
6 Health management issues

Some fundamental changes have taken place in the Australian health care system in recent years. Policy makers are seeking alternative service delivery settings and a more coordinated approach to managing health problems. The growing interest in preventative care, for example, has given prominence to community based health services. The ability of governments to improve particular health outcomes is maximised when health care providers integrate their prevention/early detection and intervention services. Measuring the management of a health problem involves measuring the performance of service providers and the management of prevention/early detection and intervention programs.

The issues discussed in this chapter relate to breast cancer management strategies and mental illness management. Each has a broad ranging public health focus and involves a variety of services (prevention/early detection and intervention) available in a range of settings (public acute care hospitals, community health services and general practice) (box 6.1). Cancer control and mental health are identified by governments as National Health Priority Areas, along with diabetes mellitus, cardiovascular health, injury prevention and control and asthma. These areas represent a significant proportion of the burden of illness in Australia, and their management offers considerable scope for reducing this burden (AIHW 1998a).

Chapter 6 provides descriptive information for each health management issue (section 6.1), a discussion of the framework of performance indicators for each area (section 6.2), the key performance results (section 6.3) and the future directions in performance reporting in these areas (section 6.4). The chapter also includes comments from each jurisdiction on their performance in managing breast cancer and mental illness (section 6.5).

Performance data are presented for these health issues for the second time in this Report. The data for breast cancer management covers selected performance measures that monitor the effectiveness of BreastScreen Australia and the effectiveness of breast cancer control generally. The data for mental illness cover aspects of both the efficiency and effectiveness of health care services provided to treat mental illness.

Box 6.1 Some common health terms used in this chapter

Affective disorder: a mood disturbance that includes mania, hypomania and depression

Ambulatory care: services provided by hospitals to non-admitted patients

Anxiety disorder: represented by feelings of tension, distress or nervousness. Includes agoraphobia, social phobia, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder and post traumatic stress disorder

Community health services: health services for individuals and groups delivered in a community setting, rather than in hospitals or in private facilities

General practice: a medical practice that offers primary, continuing, comprehensive, whole-person care for individuals, families and the community

Health management: the ongoing process beginning with initial client contact and including all actions relating to the client. Included are assessment/evaluation, education of the person, family or carer(s), diagnosis and treatment. Problems associated with adherence to treatment and liaison with or referral to other agencies are also included

Incidence rate: the proportion of the population suffering from a disorder or illness for the first time during a given period (often expressed as per 100 000 persons)

Invasive cancer: a tumour whose cells invade healthy or normal tissue

Mental disorder: a diagnosable illness that significantly interferes with an individual's cognitive, emotional or social abilities

Mental health: 'the capacity of individuals within groups and the environment to interact with one another in ways that promote subjective wellbeing, optimal development and use of mental abilities (cognitive, affective and relational) and achievement of individual and collective goals consistent with justice' (DHAC 1999)

Mental health prevention: 'interventions that occur before the initial onset of a disorder' (DHAC 1999a)

Mental health problem: a disruption in the interactions between the individual, the group and the environment, producing a diminished state of mental health

Mental health promotion: 'focuses on improving environments (social, physical, economic) which affect mental health and enhancing the 'coping' capacity of communities as well as individuals' (DHAC 1999a)

Prevalence: the number of cases of a disease present in a population at a given time (point prevalence) or during a given period (period prevalence)

Screening: the performance of tests on apparently well people to detect a medical condition at an earlier stage than would otherwise be the case

6.1 Profile of health management

Breast cancer and mental illness are significant causes of morbidity and mortality in Australia, so appropriate management of these illnesses will have a large effect on the health and wellbeing of many Australians. Both are the subjects of public health campaigns designed to improve community awareness (box 6.2). Their treatment also requires public acute care hospital services, community health services and general practice services. (The public acute care hospital and general practice components of the health care system are discussed in chapters 4 and 5 respectively).

Breast cancer management

Breast cancer was the most common cancer affecting Australian women in 1996, with over 9500 new cases diagnosed in that year (AIHW 1999b). It was also responsible for 2542 deaths in 1998, making it the most common cause of cancer deaths among females (ABS 1999).

The risk of a woman developing breast cancer before the age of 75 years is 1 in 12 in Australia. The major risk factors for breast cancer are age (breast cancer rates typically increase with age from the third decade), family history of breast cancer, long duration of menstrual life, late first birth and low parity (number of children) (AIHW 1999a). However, known risk factors explain only one-third of all breast cancers. Age is the best indicator of risk, with women over the age of 50 years accounting for almost three quarters of all new cases.

Breast cancer is not amenable to practical prevention, so the focus of breast cancer control is on screening and early detection. Cancers detected early may be treated more conservatively, and patients generally have a higher likelihood of recovery. Because age is the most significant risk factor, the joint Commonwealth/State BreastScreen program targets women aged 50–69 years, although women aged 40–49 years and over 70 years may also use the service. The program aimed to achieve a participation rate of 70 per cent among women aged 50–69 years by 1999.

More than 109 000 new cases of breast cancer were diagnosed in women in Australia between 1982–96. This represented an average annual growth rate of 4.5 per cent. The number of new cases per year increased steadily from (7943) in 1992 to 1995 (9951) then fell in 1996 to (9556) (figure 6.1).

Box 6.2 Public and community health

Public health is defined as the organised social response to protect and promote health and to prevent illness, injury and disability. The starting point for identifying public health issues, problems and priorities, and for designing and implementing interventions, is the population as a whole or population subgroups. All jurisdictions perform public health services or undertake programs to enhance the health of the population. Activities provided and classified as public health are grouped under four headings:

- promotion of health (for example, public campaigns designed to improve nutrition);
- protection against hazards (for example, surveillance of food premises and control of water and air quality through legislation or regulation);
- prevention and early detection of illness (for example, child immunisation and breast and cervical cancer screening services); and
- provision of health services (for example, school dental services and drug and alcohol treatment services).

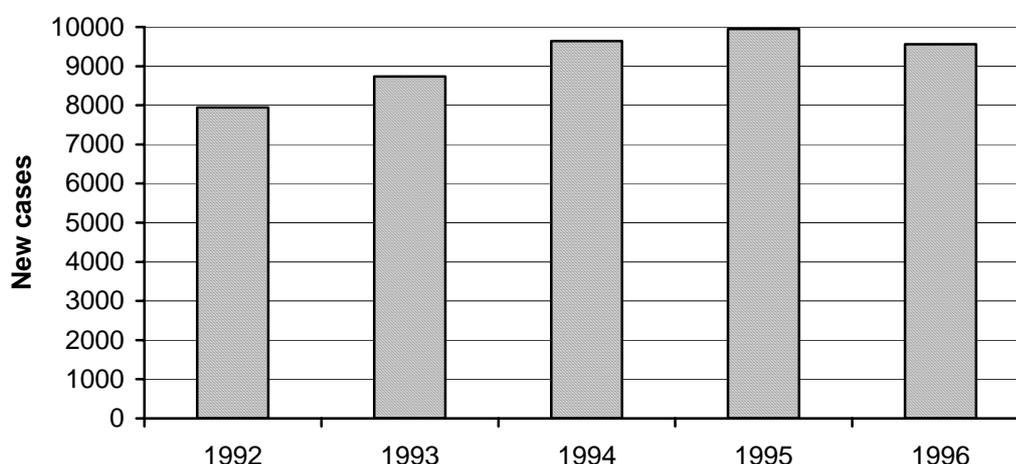
Promotion and protection activities are often referred to as population public health activities because they are delivered to populations rather than individuals. Prevention and provision activities are termed 'public health personal clinical activities'.

This Report focuses on public health activities related to promotion, prevention and provision activities. (Most protection activities are not the responsibility of health care providers and therefore are not included in the analysis.) Public health efforts currently target communicable diseases (such as HIV/AIDs and tuberculosis), childhood immunisation, asthma, oral health, nutrition and risk factors for disease.

Many public health activities are delivered by a range of health care providers — general practitioners, public hospitals and community health services. General practitioners and public acute care hospitals provide a range of services in addition to these public health services, whereas community health services concentrate on health promotion, early detection of health problems, and the assessment and care of health problems. Community health care services are diverse by nature, incorporating a range of service providers (dietitians, community nurses, psychologists and so on). This multidisciplinary approach makes it difficult to attribute health outcomes to a particular service or provider.

Sources: AIHW (1998a); Fry (1994); NPHP (1997).

Figure 6.1 Number of new cases of breast cancer, across Australia



Source: AIHW (1999b).

Between 1982 and 1996, the average annual growth rate in the incidence (number of new cases) of breast cancer among women aged 40–49 years was 5.5 per cent and 4.4 per cent among women aged 50–69. For women in the age group 15–39 years, the average annual growth rate was 2 per cent for the same period.

The age-standardised incidence rates of breast cancer from 1982–86 to 1992–96 are shown in table 6.1. The incidence of breast cancer among women aged between 15 and 39 years remained relatively stable between 1987 and 1996, but continued to rise for each of the older age groups.

Table 6.1 Age-standardised incidence rates of breast cancer per 100 000 woman years in Australia ^{a, b}

Age group	1982-86	1987-91	1992-96
15-39 years	16.6 (16.0-17.3)	17.9 (17.2-18.5)	17.8 (17.2-18.5)
40-49 years	119.2 (115.9-122.5)	134.8 (131.6-137.9)	146.3 (143.3-149.3)
50-69 years	179.7 (176.6-182.9)	211.9 (208.5-215.2)	264.8 (261.1-269.4)
70+ years	254.9 (249.3-260.5)	282.7 (261.1-268.4)	304.4 (299.1-309.8)

^a Age-standardised rates are expressed per 100 000 woman years, and are age-standardised to the Australian 1991 Population Standard. ^b Data in brackets are 95 per cent confidence intervals.

Source: AIHW (1999b).

Mental health management

Mental disorders refer to a group of problems such as depression, bipolar disorder, eating disorders (anorexia and bulimia), anxiety, phobias, schizophrenia and other psychoses, dual diagnosis (problematic alcohol and drug abuse in addition to a mental disorder) and personality disorders. There is evidence that some people may be predisposed to mental disorders such as schizophrenia. Factors such as stress, bereavement, relationship breakdown, child abuse, unemployment and social isolation can also contribute to the onset of mental disorders (DHAC 1999a).

The results from the first component of the National Survey of Mental Health and Wellbeing (ABS 1997) found that almost one in five Australians had an anxiety, affective or substance use disorder (or more than one of these disorders) during the 12 months prior to the survey. However, this figure underestimates the prevalence of all mental disorders among Australian adults, mainly because it excludes mental disorders such as schizophrenia, dementia and the personality and somatoform disorders. These disorders are estimated to add approximately 3 per cent to the overall prevalence of mental disorders.

Of the nearly 18 per cent of people suffering from a mental disorder, only 38 per cent contacted a health service for their problem and 50 per cent of this group saw a mental health professional. General practitioners were the main service providers, seeing 29 per cent of those people with a mental disorder who contacted a health service because of their mental health problem. These data suggest that almost two thirds of Australians with a mental disorder do not receive any form of treatment.

The episodes of mental disorders experienced may be mild or temporary for some people, but severe or prolonged for others. Some people recover spontaneously, although the majority requires some form of treatment (such as counselling and/or pharmacotherapy). Most requiring treatment recover fully; only a small number of people experience long periods of distress and disability (DHAC 1999a).

The National Survey of Mental Health and Wellbeing found that the prevalence of mental disorders differed between males and females although this difference was not large. Females were more likely to suffer from anxiety disorders (12 per cent) and males were more likely to suffer from substance use disorders (11 per cent) (table 6.2).

Table 6.2 Prevalence of mental disorders in all Australian adult men and women, 1997

<i>Mental disorder</i>	<i>No. of affected persons</i>		<i>Proportion of population affected</i>	
	<i>Males</i>	<i>Females</i>	<i>Males</i>	<i>Females</i>
	<i>no.</i>	<i>no.</i>	<i>per cent</i>	<i>per cent</i>
Any affective disorder	275 300	503 300	4.2	7.4
Any anxiety disorder	470 400	829 600	7.1	12.0
Any substance use disorder	734 300	307 500	11.1	4.5
Total	1 151 600	1 231 500	17.4	18.0

Source: DHAC (1999c).

The World Health Organisation and the World Bank have identified that the burden of mental illness, while responsible for little more than 1 per cent of all deaths, accounts for almost 11 per cent of the disease burden worldwide. It has been estimated that depression alone will constitute one of the greatest health problems worldwide by 2020 (Murray and Lopez 1996).

Commonwealth and State and Territory governments recognised the importance of mental health (in terms of its effect on both quality of life and the total health care budget) by launching the National Mental Health Strategy in April 1992. The aim of the strategy was to set directions for the reform of Australia's mental health services. It also established a collaborative framework to assist the State, Territory and the Commonwealth governments in pursuing these directions.

The extension of the strategy for a further five years (1998–2003) has been accompanied by a Second National Health Mental Plan, which was endorsed in July 1998 (box 6.3). The plan provides a framework for a coordinated national approach to mental health service and policy reform within which all jurisdictions will work. It includes policy objectives and service delivery plans provided by the Commonwealth and State and Territory governments. The focus of the plan is consistent with the need to consider mental health reform within the broader health reform context. The plan retains the national policy framework outlined in the National Mental Health Policy, builds on achievements to date, and identifies further priority areas for reform within three key areas.

Box 6.3 **The Second National Mental Health Plan**

The Second National Mental Health Plan is a joint statement by the health ministers of the Commonwealth, State and Territory governments of Australia. The five-year plan commenced on 1 July 1998 and will end on 30 June 2003.

The aim of the second plan is to build on the achievements of the first National Mental Health Plan by identifying additional areas for national activity. It will also provide the future framework for policy development and activity in mental health service reform.

The second plan targets three additional areas for reform: They are:

- *promotion and prevention*, including mental health promotion, community education, prevention of mental disorder and early intervention;
- *partnerships in service reform*, recognising that specialised mental health services can only meet some of the needs of people with mental disorders; and
- *quality and effectiveness*, which focuses on the quality and effectiveness of mental health services, with particular emphasis on improved consumer outcomes across the lifespan of the plan.

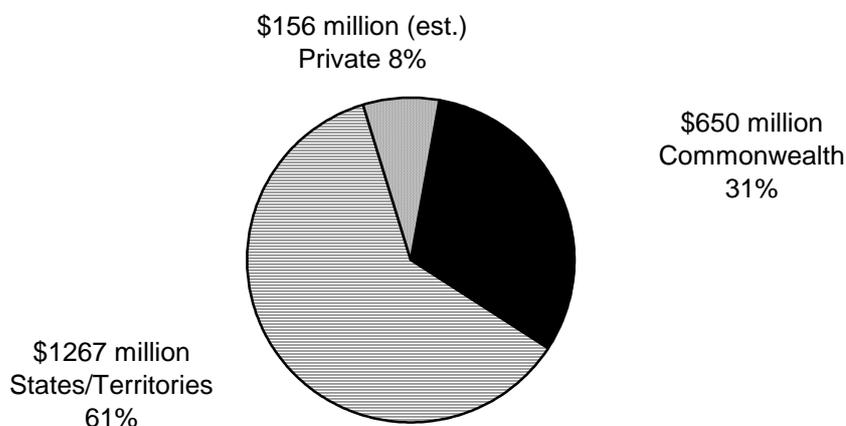
The plan clarifies Commonwealth, State and Territory government roles and responsibilities as a basis for a national approach to mental health reform. It also provides an agreed nationally consistent framework for future activity at all levels of government.

Source: DHFS (1998b).

The analysis of expenditure on mental health services is limited because the scope of the expenditure data only covers the provision of ‘specialised mental health services’, and thus understates total health expenditure. Expenditure estimates exclude services such as general hospital and medical services, and general community support programs. For example, expenditure on mental health services excludes the treatment of a patient for depression who was admitted to a general ward of a hospital. Further, the focus is on recurrent expenditure only, and fails to take account of capital costs.

Targeted spending on mental health and related services was \$2074 million in 1996-97. Of the 1996-97 expenditure, State and Territory governments contributed \$1267 million (61 per cent of targeted spending on mental health), the Commonwealth Government contributed \$650 million (31 per cent), and \$156 million (8 per cent) was privately funded (figure 6.2).

Figure 6.2 **Distribution of recurrent expenditure on mental health services, 1996-97**

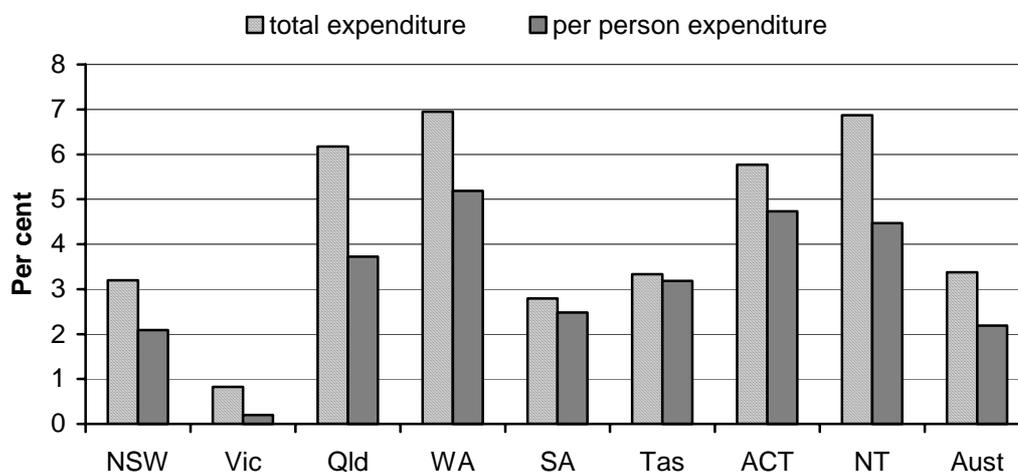


Source: table 6A.31.

Targeted funding for mental health services increased by an average of 5.7 per cent per year (in 1996-97 dollars) between 1992-93 and 1996-97 across Australia. The largest increase came from the Commonwealth Government, whose expenditure rose by nearly \$213 million (10.4 per cent per year). Private health insurance funding of private hospitals rose by \$42.8 million (8.3 per cent per year), while total expenditure by State and Territory governments rose by \$157.5 million (3.4 per cent per year). The average annual growth rate in recurrent expenditure across jurisdictions was highest in WA, the NT and Queensland (6.9 per cent, 6.9 per cent and 6.2 per cent respectively) and lowest in Victoria (0.8 per cent) in real terms over this period (figure 6.3).

In contrast, per capita mental health expenditure has grown relatively slower than total expenditure. The average annual growth rate of targeted expenditure per person on mental health services was 2.2 per cent per year (in 1996-97 dollars) across Australia between 1992-93 and 1996-97. The highest average annual growth rate for the same period was in WA (5.2 per cent), with both the ACT and the NT recording 4.7 per cent and 4.5 per cent respectively (figure 6.4). Victoria had the lowest average annual growth rate. However, in absolute terms, per person expenditure on mental health services remained at a consistently high level in Victoria. Across jurisdictions, WA had the highest per person expenditure (\$78.10) in 1996-97 and Queensland had the lowest (\$61.80) (figure 6.4).

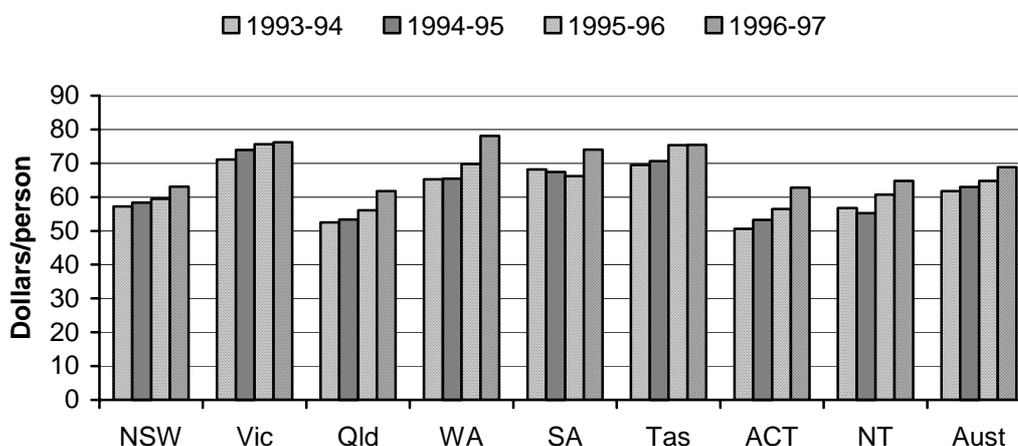
Figure 6.3 Average annual growth rate in recurrent expenditure by jurisdiction, 1992-93 to 1996-97^a



^a In 1996-97 dollars.

Sources: table 6A.33.

Figure 6.4 Average targeted real expenditure on mental health services^a



^a In 1996-97 dollars.

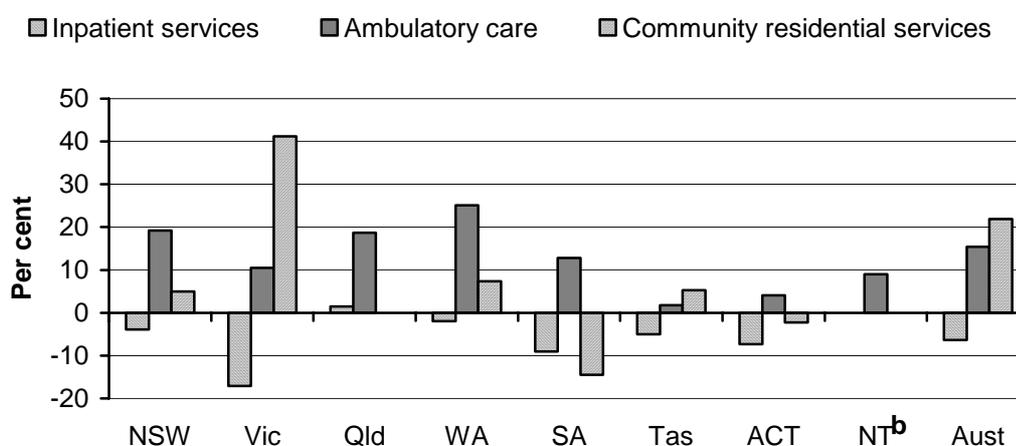
Source: table 6A.34.

Nearly 19 000 full time equivalent staff were estimated to be employed in public mental health services in 1996-97, of whom 59 per cent worked in inpatient facilities (psychiatric hospitals and general hospitals). Nursing and related occupations accounted for 53 per cent of the total workforce, while medical,

diagnostic and allied health, and administrative/domestic staff comprised 8 per cent, 15 per cent and 20 per cent respectively (DHAC 1999a).

The overall size of the workforce did not change substantially between 1993-94 and 1996-97. However, there were some important changes in composition. The average growth rate per year of full time equivalent staff working in ambulatory care settings and community residential services rose by 15 per cent and 22 per cent respectively, while there was a decrease of 6 per cent per year in the number of staff employed in inpatient facilities. Across jurisdictions, staff composition across service settings changed most noticeably in Victoria, where there was an average annual increase of 41 per cent in full time staff employed in community residential services and a decrease of 17 per cent for those working in inpatient services. These trends reflect the major structural reform which has taken place under the National Mental Health Strategy since its inception (figure 6.5).

Figure 6.5 **Average annual growth rate in the number of full time equivalent staff employed in specialist mental health services, by service setting and jurisdiction^a, 1993-94 to 1996-97**



^a Community residential services are not provided in Queensland and the NT. ^b The annual growth rate in staff employed in inpatient services is zero.

Source: table 6A.35.

6.2 Framework of performance indicators

The 'Health preface' outlines the complexities of reporting on the performance of the health system in meeting its objectives. This Report breaks the health system into smaller components and reports on their performance (see figure C.4 in the 'Health preface'). Frameworks for public hospitals and general practitioners report

the performance of particular service delivery mechanisms. The appropriateness of the mix of services (prevention versus intervention) and the appropriateness of the mix of delivery mechanisms (hospital based versus community based) are indicated in this chapter.

The framework for breast cancer management focuses on achieving a balance between early detection of the disease and intervention. Thus the performance indicators developed relate to early detection, intervention and overall performance. A similar approach is adopted for emergency management services (see chapter 10).

The distinction between prevention and intervention is more difficult for mental illness. Preventing the onset of mental illness is challenging primarily because individual disorders have many origins. Most efforts have been directed at treating mental illness when it occurs and, in particular, at determining the most appropriate setting for providing treatment. Thus, the mental illness indicators focus on aspects of service delivery by different providers. However, the Second National Mental Health Plan places considerable emphasis on promoting and preventing mental illness. The Mental Health Promotion and Prevention National Action Plan has been drawn up specifically to meet the prevention and promotion priorities and outcomes outlined in the second plan. Indicators representing these components of mental illness management will be developed for future Reports.

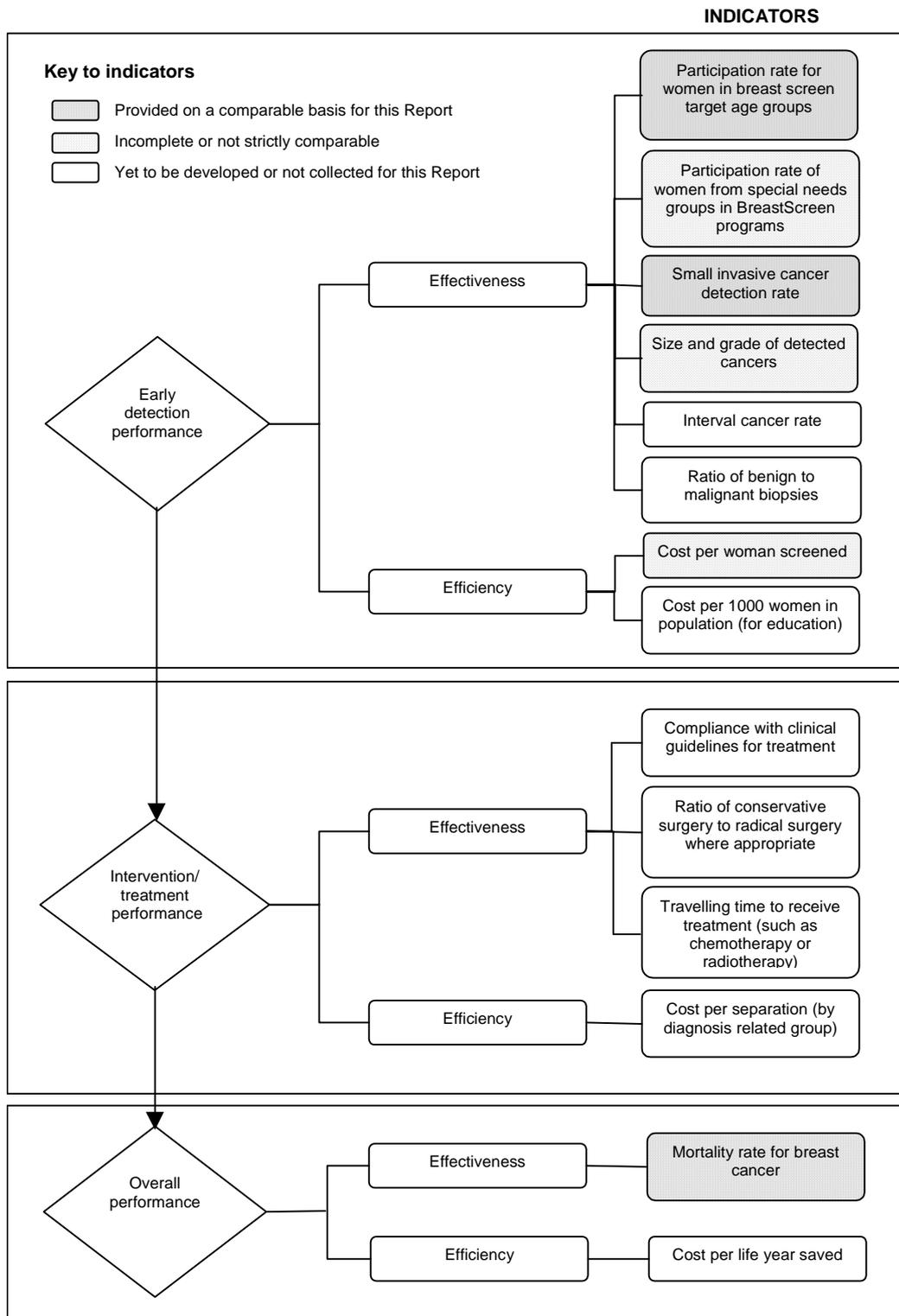
Breast cancer management

The measures developed to report on the performance of breast cancer management are based on the shared government objective for managing the disease (box 6.4). These measures are indicators of the performance of the program to undertake early detection of breast cancer through an organised public health initiative, and of the treatment of breast cancer in public acute care hospitals (figure 6.6). The framework includes indicators of performance related to age-specific mortality rates for breast cancer and combined expenditure on early detection and treatment per episode of illness, as well as indicators of the performance of early detection and intervention strategies.

Box 6.4 Objective for breast cancer management

The objective for breast cancer management is to provide an effective balance of early detection and treatment services with a view to reducing morbidity and mortality in a manner that is equitable and efficient.

Figure 6.6 Performance indicators for breast cancer management



The BreastScreen Australia program aims to detect breast cancer early through organised breast screening services, primarily targeted at women aged 50 to 69 years. If breast cancer is detected early, while still localised in the breast, chances of

five-year survival are around 90 per cent; the survival rate drops to 18 per cent if the tumour has spread to other parts of the body (NBCC 1999). The size and grade of detected cancers reflect the effectiveness of early detection programs. Other effectiveness indicators, such as the participation rate of women in screening and the small cancer detection rate, are specific to breast cancer screening programs. The two efficiency indicators for early detection programs are the cost per woman screened and the cost of education programs per 1000 women in the population.

Effectiveness indicators for treatment focus on appropriateness (general practitioner and surgeon compliance with clinical practice guidelines for the management of early and advanced breast cancer, and the ratio of conservative surgery to radical surgery), and access (travelling time for radiotherapy and/or chemotherapy).

Some data on the effectiveness of breast cancer screening services, such as the participation rate of women in the target age group in breast screening programs and the small cancer detection rate, are presented in this Report for the second year. Data on the overall effectiveness of breast cancer management, as indicated by mortality rates from breast cancer, are also presented for the second time.

Other effectiveness indicators are being reported for the first time. These include the size and grade of detected cancers, and the participation rates of Indigenous women and those from culturally and linguistically diverse backgrounds. Data on these indicators have been sourced from jurisdictions directly, and in the absence of validation, are not strictly comparable.

Efficiency data on the cost per woman screened are presented for the first time. Data have been sourced from jurisdictions and are not strictly comparable as the reporting period is not yet uniform across all jurisdictions.

Data collection for some of the other indicators (such as the ratio of benign to malignant biopsies, cost of education programs per 1000 women in the population, and cost per separation for treatment services) is hampered by conceptual and practical issues with data definitions and identifying data items. These issues will be addressed for future Reports, thus the indicators may change over time as better ones are developed. The framework can also be expected to evolve as the focus of and objectives for breast cancer management change.

Mental health

The framework of performance indicators for mental health services builds on governments' objectives for mental health service delivery (box 6.5) as encompassed in the National Mental Health Strategy. The framework reports on the

effectiveness (in terms of quality, appropriateness, access and outcomes) and efficiency (in terms of unit cost) of mental health services (figure 6.7). It covers a number of service delivery types (institutional and community based services) and indicators of systemwide performance.

Box 6.5 Objectives for mental health service delivery

Key objectives include:

- to promote the mental health of the Australian community;
- to prevent, where possible, the development of mental health problems and mental disorders;
- to reduce the impact of mental disorders on individuals, families and the community;
- to assure the rights of people with mental disorders;
- to encourage partnerships between service providers; and
- to improve the quality of service delivery.

Governments also aim to provide services in an equitable and efficient manner.

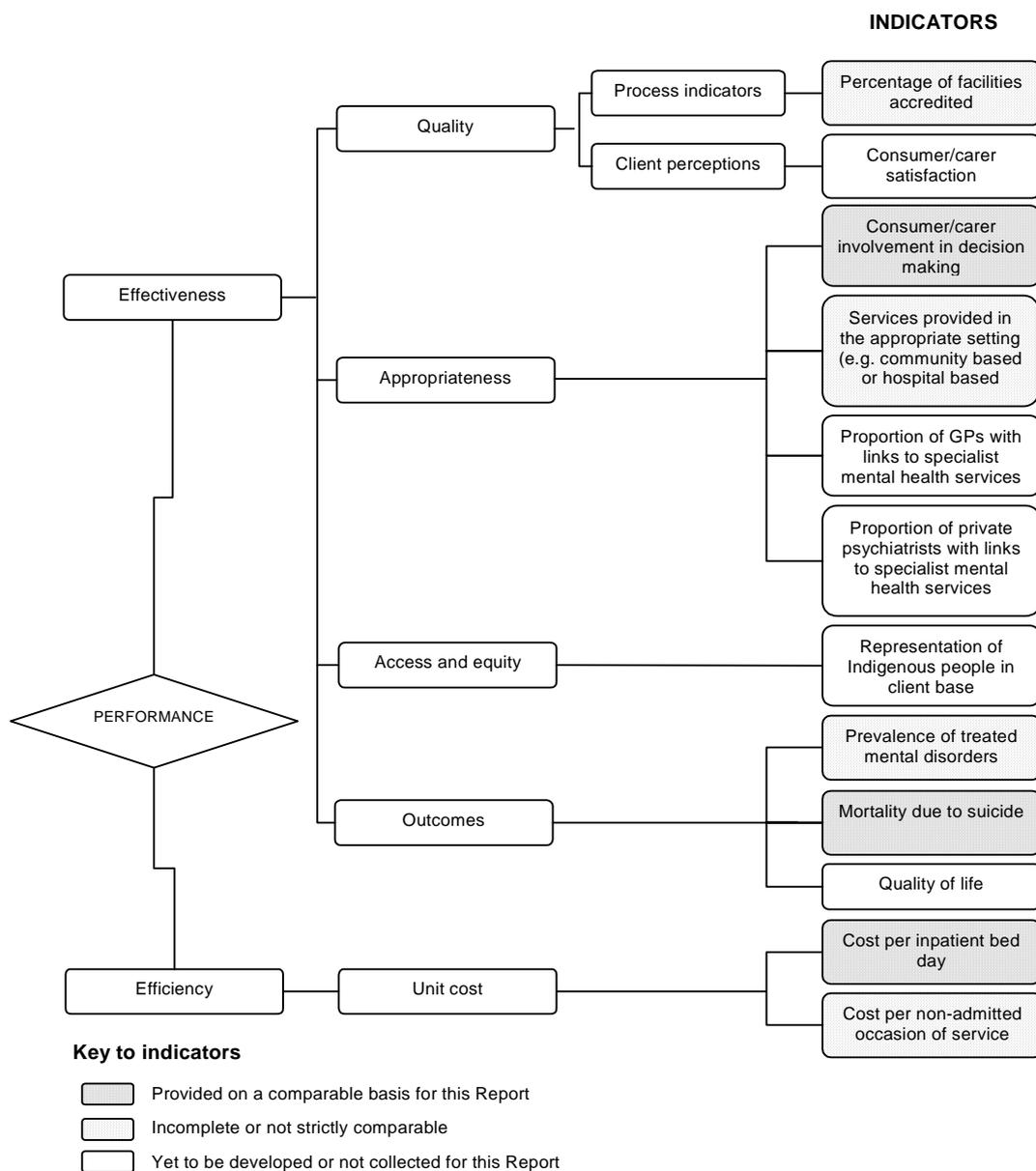
Source: DHFS (1998b); DHAC (1999a).

The prevalence of mental disorders in the general population and the mortality rate from suicide (both indicators of outcomes of mental health services) reflect two goals of the National Mental Health Strategy: to promote the mental health of the Australian community, and where possible, to prevent the development of mental health problems. The quality of life outcome indicator, which has still to be developed, provides some information on the ability of mental health services to reduce the effect of mental illness on individuals, families and the community. It is important to note that these outcome indicators may be influenced by a range of factors in addition to mental health care services; for example, social and disability support, education and employment are all likely to have an effect on the prevalence of mental illness and the number of deaths from suicide.

The percentage of accredited facilities delivering mental health services to people with a mental health problem is used as a process indicator of quality. Some data are available and are being reported for the first time this year.

Consumer/carer involvement in decision making is an appropriateness indicator, which reflects the National Mental Health Strategy's aim to assure the rights of people with mental disorders, and to focus on improving the outcomes for consumers.

Figure 6.7 Performance indicators for mental health services



A number of other effectiveness indicators are included in the framework. For example, the extent to which mental health services are offered as part of mainstream health care services, quality imperatives (the proportion of facilities accredited and consumer/carer satisfaction) and access and equity (the representation in the client base of special needs groups, such as Indigenous people and those from culturally and linguistically diverse backgrounds, and people in rural and remote areas). The efficiency of mental health services is indicated by the cost per bed day for inpatient services and the cost per non-admitted occasion of service for outpatient and community based services.

Reporting requirements under the National Mental Health Strategy mean that some performance data for mental health services are already available. This Report presents data on some aspects of the effectiveness of mental health services (consumer/carer involvement in decision making, the appropriateness of care setting, the prevalence of mental disease in the general population, mortality rates from suicide) and the efficiency of institutional services (cost per inpatient bed day).

Ongoing work to provide a more comprehensive set of performance indicators and to improve existing indicators and the data, is discussed in section 6.4.

6.3 Key performance indicator results

Breast cancer management – Early detection

Participation rates of women in the target age group

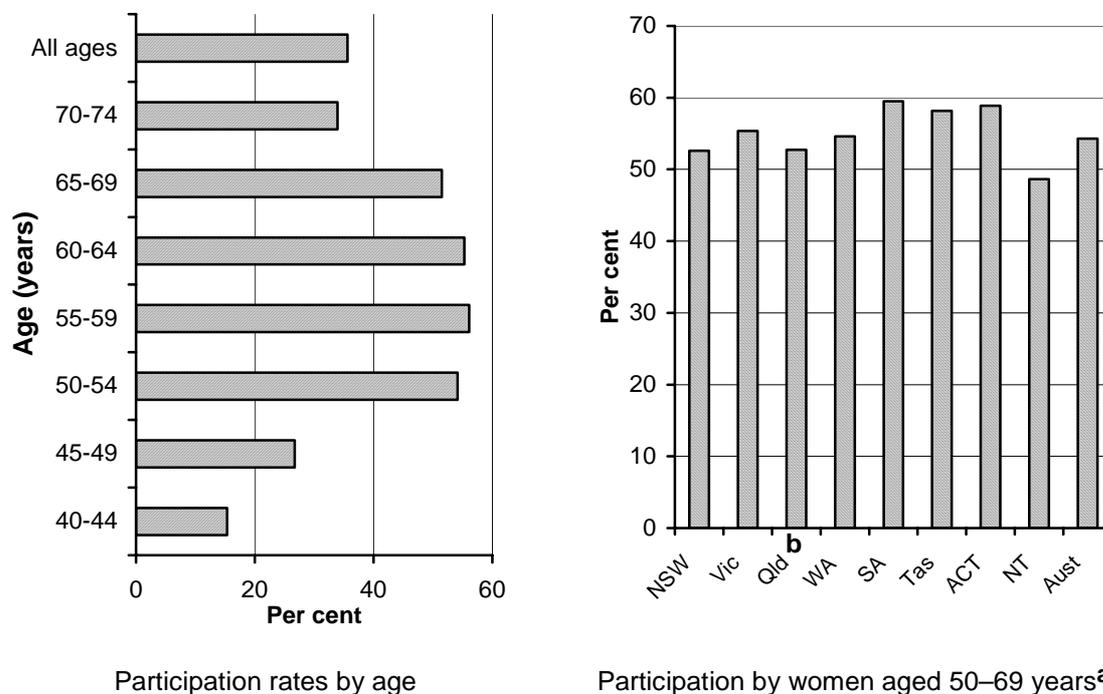
The aim of BreastScreen Australia is to screen 70 per cent of women aged 50–69 years, regularly at two-yearly intervals. The participation of women in the target age group in breast cancer screening is an indicator of the effectiveness of early detection programs (figure 6.8). Fifty-four per cent of all women in this age group participated in the program in 1997 and 1998, along with 26.7 per cent of women aged 45–49 years and 33.9 per cent of women aged 70–74 years.

Age standardised participation rates varied within the target age group (50–69 years) in 1997 and 1998. Women aged 55–59 years were most actively involved in breast screening (with 56.1 per cent participating in the BreastScreen Australia program), whereas women in the 65–69 age group had the lowest participation rate (51.5 per cent). Participation of women in the target age group was highest in SA (59.5 per cent of women aged 50–69 years), followed by ACT (58.9 per cent). By contrast, the NT recorded the lowest participation rates in the target group (48.6 per cent).

Participation rates of women from special needs groups in breast screen programs

The participation rate of Indigenous women and women from culturally and linguistically diverse backgrounds in breast cancer screening is another indicator of the effectiveness of early detection programs. Data on this indicator are being presented for the first time in this Report. However, the data for jurisdictions are not comparable as different time periods for screening have been reported.

Figure 6.8 Participation rates of women in BreastScreen Australia, 1997 and 1998



^a Rates are age standardised to the Australian 1991 population. ^b Only five of the 11 BreastScreen services were in operation five or more years.

Source: table 6A.1.

Jurisdictions reported the following results:

- NSW reported that in 1998-99, 18 per cent of Indigenous women and 23 per cent of women from culturally and linguistically diverse backgrounds, in the target age group 50–69, were screened (table 6A.5);
- Victorian data for the 1997 calendar year indicated that 36 per cent of Indigenous women and 52 per cent of women from culturally and linguistically diverse backgrounds, in the target age group 50–69, were screened (table 6A.7);
- Queensland and WA reported that in 1997-98, the participation rates for Indigenous women in the target age group 50–69 years were 46 per cent and 36 per cent respectively. For women from culturally and linguistically diverse backgrounds in the target age group 50–69 years, the participation rates were 61 per cent and 47 per cent respectively (tables 6A.11 and 6A.15). Queensland anticipates that, with the establishment in 1999 of a relocatable service that travels to the far north of the State, the participation rate of Indigenous women in breast screening services will increase;
- SA reported that 42 per cent of Indigenous women and 53 per cent of women from culturally and linguistically diverse backgrounds, in the target age group

50–69, were screened in the 24 month period to 31 December 1998 (table 6A.20);

- Tasmania reported that in the period 1 April 1994 to 30 June 1999, 39 per cent of Indigenous women and 53 per cent of women from culturally and linguistically diverse backgrounds, in the target age group 50–69, were screened (table 6A.23);
- the ACT reported that in the period 1 April 1997 to 30 June 1999, 50 per cent of Indigenous women and 71 per cent of women from culturally and linguistically diverse backgrounds, in the target age group 50–69, were screened (table 6A.26);
- the NT reported that from 1 October 1996 to 31 December 1998, 57 per cent of Indigenous women and 70 per cent of women from culturally and linguistically diverse backgrounds, in the target age group 50–69, were screened (table 6A.29).

Small invasive cancer detection rate

The small invasive cancer detection rate is also an indicator of the effectiveness of early detection programs for breast cancer. The BreastScreen Australia National Accreditation Requirements standard is that more than eight invasive cancers per 10 000 women screened have a diameter of 10 millimetres or less. Small cancers (those with a diameter less than or equal to 10 millimetres) are generally associated with increased survival rates and reduced morbidity and mortality, thus are less expensive to manage. Women with small cancers are less likely than women with larger tumours to require a mastectomy (AIHW 1998b).

The rate of small cancers detected, under the BreastScreen Australia screening and assessment services in 1998, was unavailable for NSW and consequently national totals have not been presented. However, data from other jurisdictions showed that the age standardised rate of small cancers detected over all age groups was highest in Tasmania (32.2 for every 10 000 women screened) and lowest in the ACT (10.4 per 10 000 women screened (table 6.3).

There was significant variation in the age standardised small cancer detection rate within the target age group (50 - 69 years) across jurisdictions in 1998. The rate of small invasive cancers detected per 10 000 women was highest in Tasmania (22.3 for every 10 000 women screened), compared with 13.4 in Queensland and 15.1 in SA (table 6.3).

**Table 6.3 Detection rate of small diameter, invasive breast cancers, 1998
(number per 10 000 women screened)**

<i>Women aged</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
40-44	na	1.5	4.8	0.0	2.9	0.0	10.5	0.0	na
45-49	na	10.3	5.7	5.5	5.6	5.8	0.0	14.3	na
50-54	na	13.2	10.1	9.1	11.1	22.1	16.8	8.3	na
55-59	na	15.2	10.3	18.2	14.3	10.8	24.0	15.9	na
60-64	na	24.2	18.8	18.3	19.7	29.2	14.0	59.0	na
65-69	na	22.2	15.1	31.5	15.9	27.3	19.1	0.0	na
70-74	na	28.3	35.8	20.9	30.1	0.0	0.0	0.0	na
75-79	na	28.7	36.4	31.8	25.0	94.6	0.0	344.8	na
80-84	na	64.7	30.6	84.0	129.4	0.0	0.0	0.0	na
85+	na	0.0	101.3	0.0	0.0	666.7	0.0	0.0	na
All ages ^a	na	16.4	16.3	15.7	16.6	32.2	10.4	31.8	na
50-69 ^a	na	18.4	13.4	18.7	15.1	22.3	18.4	20.8	na

^a Age standardised to the Australian 1991 population.

Source: table 6A.2.

Size and grade of detected cancers

The size and grade of detected invasive cancers is also an indicator of the effectiveness of early detection programs for breast cancer. The tumour grade describes the degree of similarity of the cancer cells to normal cells. The degree of differentiation of the cancer indicates the prognosis of the disease. For example, a well-differentiated cancer is associated with a good prognosis and those which are moderately differentiated are associated with an intermediate prognosis. Data on this indicator are being presented for the first time in the 2000 Report. Most jurisdictions were able to supply data and the results are as follows:

- Victoria reported that in 1997, 40 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while nearly 21 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (48 per cent) were moderately differentiated (table 6A.8);
- Queensland reported that in 1998, 43 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while nearly 18 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (51 per cent) were moderately differentiated (table 6A.13);
- WA reported that from January 1996 to December 1998, 50 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while 9 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (46 per cent) were well differentiated (table 6A.17);

-
- SA reported that in 1998, 56 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while nearly 7 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (48 per cent) were well differentiated (table 6A.21);
 - Tasmania reported that in 1998, 40 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while 17 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (55 per cent) were moderately differentiated (table 6A.24); and
 - the ACT reported that in 1998, 54 per cent of cancers which were 10mm or less in diameter were found to be well differentiated, while 8 per cent of this group were poorly differentiated. For cancers 11-15mm in diameter, the majority (50 per cent) were moderately differentiated (table 6A.27).

Cost per woman screened

The cost per woman screened is an efficiency indicator for the prevention and early detection of breast cancer. It measures the total cost per woman screened of providing the BreastScreen program. Costs include screen taking, reading X-rays, assessment, recruitment, data collection and service management, in addition to the cost of providing the service to women. Data on this indicator are being reported for the first time in the 2000 Report. The results presented are not yet strictly comparable, and further work will be required to improve the data.

Jurisdictions reported the following results:

- NSW reported that for 1998-99, the cost per woman screened, including capital expenditure was \$91 and excluding capital expenditure was \$87 (table 6A.6);
- Victoria reported that for 1997, the cost per woman screened in rural areas was \$112 and in urban areas \$90 (table 6A.10);
- Queensland and WA reported that for 1998-99, the cost per woman screened was \$108 and \$94 respectively (table 6A.14 and table 6A.19);
- SA and Tasmania reported that for 1997-98, the cost per woman screened was \$97 and \$115 respectively (table 6A.22 and table 6A.25);
- the ACT reported that for 1997-98, the cost per woman screened was \$116 (table 6A.28); and
- the NT reported that for 1998-99, the cost per woman screened was \$235 (table 6A.30).

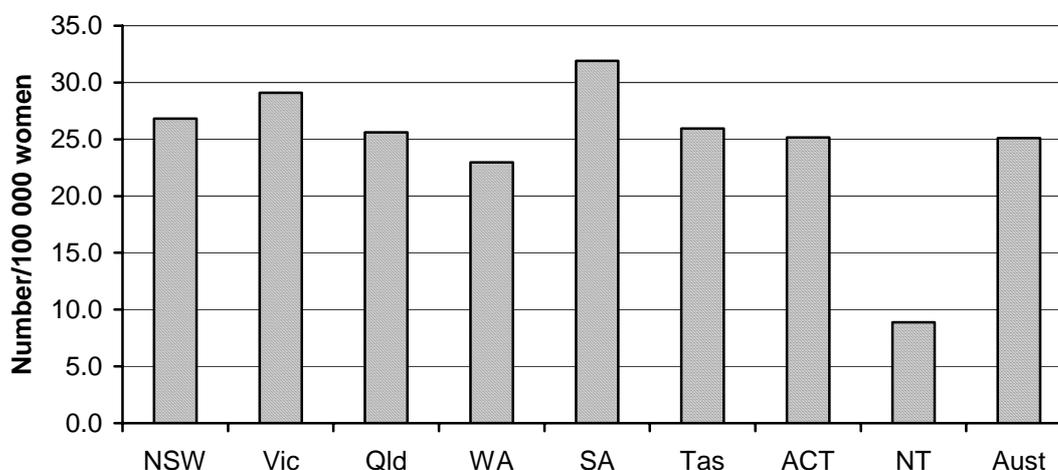
Breast cancer management – Overall performance

Mortality rate for breast cancer

The number of women dying from breast cancer and age-specific mortality rates partly indicate the effectiveness of both early detection and treatment services for breast cancer. The number of deaths due to breast cancer rose steadily from 1989 to 1995 but has been decreasing since then. Breast cancer claimed the lives of 2542 Australian women in 1998, accounting for the largest proportion of cancer deaths of women in that year. It also comprised 4.2 per cent of all deaths in that year (ABS 1999).

There were 25.1 deaths from breast cancer per 100 000 women in 1998 (figure 6.9). The highest rates were recorded in Victoria and SA (29.1 and 31.9 deaths per 100 000 women respectively), and the NT recorded the lowest rate (8.9 deaths for every 100 000 women).

Figure 6.9 **Mortality rate from breast cancer, 1998**



Source: table 6A.4.

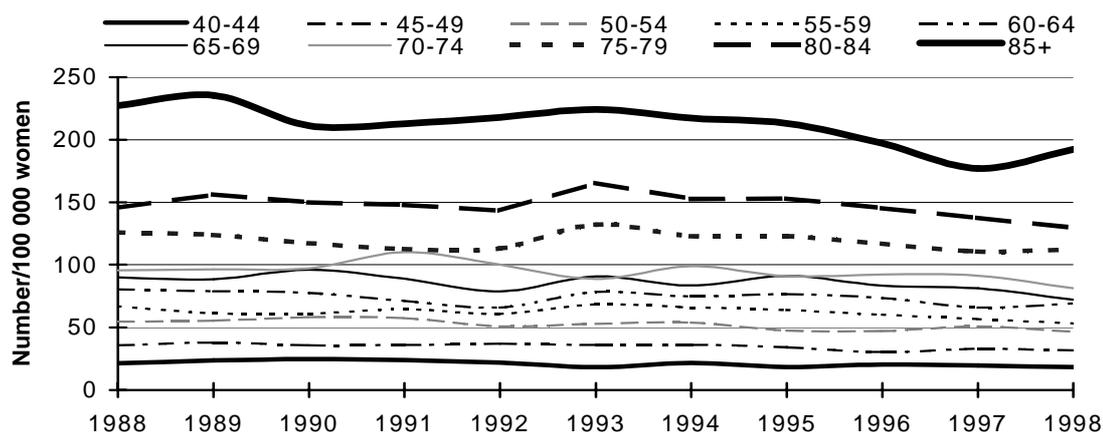
Age-standardised mortality rates are the most appropriate measure for looking at changes in mortality rates over time and these data are available for the 10 years to 1998. The age-standardised mortality rate for all ages fell from 27 deaths per 100 000 women in 1988 to 23 deaths per 100 000 women in 1998 (figure 6.9).

The age-standardised mortality rate in 1998 was:

- 18 per 100 000 woman years for women aged 40–44 years;
- 32 per 100 000 woman years for women aged 45–49 years;

- 59 per 100 000 woman years for women in the target age group 50–69 years; and
- 121 per 100 000 woman years for women aged 75–79 years and over (AIHW unpublished).

Figure 6.10 **Age-specific and age-standardised mortality rates from breast cancer^a**



^a Rates were age standardised to the Australian 1991 population.

Source: table 6A.3.

The changes in age-specific breast cancer mortality rates varied across age cohorts. The age standardised mortality rate for women in the target age group, 50–69 years, fell from 68.3 deaths per 100 000 women in 1982 to 64.9 in 1996. The mortality rates also fell for women aged 40–49 years from 27.3 to 25.3 deaths and for women aged over 70 years (from 125.5 to 121 deaths). Over the same period, the death rates remained fairly constant for women in younger age groups 15–39 years.

Mental health management – Quality

Percentage of facilities accredited

The percentage of accredited facilities, delivering services to people with a mental health problem, is used as a process indicator of quality. Imperfect data are available for this Report (number of facilities accredited, not percentage) but improvements can be expected when the National Standards for Mental Health Services review is complete in about two years.

Jurisdictions reported the following:

-
- NSW reported that, as at 30 June 1999, 43 facilities providing inpatient public mental health services were accredited. The number of accredited beds available in these facilities was 1933;
 - Victoria reported that, as at 30 June 1998, 55 facilities providing acute inpatient public mental health services were accredited. The number of accredited beds available in these facilities was 1120. There were 39 community and residential facilities accredited with 868 beds available;
 - Queensland reported that, as at 30 June 1999, 12 public hospitals providing acute inpatient public mental health services were accredited. The number of accredited acute and non-acute beds available in these facilities was 375;
 - in WA, as at 30 June 1998, 16 facilities were accredited. These facilities included authorised hospitals, extended care units and psychiatric wards in public acute care hospitals. The number of accredited beds available in these facilities was 372;
 - in SA, as at 30 June 1998, eight public hospitals with designated/specialist mental health facilities were accredited. The number of accredited beds available in these facilities was 183;
 - Tasmania reported that, as at 30 June 1998, four public hospitals with designated/specialist mental health facilities were accredited. The number of accredited beds available in these facilities was 80; and
 - the ACT reported that, in 1997-98, two public hospitals with designated/specialist mental health facilities were accredited. The number of accredited beds available in these facilities was 52.

Mental health management - Appropriateness

Consumer/carer participation in decision making

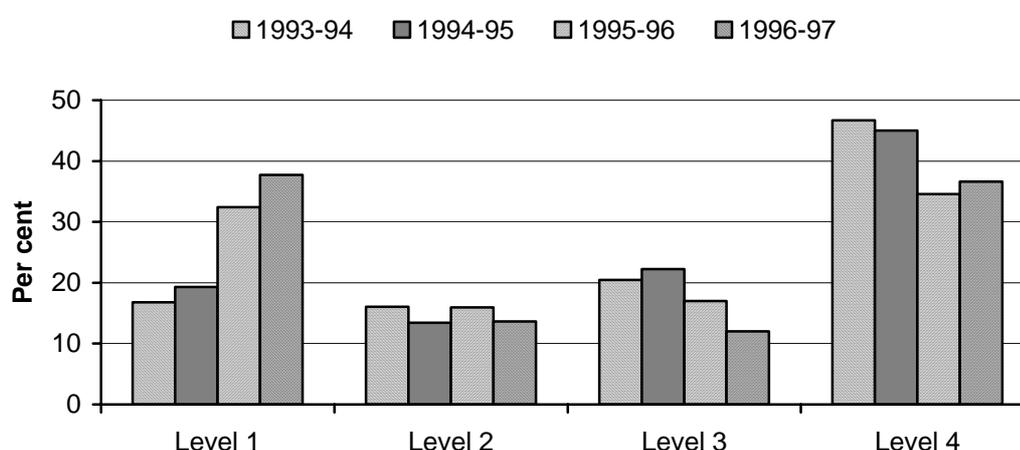
An indicator of appropriateness is consumer/carer participation in decision making. Public sector mental health service organisations are asked each year to describe the arrangements provided to allow consumers and carers to contribute to local service planning and delivery. Responses are grouped into four categories:

- level 1 — appointment of a person to represent the interests of consumers and carers on the organisation management committee or a specific consumer/carer advisory group to advise on all aspects of service delivery;
- level 2 — a specific consumer/carer advisory group to advise on some aspects of service delivery;

- level 3 — participation of consumers/carers in broadly based committees; and
- level 4 — other/no arrangements.

Of the 137 organisations responding in 1993-94, 17 per cent reported a level 1 rating. Approximately 16 per cent reported a level 2 rating, 20 per cent reported a level 3 rating, and almost half (47 per cent) reported a level 4 rating. By 1996-97, the survey results suggested consumers/carers had a greater involvement in decision making, with 38 per cent of the 183 respondents reporting a level 1 rating. For level 2, the rating was 14 per cent and for levels 3 and 4, 12 and 37 per cent respectively (figure 6.11).

Figure 6.11 Trends in consumer/carer participation in decision making



Source: 6A.40.

Services provided in the appropriate setting

The National Mental Health Strategy advocated the development of local, comprehensive mental health service systems. The services must be capable of responding to the individual needs of people with mental disorders and provide continuity of care, so consumers can move between services as their needs change. Under the directions set by the Strategy, structural reform of mental health services has resulted in:

- reduced reliance on stand-alone psychiatric hospitals;
- expanded delivery of community based care integrated with inpatient care; and
- mainstreamed mental health services with other components of health care.

By encouraging treatment of patients in community settings and general hospitals, rather than in stand-alone psychiatric hospitals — that is, to substitute the service settings — more appropriate treatment options can be provided.

Across Australia, per person expenditure on community based mental health services was \$31 in 1996-97, compared with \$16 for services in co-located units in general hospitals and \$23 for stand-alone psychiatric hospitals (table 6.4). Across jurisdictions, per person expenditure on community services ranged from \$21 in Queensland to \$47 dollars in Victoria. For stand-alone hospitals, per person expenditure was highest in SA and lowest in Victoria (\$39 and \$15 respectively).

The average annual growth rate for community services across Australia was almost 14 per cent between 1992-93 and 1996-97. The annual growth rate was highest in Victoria (19 per cent) and lowest in the ACT (nearly 6 per cent). Per person expenditure rose by 4 per cent annually over the same period for co-located units, but fell by almost 8 per cent for stand-alone hospitals (table 6.4).

Table 6.4 Average per person real government expenditure, by service type^{a, b}

	<i>Stand-alone hospitals</i>			<i>Co-located units</i>			<i>Community services</i>		
	<i>1992-93</i>	<i>1996-97</i>	<i>Change</i>	<i>1992-93</i>	<i>1996-97</i>	<i>Change</i>	<i>1992-93</i>	<i>1996-97</i>	<i>Change</i>
	\$	\$	%	\$	\$	%	\$	\$	%
NSW	27	23	-4.0	15	16	0.6	18	26	10.3
Vic	41	15	-21.9	10	14	9.1	24	47	18.9
Qld	25	25	-0.6	17	17	0.2	12	21	16.5
WA	33	29	-3.1	14	21	10.8	17	29	14.4
SA	39	39	-0.4	7	10	8.3	20	27	7.1
Tas	32	25	-5.8	13	18	7.5	21	34	12.7
ACT	0	0	0.0	21	27	5.7	29	36	5.7
NT	0	0	0.0	30	37	5.5	22	35	12.4
Aust	31	23	-7.8	14	16	4.2	19	31	13.9

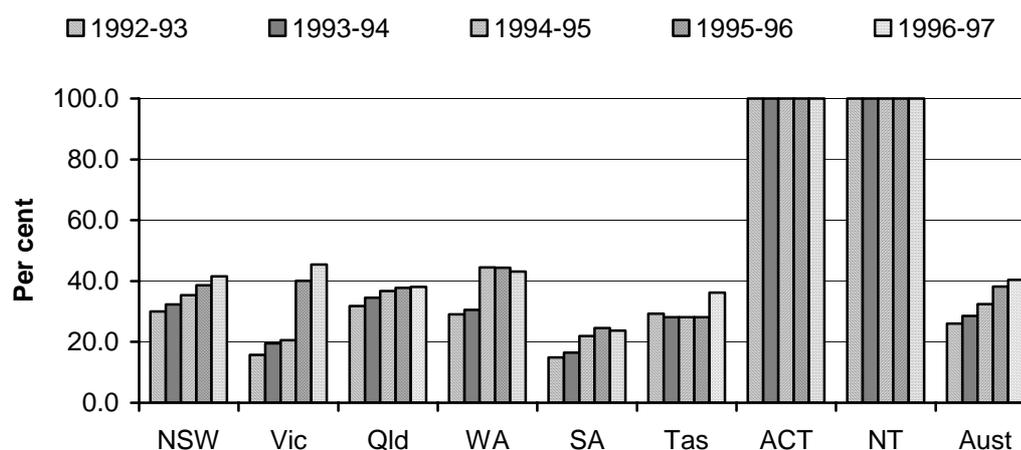
^a In 1996-97 dollars. ^b Numbers have been rounded off to the nearest dollar.

Source: table 6A.36.

The trend away from stand-alone hospitals towards co-located units in general hospitals and services offered in community settings was also reflected in changes in patient days over the period. Approximately 26 per cent of total inpatient bed days occurred in co-located units in general hospitals in 1992-93, rising to 40 per cent in 1996-97. Across jurisdictions, the largest increase occurred in Victoria, where the growth rate in patient bed days spent in co-located units as a proportion of total bed days was 30 per cent per year over the same period. The growth rate was lowest in Queensland (4.6 per cent) (figure 6.12).

Victoria recorded the highest proportion of inpatient days occurring in co-located units in 1996-97 (46 per cent), followed by (43 per cent) in WA (among jurisdictions where both service types are available). By contrast, the proportion was lowest in SA and Tasmania (24 per cent and 36 per cent respectively) (figure 6.12).

Figure 6.12 Bed days in co-located units as a proportion of total inpatient bed days



Source: table 6A.38.

The number of patient bed days, recorded in community based services delivering 24-hour specialised mental health care, rose by 13 per cent per year between 1992-93 and 1996-97 — up from 259 200 to 427 208 (figure 6.13). There was strong yearly growth in the number of bed days in Victoria (27 per cent). The other two States in which growth occurred over the same period were NSW and Tasmania (5 and 3 per cent respectively). There was a fall in South Australia (19 per cent per year) and in WA (4 per cent per year). The ACT did not record any growth during this period. These services were not available in Queensland and the NT.

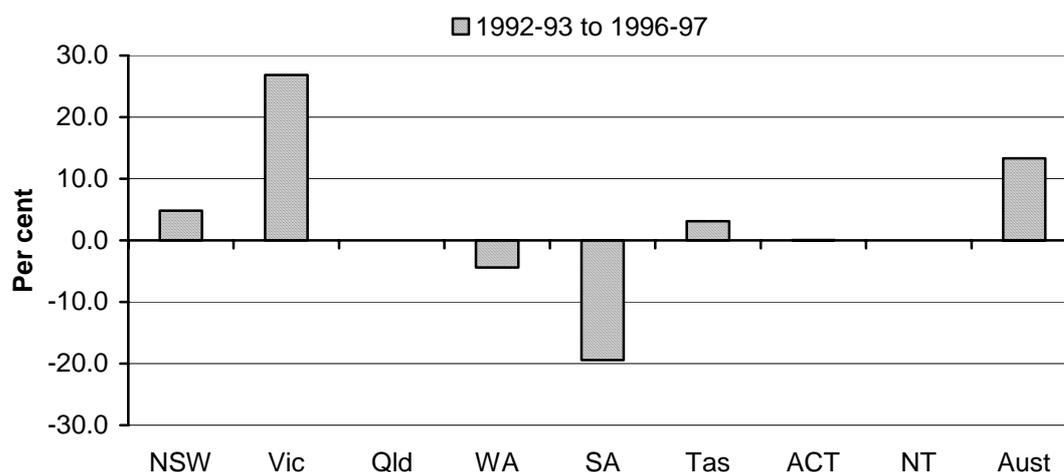
Mental health management - Outcomes

Prevalence of mental disorders

Outcome indicators for mental health management include the prevalence of mental illness in the community and deaths from suicide. According to the 1997 National Survey of Mental Health and Wellbeing, approximately 2.4 million adults (or

17.7 per cent of all adults) experienced the symptoms of a mental disorder at some time in the 12 months before the survey.

Figure 6.13 Average annual growth rate in the number of patient bed days in community based residential services



^a These services were not available in Queensland or the NT.

Source: 6A.39.

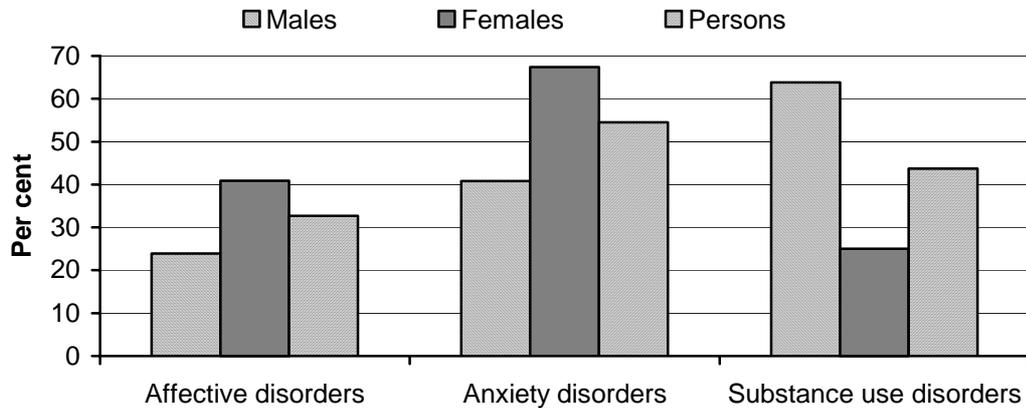
Overall, anxiety disorders (such as agoraphobia, post-traumatic stress disorder and social phobia) were the most common type of mental disorder reported in 1997, with persons reporting anxiety symptoms accounting for 54.5 per cent of those reporting symptoms of a mental disorder. Persons reporting substance use disorders accounted for 43.7 per cent of the total, and persons with affective disorders (such as depression, mania and bipolar disorder) accounted for 32.7 per cent (figure 6.14).

There were differences between males and females. Females most commonly experienced anxiety disorders (which accounted for 67.4 per cent of females experiencing mental disorder symptoms), followed by affective disorders (40.9 per cent) and substance abuse (25.0 per cent). By contrast, males most commonly suffered substance abuse (which accounted for 63.8 per cent of males experiencing mental disorder symptoms), followed by anxiety disorders (40.8 per cent) and affective disorders (23.9 per cent) (figure 6.14).

The prevalence of mental disorders was higher for younger people than older people (figure 6.15). Almost 27 per cent of adults aged 18–24 years experienced symptoms of a mental disorder in the 12 months before the survey, compared with 6.1 per cent of people aged 65 years and over. The prevalence of anxiety disorders was highest for adults aged 45–54 years (11.9 per cent); the prevalence of affective disorders

was highest in the 35–44 year age range (7.2 per cent); and the prevalence of substance use disorders was highest in adults aged 18–24 (16.1 per cent).

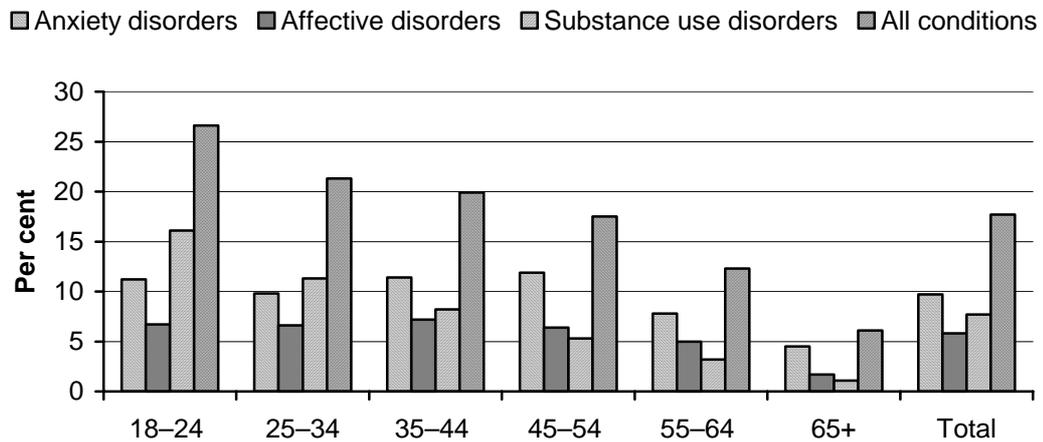
Figure 6.14 Prevalence of mental disorders, 1997^a



^a Defined as the percentage of adults with a mental disorder. Components do not add to 100 because respondents may have reported symptoms for more than one type of mental disorder.

Source: table 6A.41.

Figure 6.15 Prevalence of mental disorders, by age, 1997^a



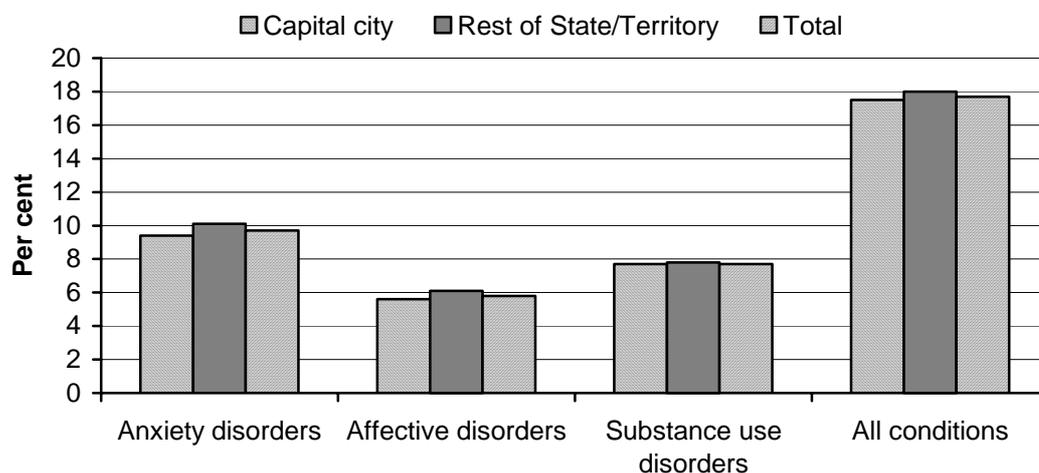
^a Percentage of all adults with a mental disorder. Components do not add to 100 because respondents may have reported symptoms for more than one mental disorder.

Source: table 6A.42.

The prevalence of mental illness did not vary greatly with geographic location (figure 6.16). Eighteen per cent of adults residing outside capital cities experienced mental disorder symptoms in the 12 months before the survey, compared with

17.7 per cent of adults living in capital cities. A similar pattern was recorded for individual disorders.

Figure 6.16 Prevalence of mental disorders, by geographic location, 1997^a



^a Components do not add to 100 because respondents may have reported symptoms for more than one mental disorder.

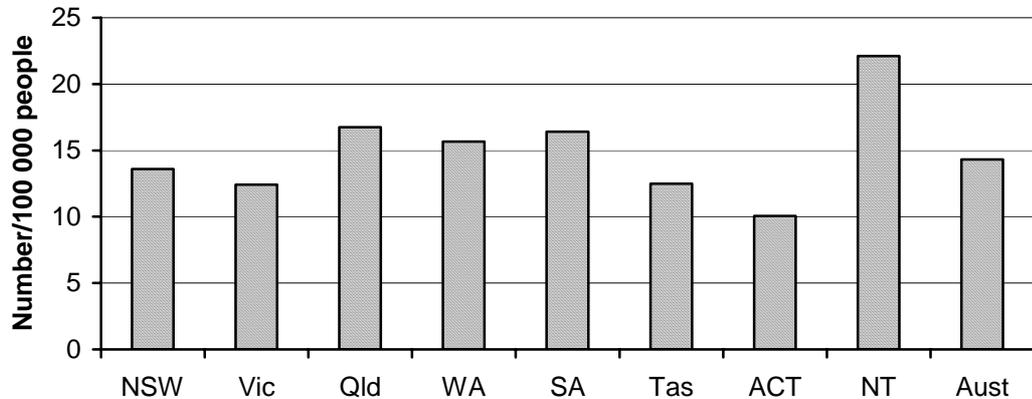
Source: table 6A.43.

Mortality due to suicide

The prevalence of mental illness is thought to have a significant effect on the number of deaths from suicide. Nearly 2700 deaths from suicide were recorded in Australia in 1998, which equalled 14.3 deaths for every 100 000 people. Across jurisdictions, the death rate from suicide in 1998 ranged from 10.1 per 100 000 people in the ACT to 22.1 in the NT (figure 6.17).

The mortality rate due to suicide for males was more than three times that for females in 1998 — a trend that was consistent over the 10 years to 1998. Overall, the mortality rate was relatively stable, although there was a large increase in the number of deaths between 1996 and 1997. The mortality rate increased in that period from 13.1 deaths per 100 000 people in 1996 to 14.7 in 1997, falling slightly to 14.3 deaths per 100 000 people in 1998 (figure 6.18).

Figure 6.17 Mortality rate due to suicide, 1998

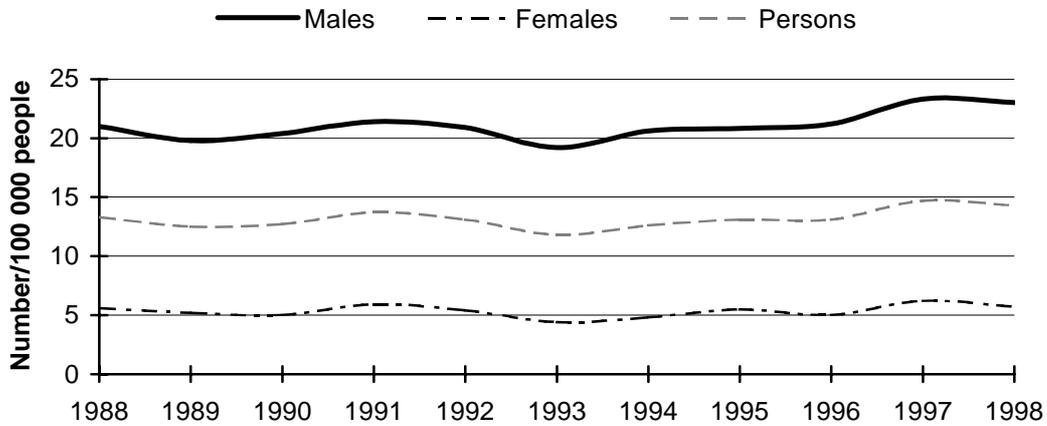


Source: table 6A.45.

The largest proportion of suicides in 1998 was committed by people aged 15–24 years (23.8 per cent), followed by people aged 25–44 years (20.1 per cent). Moreover, suicide was the second leading cause of death for people in both age groups (ABS 1999). The death rate from suicide for people aged 15–24 years was 16.7 deaths per 100 000 people of that age group in 1998. Across jurisdictions, the NT recorded the highest rate (38.7 deaths per 100 000 people), while Tasmania recorded the lowest (6.3 deaths per 100 000 people) (figure 6.19). There was an average annual increase in the mortality rate due to suicide in this age group of 4.7 per cent between 1996 and 1998, with the largest rises occurring in the NT (30.3 per cent), and SA (23.5 per cent). Queensland, Tasmania and the ACT recorded a decrease in the annual mortality rate.

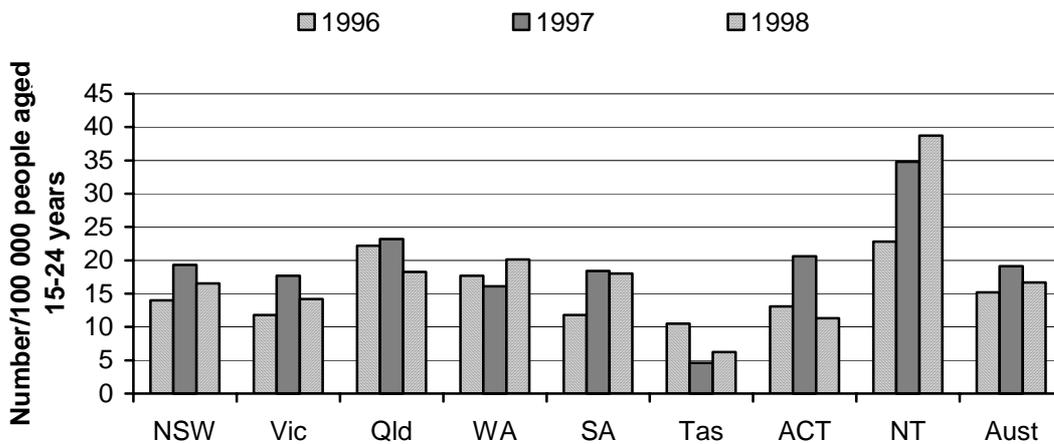
The high proportion of deaths of people aged 15–24 years (especially males) attributable to suicide prompted governments to establish the National Youth Suicide Prevention Strategy in 1995. The strategy aims to address Australia's youth suicide rates that are high in comparison with a number of other Western countries. It recognises the complexity of youth suicide prevention, and the necessary links between preventing youth suicide and promoting emotional and social health and wellbeing (DHAC 1999a).

Figure 6.18 Mortality rate due to suicide



Source: table 6A.44.

Figure 6.19 Mortality rate due to suicide for people aged 15–24 years



Source: table 6A.46.

Mental health management - Efficiency

Cost per inpatient bed day

It is an objective of the Review to report comparable estimates of costs. Comparability is maximised when the full range of costs to government is counted on a comparable basis. Where the full costs cannot be counted, comparability is achieved by estimating costs on a consistent basis.

A proxy indicator of efficiency is the level of government inputs per unit of output (unit cost). The most suitable indicator for mental health services would be to adjust the number of separations by the type and complexity of cases to develop a cost per case mix adjusted separation similar to that presented for public acute care hospitals. However, the current method for adjusting inpatient separations (AN-DRGs) does not accurately reflect differences in treating those with mental illnesses (section 6.3). Until an appropriate casemix classification has been developed and introduced, average inpatient day costs will be used as an indicator of efficiency. However, this data should be used cautiously in any comparative assessment.

The cost per inpatient bed day is affected by factors such as differences in the client mix and average length of stay. The client mix in inpatient settings may differ, for example, if some jurisdictions treat a higher proportion of less complex patients in inpatient settings rather than in the community. Longer lengths of stay may also be associated with lower average inpatient day costs, because the cost of admission and discharge and more intensive treatment early in a stay is spread over more days of care. Across Australia, the average length of stay for patients with mental illness was nearly 16 days in 1997-98. Queensland reported the highest average length of stay (25 days) and the NT the lowest (10 days) (table 6.5).

Table 6.5 Average length of stay in public acute and psychiatric hospitals for mental health^a, 1997-98

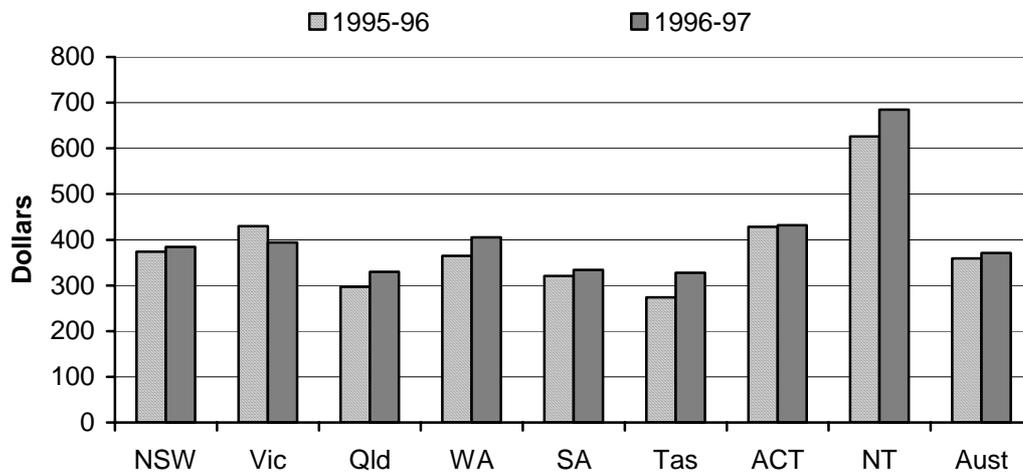
	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Average length of stay	14.1	13.3	25.0	15.9	12.0	11.8	13.1	9.9	15.8

^a Excludes alcohol and drug related episodes.

Source: AIHW (1999a).

The average cost of treating an inpatient was \$371 per day in 1996-97 which was 3 per cent higher than the previous year. Across jurisdictions, the average cost ranged from \$328 in Tasmania to \$685 in the NT. Compared to 1995-96, there was a decrease of 8 per cent in average inpatient costs in Victoria in 1996-97. In Tasmania there was a steep increase of 20 per cent and in both Queensland and WA the increase in inpatient costs was 11 per cent (figure 6.20).

Figure 6.20 Average inpatient costs per day for patients with mental illness



Source: table 6A.47.

Cost per non-admitted occasion of care

The provision of ambulatory treatment, rehabilitation and support to non-inpatients is an important component of public hospital services. Community health services also play an important role in the provision of services to people in an acute phase of a mental health problem or who are receiving post-acute care. The average cost per occasion of service in both service settings provides a measure of the efficiency with which non-inpatient services are provided. The following results from jurisdictions are not comparable due to differences in definitions.

Jurisdictions reported the following results:

- NSW estimated that the average cost of treating a public psychiatric patient in an emergency department, outpatient clinic, and in a primary and community based setting was \$80, \$133 and \$93 respectively (table 6A.50);
- in WA the average cost of treating a public psychiatric patient under community management in 1997-98 was \$1859, which was 7 per cent less than the previous year (table 6A.57); and
- in SA the average cost of treating a public psychiatric patient in an outpatient clinic was \$92 in 1996-97. The cost per patient of treating adults and children in primary and community based settings was \$118 and \$184 respectively (table 6A.50).

6.4 Future directions in performance reporting

Key challenges for improving reporting on health management performance are:

- filling gaps in reporting;
- improving the reporting on Aboriginal and Torres Strait Islander peoples' access to mainstream health services;
- improving the measurement of unit costs;
- reviewing the indicator framework; and
- extending the coverage of the Review.

Filling gaps in reporting

Breast cancer

Currently performance data for breast cancer management are limited to some aspects of the effectiveness and efficiency of the breast cancer screening program, BreastScreen Australia, and breast cancer management overall. Data on the effectiveness indicators—the participation rate of Indigenous women and women from culturally and linguistically diverse backgrounds in screening programs and the size and grade of detected cancers—have been reported by jurisdictions for the first time. It is anticipated that more comparable and comprehensive data will be available for future Reports.

Data on the efficiency of early detection (such as cost per woman screened) have been reported by some jurisdictions for the first time. An evaluation plan has been developed by BreastScreen Australia which will provide a comprehensive analysis of the effectiveness and efficiency of the program, including an economic evaluation. It is anticipated that nationally comparable data will be available for future Reports.

The National Breast Cancer Centre announced the release of a new protocol in July 1999 for *'The ascertainment and reporting of interval cancers within the BreastScreen Australia Program'*. This report has been endorsed by the BreastScreen National Advisory Committee. The protocol outlines the major reasons for measuring interval cancer rates in a screening program, including measuring the effect of the screening program on mortality. Program evaluation and comparison can also be achieved using measures such as program sensitivity, which relies on the calculation of the interval cancer rate (NHMRC 1999a). The development and reporting of the interval cancer rate, which is an indicator of the

effectiveness of the screening program, will also facilitate program outcomes to be compared across States and Territories and on an international basis. It is anticipated that national data will be made available from the Australian Institute of Health and Welfare in March 2000. Reporting of this new performance indicator for effectiveness is expected to take place for the first time in the 2001 Report.

It is anticipated that data will be available for the 2001 Report on the effectiveness indicators, the ratio of benign to malignant biopsies and the ratio of conservative surgery to radical surgery. Clarification is also being sought on the availability of data on the indicators, travelling time to receive treatment, cost per separation by AN-DRG and cost per life year saved.

The National Health and Medical Research Council (NHMRC) *Clinical Practice Guidelines: The Management of Early Breast Cancer* was first published in 1995. The initiative was part of the national program to promote the development of evidence-based clinical practice guidelines. The guidelines summarise areas of knowledge and highlight those areas where there is a deficiency in knowledge. Continuing evaluation of the guidelines will be carried out to determine the degree of use by practitioners, and the resultant effects on patient outcomes (NHMRC 1999b). The guidelines are specifically designed to:

- assist in decision making by women and their doctors, and educate all involved in the care of women with breast cancer; and
- assess and assure the quality of care.

The second edition of the guidelines are expected to be released in early 2000.

The National Health and Medical Research Council National Breast Cancer Centre established a multi-disciplinary working group in 1996 to develop *Clinical Practice Guidelines: The Management of Advanced Breast Cancer*. The first edition is expected to be released in mid 2000. The overarching aim of the guidelines is to develop a process of caring support when a woman is diagnosed with advanced breast cancer. This includes outlining the patterns of care available to her in a clear and compassionate manner over an appropriate period of time.

When developing the guidelines for the management of early and advanced breast cancer, it became evident that women with breast cancer suffer significant emotional morbidity. This impacts on the ability of the woman to function as an individual and impacts on her family as well. In response to this, *Psychosocial Clinical Practice Guidelines: Providing Information, Support and Counselling to Women with Breast Cancer* has been developed and will be released on 14 February 2000. These guidelines aim to consider the extent and type of psychosocial needs of women with breast cancer and the most effective ways of providing appropriate interventions.

In addition, it was recognised that an important risk factor for common cancers is considered to be attributable to inherited cancer predisposition. Therefore, the need for a coordinated national policy on cancer genetics has become apparent. In response to this, the Australian Cancer Network, the National Breast Cancer Centre and the National Health and Medical Research Council have developed *Guidelines on Familial Aspects of Cancer*, which are expected to be released in mid 2000.

Mental health management

The National Health Priority Areas initiative, which is a collaborative effort between Commonwealth and State and Territory governments, has targeted depression as a primary focus. This is allied to the estimates of the World Health Organisation and the World Bank which predict that depression will constitute the greatest disease burden in the developing world and rank second to ischaemic heart disease world wide by 2020. Depression is also a major focus of the Second National Mental Health Plan that includes the development of a proposed three-year National Depression Action Plan. It is anticipated that greater emphasis for future Reports will be placed on reporting indicators, such as prevalence rates of depression in the community, hospital separations for suicide, self-inflicted injury among young adults, and exploration of the link between depression and suicide.

Under the first National Mental Health Plan, policies were proposed to encourage increased involvement of general practitioners in the management of psychiatric clients. The second of the key themes in the Second National Mental Health Plan highlights the Commonwealth's commitment to the integration of mental health services with other health services, and to the development of strategic partnerships and alliances. Particular importance is placed on establishing closer working relationships with general practitioners.

Arrangements designed to develop better links between GPs and mental health specialists are often described as shared care models. Governments have sought to increase access to joint or shared care for suitable patients, but currently there are no data that enable reporting on these efforts (AHM 1998).

Government funding arrangements can affect the adoption of these models. One shared care project used a seeding grant to the local Division of General Practice to pay general practitioners for time spent consulting about their patients with psychiatrists from the Area Mental Health Service. A paper examining this project noted that the most common single impediment to transfer of a patient from the care of the Area Mental Health Service to a GP was drug costs. Some drugs are free to patients under Area Mental Health Service care but costly if prescribed by a GP (Meadows 1998).

Before data can be collected for this indicator, a nationally agreed definition of shared care against which data can be collected will need to be developed. This will be complicated as the concept is still being developed and, as a result, a range of shared care models may evolve. One such shared care model is Consultation Liaison in Primary Care in Psychiatry, based in the northwest of Melbourne (box 6.6).

Box 6.6 Shared care models — Consultation Liaison in Primary Care Psychiatry

The Northwest Melbourne Area Mental Health Service has promoted collaboration between GPs and public sector mental health services through the clinical consultation-liaison in primary care psychiatry (CLIPPP) service since 1995. During the first two years, more than 220 patients had consultations in their general practice clinic with psychiatrists from the area mental health service. More than 90 were transferred from the specialist care of the area mental health service to shared care. Forty GPs from seven group practices participated. Key features of the shared care model are:

- case managers within the area mental health service identify candidate patients — typically clinically stable, without recent relapse, with fair to good insight, and with some social support;
- patients are prepared for transfer. A concise summary of diagnosis, history and treatment adherence is prepared from the case notes. Impediments to transfer are identified and acted upon, where possible; the outcome of this action is recorded;
- a management plan is drawn up. An appointment between the GP, psychiatrist and patient is arranged to discuss the draft plan and establish the plan for continuing management;
- the GP takes over primary responsibility for the care of the patient;
- a patient registration and tracking system, maintained by area mental health service staff, supports the GP in maintaining continuity of care and provides information about satisfaction and other quality assurance;
- an electronic diary of due dates for review of each patient is maintained. Clinical staff review patients at three monthly intervals, by telephone contact with the patient and by checking the GP's case notes for continued contact; and
- a psychiatrist usually reviews patients every six to 12 months.

Source: Meadows (1998).

A shared care model is also being developed in Queensland under the General Practice and Psychiatric Partnerships (GPAPP) project. This project commenced in July 1999 and is expected to be completed in July 2003. The appropriateness indicator, the proportion of GPs having shared care arrangements with specialist mental health services, attempts to measure the extent of this involvement. Priority

will be given to developing this indicator to reflect the directives and aims of the Second National Mental Health Plan.

Improving reporting on Aboriginal and Torres Strait Islander peoples' access to mainstream services

In May 1997, the Prime Minister requested that the Steering Committee give priority to developing indicators that measured the performance of mainstream services in meeting the needs of Indigenous Australians. This is an important task, but large gaps remain. The availability and coverage of nationally consistent data on the provision of services to Indigenous clients will increase in future Reports.

A number of reports have contributed to the identification of the mental health needs of the Aboriginal and Torres Strait Islander communities. They include the Royal Commission into Aboriginal Deaths in Custody 1988, the Report of the Human Rights and Equal Opportunities Commission Inquiry into Human Rights and Mental Illness 1993, and the National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health 1995. There is an acknowledgment of the holistic concept of health held by Aboriginal and Torres Strait Islander communities (NACCHO 1997):

Not just the physical well-being of the individual but the social, emotional, spiritual and cultural well-being of the whole community ... Health services should strive to achieve the state where every individual can achieve their full potential as human beings ...

There is also recognition of the complexity and breadth of issues that contribute to the psychological wellbeing and mental health of individuals, and their significance in the development of culturally appropriate and effective treatment models and programs. The Second National Mental Health Plan seeks to identify better ways of meeting the mental health needs of Indigenous people, people from culturally and linguistically diverse backgrounds, and those living in rural and remote areas.

Only limited national statistics are available on the mental health status of Indigenous people. Investigations have shown that loss, separation and traumatic experiences for Indigenous peoples significantly contribute to psychosocial morbidity. Trauma, grief and loss have affected the physical as well as mental health of Indigenous people, yet no data are available to quantify the extent and role of this impact. Studies have shown that these risk factors are key variables contributing to the high levels of psychiatric disorder found in Indigenous communities, particularly to a high frequency of depression (Swan and Raphael 1995). The high rate of entry into the criminal and juvenile justice system for Indigenous peoples is also a risk factor.

Improving the measurement of unit costs

The Steering Committee is working to improve estimates of unit costs by introducing a more consistent treatment of:

- superannuation costs (see SCRCSSP 1998);
- payroll tax (see SCRCSSP 1999); and
- depreciation and the user cost of capital.

Accounting for these should improve the comparability and accuracy of unit cost information in future Reports.

Little accurate cost data are available for reporting the efficiency of mental health services, particularly services provided outside hospitals. Funding for these services is generally based on historic cost or input based funding methods which hardly allow for differences in the illness and/or severity of clients. Further, these funding methods do not provide strong financial incentives for efficiency, quality, improved consumer outcomes or substitution between different service types.

The framework for public hospitals includes cost per case mix adjusted separation as an efficiency indicator, which accounts for the differences in patient mix across operators. Each case mix class groups patients with clinical similarities and resource use similarities.

The main classification system used in Australia is the AN-DRG model. However, AN-DRGs do not accurately predict the cost of treating different people with mental illnesses. Further, they were developed for classifying acute inpatient episodes and therefore may provide perverse incentives to substitute inpatient care for community based care.

The Mental Health Classification and Service Costs (MH-CASC) project was a major service utilisation study conducted under the National Mental Health Strategy. The project commenced in 1995 and continued over three years. The aims of the project were to determine whether clinical factors predict service costs and to develop the first version of a national case mix classification (with associated cost weights) for specialist mental health services that:

- can be used to classify mental health patients in the various treatment settings;
- has sensible clinical groupings; and
- relies on information generated for clinical purposes.

The project developed an episode classification for inpatient and community health care. The recommended first version of the classification system includes 42 patient

classes — 19 for community episodes and 23 for inpatient episodes. The classification may be used for management information and funding purposes (Buckingham *et al.* 1998).

Under the National Information Priorities and Strategies, which is part of the Second National Mental Health Plan, further development and refinement of the mental health case mix classification will be undertaken. This will build on the findings of the MH-CASC project.

Reviewing the indicator framework

The Second National Mental Health Plan incorporates three key themes that form the basis for the plan: promotion/prevention, development of partnerships in service reform, and the quality and effectiveness of service delivery. Under this plan, strategies to implement change in each area and the resulting outcomes have been developed. It is anticipated that in the future priority will be given to developing new indicators which reflect the focus areas of the Second National Mental Health Plan.

Extending the coverage of the Review

A longer term goal of the Review is to extend the health management framework to other health issues, such as the remaining National Health Priority Areas (that is, cardiovascular health, diabetes mellitus, asthma and injury prevention and control). These priorities focus government attention on areas where a concerted effort could achieve significant gains in the health of the nation. A limited number of priority indicators, encompassing the continuum of care (from prevention through to treatment, rehabilitation and palliation) are reported for each area every two years. The first report on injury prevention and control was released in 1998, and reports for cardiovascular health and diabetes mellitus were released in 1999.

6.5 Jurisdictions' comments

This section provides comments from each jurisdiction on the services covered in chapters 4, 5 and 6. Appendix A contains detailed statistics and short profiles on each State and Territory, which may assist in interpreting the performance indicators presented in this chapter. The information covers aspects such as age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (such as aboriginality and ethnicity).

New South Wales Government comments

“ A scan across performance indicator development activities in health reveals the scale of effort currently devoted to these enterprises. Performance indicators are being developed for the Review of Government Services, under the previous National Health Ministers Benchmarking Working Group, for each of the National Health Priority areas (such as cardiovascular health, cancers, diabetes, and mental health) and through the National Mental Health Report. Indicators have been developed for over 20 national strategies such as BreastScreen Australia, the National Tobacco Strategy and the National Alcohol Strategic Plan. Through the Public Health Partnership a public health indicator framework is being developed. Performance indicators are reported through the Australian Health Care Agreement and the Public Health Outcome Funding Agreements. Performance indicators are reported by various State health portfolios (for example see the NSW Hospital Comparison Data Book and the Chief Health Officer's Report at <http://www.health.nsw.gov.au/pubs/>). Outside the public sector many other performance comparison activities are under way for example as an adjunct to accreditation processes.

The breadth of these activities highlights the need for a national framework for performance measurement that delivers meaningful, useful and timely information. To be justified these efforts must contribute to improved policy, management and delivery of health services, and not remain interesting but esoteric exercises. Despite existing efforts there remain concerns that identifying the performance of whole health systems is elusive, and significant gaps remain in areas such as the contribution of the health system to improved health, the quality of services and the performance of important services such as community based services. Some of these concerns lay behind the recent establishment, by Health Ministers, of a National Health Performance Committee. This Committee has commenced its work and will be seeking to develop an appropriate framework during 2000. The Committee will be working closely with the Review and other national processes concerned with performance comparison. NSW Health strongly supports these developments.

The 2000 Report further expands reporting of measures and this is welcomed. This year's report has also been able to further explore issues lying behind the comparisons. The inclusion of waiting times for elective surgery across all jurisdictions comes after a gap of many years. These data suggest Australia is achieving waiting times that exceed the performance of many western countries. However issues of comparability across States remain, particularly in the allocation of 'urgency' categories. The discussion of unit costs for public hospitals demonstrates key issues have yet to be resolved. A key step is to estimate costs for 'acute' patients. NSW aims to provide these estimates for the next report. A challenge for the review is to create a process that leads to improved services, not just interesting comparisons. To meet this challenge the Review needs to consider ways of comparing services below the jurisdiction level, for example comparing peer organisations and services. Information on underlying variation in performance should also be presented.

”

Victorian Government comments

“

Victoria continues to strongly support comparisons of overall performance and key performance indicators between jurisdictions and with the best practitioners worldwide. The increased and broader emphasis on health care services in recent editions of this report is also welcome and reflects the level of government expenditure on these services.

The development of a performance measurement framework for general practice, including indicators of quality, safety and evidence of best practice, is particularly important in a funding environment where outcomes are rewarded and emphasis is placed on quality. Mental health, aged care, palliative care and other chronic illness management are major areas of general practice involvement where *care* is important and *cure* less certain. In the absence of standard measures for assessing the outcomes of general practice there is a risk of focusing on doing what can be counted, and on programs where improvements can be clearly demonstrated, in return for resource investment.

The breast cancer control services overseen by BreastScreen Australia provide an example of a comprehensive mechanism for assessing the effectiveness and efficiency of service delivery at both national and jurisdictional levels. There is an extensive national data collection covering all aspects of the screening service and arrangements are in place for national reporting by State and Territory BreastScreen programs against agreed key performance indicators. State/Territory data are provided for annual national reports, prepared by the AIHW on behalf of the Commonwealth. The purpose of the AIHW reports is to collect and publish critical descriptive data on national program performance. Considerable work is being done to ensure that the data are accurate, valid and comparable both between States/Territories and from year to year.

It is acknowledged that many of the indicators in the health chapters of this report need further development as they often highlight differences in state administrations, funding mechanisms and service provision rather than performance. However, they do provide a useful starting point for further analysis. The recognition of the need for separate unit cost measures for acute, psychiatric and sub-acute admitted patient services provides an example of this and highlights the need for continual development of even the most conceptually simple indicators. For this reason the Review's iterative approach to reporting, publishing imperfect data with caveats and then working to improve quality and comparability, is strongly supported.

Encouragement should also be given for individual service providers to benchmark at a much greater level of detail, and to achieve improvements at the organisational level, as well as for benchmarking between jurisdictions.

”

“

Queensland Government comments

Queensland Health supports enhanced cooperation between the public and private sectors aimed at improving quality, efficiency and accessibility to health services. For example, the General Practitioners Integration Project will improve integration of care between public hospital services and the broader health and community care services, particularly the general practice sector. Another example is the establishment of a number of collocated public and private hospitals including at Caboolture, Gladstone, The Prince Charles Hospital, Logan and Redland Hospital. Two Build, Own, Operate and Transfer hospital projects have also been initiated at Noosa and Robina.

Better integration of internal resources is also crucial to achieving more efficient and effective service delivery. The Clinical Benchmarking Project will establish an interface between clinical costing software and core feeder systems to support coordinated clinical service reform. The project will integrate feeder systems including finance, payroll, patient admissions, discharge information, patient nurse dependency, theatre, pathology, imaging and pharmacy. This will enhance planning, performance management and budgeting.

Queensland Health has developed the Queensland BreastScreen Register and the Queensland Pap Smear Register during 1998-99, providing central repositories for screening information. The registers improve services to Queensland women by identifying women who are unscreened, and groups of women who are under-screened to allow more effective targeting of future educational and promotional strategies.

An Aboriginal and Torres Strait Islander Health Information Network (linking information from Queensland Health services, Aboriginal and Torres Strait Islander community health services, public health services and non-government health organisation) is being established which will enhance information relevant to the health status of Aboriginal and Torres Strait Islander people. This information will inform the future development of health services.

Queensland is taking steps to improve access to health services through a variety of measures. Access to health services for people living in rural and remote areas will be enhanced through increased use of Telemedicine. Telemedicine has proved very effective in meeting the health needs of rural and remote communities. Access to elective surgery has increased through the adoption of improved processes. Queensland Health has increased admissions for elective surgery by 3.3 per cent and the percentage of patients waiting longer than 30 days for admission was only 1.9 per cent at 1 July 1999 for category 1 patients. This has been achieved by strategies to optimise throughput, targeting long wait complex surgical cases, increasing day only surgery use, theatre utilisation and liaison with general practitioners. Additionally, waiting lists are published each quarter for 95 per cent of the State's elective surgery by hospital, category and specialty.

”

“

Western Australian Government comments

Within the constraints of limited resources, WA continues to pursue innovations in health service delivery that would maximise the value of the health dollar for the community.

The State launched a health call centre named HealthDirect in May 1999. This service gives the community a 24-hour a day, seven-day a week point of contact for assistance with health concerns. HealthDirect provides advice on the most appropriate way to deal with a health problem when the caller is unable to contact his or her own GP. After three months of operation, call volumes levelled out at approximately 3000 calls a week with the busiest periods being from 5:00pm to 11:00pm and the busiest days being the weekends.

A number of issue-specific initiatives were introduced to the community. To address the need to move from a concentration on a clinical model of maternity care, for example, a consumer information booklet titled *Your Birthing Choice* was produced and distributed through GP Divisions, the Australian College of Midwives and Health Services, the State Library and similar networks. In recognition of Western Australia's low donation rates, DonateWest was established to maximise donation rates and ensure positive outcomes for donor families and recipients. This agency provides a statewide framework for policy and practice to lift donation rates and increase community awareness about the importance of donation. The Universal Neonatal Hearing Screening Program was launched to detect hearing loss in the first three months of life. This early diagnosis and intervention has been demonstrated to make significant differences in outcomes for affected children.

Certain projects that were commenced in recent years have made significant gains. The renal dialysis program has been substantially expanded in the past four years with the addition of nine new services including an in-centre facility at Fremantle Hospital and several metropolitan and rural satellite services. In 1999-00 five new satellite services were planned including two in the northwest to provide an opportunity for repatriation of patients who had been forced to move to Perth for treatment. Innovative service delivery models are being explored including community-based dialysis and the involvement of private providers. In response to continuing issues with waiting lists, the Central Wait List Bureau was established in 1998. In its first 12 months of operation elective surgery waiting lists were reduced by 26 per cent through a combination of audits and of fast tracking patient procedures through service coordination. The Bureau is currently working with GP divisions to conduct clinical reviews of existing lists.

WA continues to develop the output based model of care delivery with a framework that supports policies of care closer to home, value for money and innovative service models. Its efforts at achieving allocative efficiency are articulated in its purchasing intentions and provider arrangements.

”

“

South Australian Government comments

The SA Department of Human Services continues to provide a quality public health service within the constraints of cost pressures and increasing demand. These ongoing pressures result from a number of factors including developments in technology and the ageing of the population. A continuing important element of demand is that arising from the increasing numbers of people in SA dependent on government income support (for example, the unemployed, single parents) who, along with the elderly, are among the largest users of the public health system.

Despite these pressures the SA public hospital system is still one of the most technically efficient (as measured by the cost per casemix-adjusted separation). The department has maintained its efforts to ensure that appropriate health care is provided to all who need it. SA has for many years had a strong community service sector, in both the health and welfare fields. The department is actively undertaking further development of integrated and coordinated service provision across all three portfolio areas of health, housing and community services.

The department has released a Strategic Plan for the Human Services portfolio for the period 1999 – 2002. This Strategic Plan includes commitments to:

- improve service outcomes through the adoption of continuous improvement and best practice processes by promoting evidence based decision making and reviewing and further trialing coordinated care,
- improve outcomes for those who receive hospital treatment by benchmarking services for best practice,
- improve the response of mainstream services to meet the needs of Indigenous people,
- improve the range and mix of services available to people with mental health needs ranging from mental health promotion and illness prevention to long term support for people with an on-going psychiatric disability, and
- an increase in the levels of community- based mental health services.

The department supports the development of performance indicators across the broader (non-hospital) health sector based on nationally agreed data definitions.

”

“

Tasmanian Government comments

In seeking to expand the focus on 'health gain' at all levels of treatment and care in the public health system, Tasmania is continuing to develop performance and quality measurement frameworks to support the collection of data and to inform decisions about the efficacy of existing service outputs.

Over the past year Tasmania has conducted the most comprehensive public health assessment ever undertaken in the state. The *Healthy Communities Survey* was sent to over 25 000 Tasmanians in November 1998 and a first analysis was published in August of this year. As a document indicating how Tasmanians assess their own health, it reveals, for example, that four out of five assess their health as good and that there is little difference in health status between men and women or between people in urban and non-urban areas.

As noted in previous reports, Tasmania supports the continued reporting and publication of information to inform governments and the public about performance in the public health sector. Care should be taken, however, in comparing data between jurisdictions because of differences in how health services are managed. It should be noted that the comparatively high number of private hospital beds in Tasmania can influence *the representation* of performance in the public hospital sector as a percentage of total population when compared with other jurisdictions. Tasmania's small population, particularly in relation to the usage of some services, also makes it prone to statistical fluctuation from year to year.

Tasmania continues to be characterised by a highly regionalised low level population base. The relative social and economic disadvantage of the population generally, statistically low health status, rising community expectations about ready access to high quality (and expensive) medical treatment, and isolation all contribute to the costs of service provision in Tasmania being higher than in other larger jurisdictions.

While some pressure on the public health system has been partially alleviated by a significant one-off budget allocation in 1999 and an increased recurrent commitment by the State Government to the Department of Health and Human Services, it will be some time before the positive impacts on service provision are reflected in performance reporting.

In terms of quality, Tasmania's public health system is highly rated, with all three major hospitals having gained full accreditation from the *Australian Council on Health Care Standards* and many other services working towards assessment and accreditation against national standards programs.

”

“

Australian Capital Territory Government comments

The ACT has entered its fourth year of operation under a purchaser-provider arrangement. The purchase of services in the acute care sector is on the basis of price, volume and quality and these are defined in purchase agreements between the Department of Health and Community Care and the two public hospitals. The Territory currently funds public hospital activity using a case mix based funding model.

Most national benchmarking studies examining the factors contributing to the costs of the public hospital system show that the ACT has a high cost system. The causes of these higher costs are the result of a number of different factors including local ACT factors and policy decisions (or opportunity costs) and higher cost structures for example the high cost of Visiting Medical Officers. The Government is concerned about the high costs and is committed to developing strategies to bring these costs more in line with national benchmarks.

Since 1995-96 there has been an increase in the number of separations and cost weighted separations produced in the ACT public hospital system. Also, the average acuity of these separations has been increasing. This reflects Government policy in a number of areas including the introduction of bone marrow transplants and cardio-thoracic surgery, the development of a clinical school and development of a regional teaching and referral role for the ACT. This trend towards increasing acuity and throughput presents a significant challenge to the ACT public hospital system.

In October 1998 the ACT Government released its *Setting the Agenda* document to guide the Department of Health and Community Care in determining and implementing the future directions of the provision of health care in the ACT. The document's objectives include reforming the hospital system by focusing hospital services on essential acute services and continually reviewing services with a view to, where clinically appropriate, shifting services to a stronger community based primary care sector. The first step in the process of moving functions to the community has occurred with the transfer of the allied health areas of The Canberra Hospital to ACT Community Care.

The ACT continues to support the comparative reporting of data across jurisdictions where it can provide meaningful indicators of the performance of the public hospital system. Care needs to be exercised in the interpretation of the comparative data because of factors such as the differences in state administration, funding models and service provision.

”

“

Northern Territory Government comments

There are five public hospitals in the Northern Territory (NT) located in Darwin, Alice Springs, Nhulunbuy (Gove), Katherine and Tennant Creek. The only private hospital in the Territory is located in Darwin. The combined hospital bed numbers are 721.

The NT has unique demographic features, which augment the challenges government faces in contributing to the wellbeing of Territorians. Our scattered population represents 1 per cent of Australians living in 17 per cent of the land area. Aboriginal people have the highest impact on demand for health services, and comprise 28 per cent of the population but account for 43.9 per cent of hospital separations.

The demographics and the high number of Aboriginal people using health services feed into high morbidity rates and greater proportion of separations than other states.

Waiting times for elective surgery in part are due to the number of public and private facilities available in the NT compared to other states, as well as the availability of specialist services. Specialist services have been expanded, and combined with new technology to reduce waiting times and the number of people travelling interstate for certain types of treatment. Data on emergency department waiting times will be included in the next edition.

Hospitals which are not accredited or booked for survey are preparing intended plans to meet accreditation requirements. The hospitals are also reporting on a broad range of clinical indicators and to that end, resolving issues of data collection and validation such is evident in the reported unplanned re-admission rate. The proportion of same day and not same day care includes gynaecological and endoscopic procedures, which in other states are more likely to be outpatient or privately sourced work.

The NT boasts a highly integrated approach to primary health care, preventive strategies and a commitment to strengthen community capacity. Although breast cancer control strategies and the management of mental illness are targeted in this edition, the interactions between community based services and hospitals are a focus in the NT. The Territory has also pioneered Australia's first fully integrated Community Care Information System to track client and health progress across the continuum of community and tertiary health care. An example of the interactions are the Coordinated Care Trials conducted in the Tiwi Islands and Katherine West.

”

