
Tim Badgery-Parker, BSc(Hons), ELS
Josephine Wall, BA, BAppSci, GradDipLib
Scientific Proof Readers
Christine Binskin, BSc; Sara Thomas, BSc;
Rivqa Berger, BSc(Hons); Katherine McLeod, BSc(Hons)
Editorial Administrator
Kerrie Harding
Editorial Assistant
Christine Hooper
Production Manager
Glenn Carter
Production Coordinator
Peter Humphries
Web Assistant
Peter Hollo, BSc(Hons), BA, LMusA
Librarian
Jackie Treadaway, BAComm(Info)
Consultant Biostatistician
Val Gebski, BA, MStat
Content Review Committee
Craig S Anderson, PhD, FRACP;
Leon A Bach, PhD, FRACP;
Flavia M Cicuttini, PhD, FRACP;
Jennifer J Conn, FRACP, MClinEd;
Marie-Louise B Dick, MPH, FRACGP;
Mark F Harris, MD, FRACGP;
Paul D R Johnson, PhD, FRACP;
Tom Kotsimbos, MD, FRACP;
Campbell Thompson, MD, FRACP;
Tim P Usherwood, MD, FRCGP;
E Haydn Walters, DM, FRACP;
Owen D Williamson, FRACS, GradDipClinEpi;
Jane Young, PhD, FAFPHM;
Jeffrey D Zajac, PhD, FRACP
Australasian Medical Publishing Co Pty Ltd
Advertising Manager: Peter Butterfield
Media Coordinators: Kendall Byron; Julie Chappell

The Medical Journal of Australia (MJA) is published on the 1st and 3rd Monday of each month by the Australasian Medical Publishing Company Proprietary Limited, Level 2, 26-32 Pyrmont Bridge Rd, Pyrmont, NSW 2009. ABN 20 000 005 854. Telephone: (02) 9562 6666. Fax: (02) 9562 6699. E-mail: medjaust@ampco.com.au. The Journal is printed by Offset Alpine Printing Ltd, 42 Boorea St, Lidcombe, NSW 2141.

MJA on the Internet: http://www.mja.com.au/

None of the Australasian Medical Publishing Company Proprietary Limited, ABN 20 000 005 854, the Australian Medical Association Limited, or any of its servants and agents will have any liability in any way arising from information or advice that is contained in *The Medical Journal of Australia (MJA)*. The statements or opinions that are expressed in the Journal reflect the views of the authors and do not represent the official policy of the Australian Medical Association unless this is so stated. Although all accepted advertising material is expected to conform to ethical and legal standards, such acceptance does not imply endorsement by the Journal. All literary matter in the Journal is covered by copyright, and must not be reproduced, stored in a retrieval system, or transmitted in any form by electronic or mechanical means, photocopying, or recording, without written permission.

Published in 2 volumes per year.
Annual Subscription Rates for 2007 (**Payable in Advance**) to:
AMPCo, Locked Bag 3030, Strawberry Hills, NSW 2012
Individual Subscriptions (includes 10% GST)
Australia: $A368.50, Medical students (Australia only): $A60.00
Overseas: $A474.00
Indexes are published every 6 months and are available on request as part of the current subscription.
Single or back issues contact: **AMPCo (02) 9562 6666.**

Advice to Authors—
http://www.mja.com.au/public/information/instruc.html

27,887 circulation as at 26 October, 2006

ISSN 0025-729X