First, ethics applications to link multiple health databases are complex and inefficient. Each state has a different process — some require only a letter, others require full applications to ethics committees and data custodians. Multiple applications to multiple states should be unnecessary when a centralised data source is being used. Further, some ethics committees only meet quarterly, and meetings do not align between states. The process can take up to 2 years before approval is achieved. While the introduction of the National Ethics Application Form in 2006 heralded the streamlining of applications, this has not occurred, as the uptake of the form has been uneven across states.1

As a nation, we should learn from other models. Scandinavian countries lead the way in health linkage research2 owing to their well thought out systems of unique health identifiers and administrative processes, which are not held up by bureaucracy. In Australia, linkage is conducted using probabilistic matching. This requires thorough understanding of the component databases and expertise in statistics and programming. This process is arduous and prone to errors and could be simplified by the use of unique health identifiers. Despite years of lobbying from researchers and some parliamentary members, we do not seem any closer to this becoming a reality.

Data linkage projects are where future public health research is headed. We need to minimise administration and long lag times between project approval and receiving data and to upskill staff in management and linkage of large datasets. This will facilitate productive research in Australia with more competitive outputs and, ultimately, better health outcomes for all Australians.

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To the Editor: The editorial by Olver1 is a reminder of the usefulness of linking health datasets for research and evaluation. While data linkage is not a foreign concept to many health services researchers, such work with regard to Australian primary care is very limited. The recent review of Medicare Locals noted that the few linkages created “only occur in pockets and are often constrained by administrative, collaborative and/or legislative factors”.2 The public interest is not served by these barriers.

The unavailability of and lack of access to general practice data have hindered our ability to build a comprehensive picture of the interface between general practice and other health care services.3 The benefits of linking anonymised, individual-level general practice data with other routinely collected health data are enormous; it enables us to map the entire patient journey both retrospectively and prospectively, gives us an insight into patients’ use of health services, and provides us with the opportunity to assess whether the organisation of care for patients is effective and whether health services can be accessed by patients at the “right time”. Such capabilities are very relevant for addressing issues such as the increasing demand for emergency department services and access to after-hours medical care.

Further attention to and investment in securing general practice data is urgently required. Until this is achieved, we will be unable to fully realise the benefits of data linkage for informing health policy and practice in primary care.

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Newborn bloodspot screening: setting the Australian national policy agenda

To the Editor: The recent article by Maxwell and O’Leary3 is timely in outlining the obstacles to introducing newborn screening tests in Australia, and the need for a nationally consistent approach, where the benefits of screening are proven. These obstacles exist despite clear policy developed by the professional newborn screening community.2

The absence of newborn screening for congenital adrenal hyperplasia (CAH) is the clearest example of the impact from the absence of any national mechanism, where initiatives to introduce such testing have bounced between state and national governments.1

2 Competing interests: The Melbourne East Monash General Practice Database (MAGNET) research platform is a collaboration between Inner East Melbourne Medicare Local and Monash University. Danielle Mazza is Scientific Director of MAGNET. Christopher Pearce is Deputy Director and Lyle Turner is the biostatistician.
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Correction

Incorrect statement: In “Aboriginal community controlled health services: leading the way in primary care” in the 16 June 2014 issue of the Journal (Med J Aust 2014; 200: 649–652), there was an error in the “Workforce and training” section on page 651. The sentence “The Leaders in Indigenous Medical Education (LIME) Network has recently signed an agreement with the National Aboriginal Community Controlled Health Organisation seeking to increase Aboriginal medical student placements in Indigenous primary care health settings with a view to increasing participation in and enhancing the effectiveness of the medical workforce” should have stated that the agreement was made with Medical Deans Australia New Zealand, not the LIME Network. The LIME Network is a project of Medical Deans that orchestrates many of their Indigenous health initiatives, but the partnerships between organisations are made at the Medical Deans level.2