NZMA
New Zealand Medical Association

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Atlas of Healthcare Variation | Opioid domain

Dear Catherine

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on a draft version of the Atlas of Healthcare Variation – Opioid Domain.

The NZMA is the country's largest voluntary pan-professional medical organisation with approximately 5,000 members. Our members come from all disciplines within the medical profession and include general practitioners, doctors-in-training, specialists, and medical students. The NZMA aims to provide leadership of the medical profession, and promote professional unity and values, and the health of New Zealanders.

We note that the Atlas of Healthcare Variation is designed to identify variation in the delivery of healthcare services across New Zealand, with a view to stimulating debate on whether observed variations are genuine and based on differences between populations, or whether they reflect variable practice. The NZMA believes that the Atlas of Healthcare Variation is a good initiative and we welcome its intended goals. As a tool, we consider that it has the potential to be of considerable value in addressing regional variability and appropriateness of practice.

We welcome the proposed addition of the opioid domain as part of the Atlas. The appropriate prescribing of opioids is of crucial importance in addressing issues relating to opioid addiction

and illegal diversion, as well as ensuring that patients in need of opioids, particularly those in palliative care, are receiving them. We understand that the HQSC is specifically seeking feedback on the following aspects of the opioid domain of the Atlas: i) whether any of the information is inaccurate (and if so why?), and ii) what is contributing to the observed variation?

While we believe that the apparent trends/variation in the opioid domain will stimulate discussion and boost awareness of the issues around opioid prescribing (in itself a positive outcome), we feel that certain distortions in the data (due to methodological issues and the reporting used) make it challenging to easily gain an overview of opioid dispensing, identify inaccuracies and speculate on what might be contributing to observed variation. Some of these methodological and reporting issues may also apply to existing and future domains in the Atlas. Given the importance of the information contained in the Atlas and its potential to help drive improved healthcare, the NZMA is providing a technical addendum to our submission that has been developed by a member with epidemiological expertise. This addendum contains specific suggestions to address issues relating to the data, its reporting and presentation (see Appendix). We are also attaching a spreadsheet that helps illustrate the points covered in the technical addendum.

Among the main suggestions in the technical addendum include age-standardising prevalence rates and presenting these routinely rather than crude prevalence rates. Our technical expert also suggests controlling for differential changes in opioid use across DHBs over time. Other suggestions include making the BPAC background material more prominent, adding maps of calculated summary measures such as age-standardised rates, and defining the time periods covered as well as the denominator values used in the tables. It was also felt that it would be useful for the Atlas to enable the viewing of opioid dispensing rates *within* DHBs by other variables (eg, ethnicity). The use of population cartograms may also be a useful way to convey information for DHBs with large populations but small geographical areas (eg, Auckland). Further details of the above suggestions are included in the Appendix.

It is difficult for us to ascertain whether any of the information in the draft opioid domain is inaccurate. While the greater than three-fold variation across DHBs for strong opioid use appears remarkable, it is not possible to definitively identify what is contributing to the observed variation (or even to be certain of the relevance). For example, we note that the opioid domain data are split into weak versus strong opioid, with no apparent publication of data for the total dispensing of 'any opioid' by DHBs. Given this split, it is possible that the variation reported could merely represent variation in preferred opioid by different DHBs/practices/practitioners – ie, some may favour tramadol (classed as a weak opioid) while others may favour morphine (classed as a strong opioid) for the same patient. As such, the reported variations by strong or weak opioid are difficult to interpret.

The usual driver for variance in a treatment choice sits with the doctor initiating that treatment. Patient factors that could be contributing to this variation include age, ethnicity, gender, indication/condition and other factors (eg, socioeconomic status). Prescriber factors that could be contributing to this variation include their type and experience (eg, years since graduation), their work setting (eg, hospital versus general practice), and their preferred choice of opioid. Further data and evaluation are needed in order to test the respective contribution of these factors to the observed variation in opioid dispensing. Furthermore, it is possible that regions with lower rates of opioid dispensing are deficient in good palliative care services, meaning that patients who need opiates for palliation are not getting them. Equally,

it may be that regions with higher rates of opioid dispensing had greater encouragement to prescribe opioids from industry representatives. These possibilities remain purely speculative.

We also wish to flag an apparent typographical error in the key findings relating to people dispensed oxycodone. The first bullet point states: *"In 2013, an average of **6.4/1000** people received oxycodone. This is a significant **reduction** from **4.2/1000** and by count is 5,000 fewer people dispensed oxycodone than in 2011."* We would appreciate clarification of the data relating to oxycodone. We note that the reported use of oxycodone in New Zealand increased by 249% between 2007 and 2011.[1] While specific regions have made significant progress in stemming this alarming trend, any nationwide reversal in the dispensing of oxycodone would be of considerable clinical significance given the concerns relating to the misuse, addiction and diversion of prescribed oxycodone.

We hope these comments are helpful and congratulate the HQSC on the publication of this latest domain in the Atlas of Healthcare Variation. We believe this tool has great potential to identify variations in healthcare and to drive changes that can lead to improved outcomes for patients and the healthcare system. The NZMA welcomes debate and questions about health service use and provision and would be happy to comment on future draft domains to be published as part of the Atlas of Healthcare Variation. Our technical expert is also happy to provide further help to the HQSC in relation to improving the methodology and reporting of the data used in the Atlas as per the suggestions in the Appendix appended with this submission.

Yours sincerely

Dr Mark Peterson
NZMA Chair

[1] BPAC. Update on oxycodone: what can primary care do about the problem? May 2012. Available from www.bpac.org.nz/bpj/2012/may/oxycodone.aspx