

Setting targets, measuring costs, tracking health outcomes and learning lessons

This issue of the *MJA* has a range of articles that examine various aspects of the Australian health system, and which then reflect on the lessons that can be drawn. The articles cover a wide diversity of topics, from stroke targets to hospital-acquired complications, cost barriers to medication access and lessons learnt from the coronavirus disease 2019 (COVID-19) pandemic in remote Aboriginal and Torres Strait Islander communities.

A perspective by Kleinig and colleagues (<https://doi.org/10.5694/mja2.52459>) describes the 30/60/90 national stroke targets, which are that, by 2030 in Australia, median times for key interventions for stroke will be under 30, 60 or 90 minutes as appropriate (eg, national median endovascular clot retrieval door-to-puncture time <30 minutes), and that certified stroke unit care will be provided to more than 90% of patients with primary stroke diagnosis. The authors note the need for a national commitment to meet these targets, and highlight that they are essential, given Australia's lagging position in both speed of treatment and admission to stroke units. Critically, the authors note that there is no need to reinvent the time saving strategies used elsewhere; rather, they need to be adapted to the Australian context.

In a research article, Ní Chróinín and colleagues (<https://doi.org/10.5694/mja2.52462>) assess the risk of hospital-acquired complications in people with dementia who were admitted to five public hospitals in the South Western Sydney Local Health District over an eleven-year period. They found that dementia was associated with higher risks of falls, pressure injury, delirium, and pneumonia. This article is an important quantification of risks that might be expected but where the size of the problem has not previously been clear; for example, it shows that patients with dementia were more than four times more likely to fall as matched individuals. It provides more evidence for the need for careful, person-centred care for these vulnerable individuals. In an editorial commenting on the research, Gordon and Hubbard (<https://doi.org/10.5694/mja2.52463>) noted that this article adds to the evidence of the risks for individuals with dementia, which is closely linked to frailty — itself a risk for hospital-acquired complications. What can be done to reduce these complications? Gordon and Hubbard emphasise the importance of hospital leadership in encouraging attitudes and behaviours that support patient safety, in addition to targeted person-centred interventions.

Costs of health care are increasingly important and can contribute substantially to cost of living pressures, now widespread across society. In a perspective, Ghinea (<https://doi.org/10.5694/mja2.52427>) discusses data on access to medication from the Australian Bureau of Statistics (ABS) 2022–23 Patient Experience Survey. They find that there are increasing cost barriers to access compared with previous years, with a disproportionate effect on women, younger people and those with poorer health. The data suggest substantial implications for the health of individuals when they delay or do not fill scripts for medicines



and which are often compounded by delays in seeing a general practitioner or specialist in the first instance. That individuals in poor health were 2.3 times more likely to be affected by cost-related non-adherence to medications than those in good health underscores how potentially problematic lack of funds can be for those in poorest health. As the author notes, the ABS data do not, however, cover the entirety of medication-related costs and “to support evidence-based policy reform to improve medicine access, more data on [cost-related non-adherence to medications] across the entire spectrum of medical services, not only general practice services, are required”.

A final article has a message with good news. During the initial stages of the COVID-19 pandemic, there was close attention paid to how COVID-19 should be managed in remote First Nations communities. A research article by Hempenstall and colleagues (<https://doi.org/10.5694/mja2.52426>) discusses how the pandemic was managed in six remote First Nations communities in Queensland, all of which had no COVID-19 cases before December 2021. The article describes the management of two waves of COVID-19 in these communities, where there was low morbidity and mortality during the outbreaks. Of the 2624 cases notified to Queensland Health, 52 were hospitalised and two individuals died. As the authors note, the common and critical feature was the collaborative, community-led approach — both in preparedness and response, including vaccination. “Decision making and governance focused on self-determination and community ownership of the public health responses implemented in each community.” The authors conclude, “This community-led approach highlights the importance of First Nations leadership in this public health response and other public health policies and initiatives”.

It's a good reminder not just of the need for good data collection but also the importance of applying that data in context, and of ensuring that health care decisions are made in consultation with the individuals and communities affected, in order to make better decisions in the future. ■

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