

Reflecting on Results

Review of the Public Health
System's Performance for 2008-2010

December 2010

Health Performance Council



Government
of South Australia

Health Performance Council

Reflecting on Results

- Review of the Public Health System's Performance for 2008-2010

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Foreword

In 2008, the South Australian Government established the Health Performance Council (HPC) to independently monitor the performance of the health system.

The health system is large and complicated. Funded by Australian, State and Local Governments, community organisations and patients, it intersects with and depends on the work of other sectors including housing, employment, education and community services. The health system is influenced by the peculiar geography and demography of South Australia, coupled with the aspirations of the community and those within the health system to have services delivered close to where people live.

Our first report reviews the performance of the public health system over the period 2008-2010. From 2014, we will report every four years on performance across the entire health system.

The review scope was also limited to focus on the strategic directions of the *South Australian Health Strategic Plan 2008-2010* (SAHSP) and considered:

- > What did SA Health say it would achieve?
- > What has been achieved, and how is this evident?

In making comments and drawing conclusions, we have been mindful that the SA public health care system is a valued, well-established and complex entity, with thousands of dedicated people serving a diversity of health needs of South Australians. The general health of the South Australian population compares favourably with the rest of Australia and many other countries. Both life expectancy and the length of life lived in good health, are increasing.

SA Health is undertaking a major reform process and there has been significant activity across the whole system to support the achievement of its strategic objectives. These reform initiatives are being implemented in a challenging context of increasing demand for services, health workforce shortages, efficiency reviews, regional governance restructures and the emerging national health care reforms. The HPC accepts that in many instances it is too early to judge progress; however, it will work with SA Health to ensure performance review mechanisms are in place to allow for ongoing tracking of progress and outcomes.

We believe that the envisaged reforms have the potential to significantly change the pattern of service delivery and benefit South Australians. With this in mind, it is important to understand in clear terms how the reform process is progressing. In this context, the HPC intends to work closely with SA Health to ensure a direct link between the collection and analysis of data and service improvements that demonstrate an improved system of care, an alignment between planning and implementation, and the evaluation of achievements.

Finally, we observed the need for more extensive and responsive health system engagement with community stakeholders to support an increasing focus on consumer experiences, including populations with specific needs.

We acknowledge the HPC Secretariat for its highly professional and dedicated work and its outstanding support to the Council.

We also appreciate the cooperation of SA Health during all stages of the review process. We observed system improvements, which were the result of our review process, and this was a positive outcome. Over the next four years, we will continue working with the health care sector and South Australians to improve the health system's accountability in delivering health care outcomes for all. We will have succeeded when our analysis, supported by sound evidence, provokes constructive debate and provides added momentum for improvement and celebration of hard won achievements.

Anne Dunn

Chairperson Health Performance Council

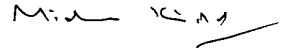
The Health Performance Council members have confirmed their commitment to this report as follows:

Signed for and on behalf of the HPC by



Ms Anne Dunn AM
Chair
31/12/2010

Signed for and on behalf of the HPC by



Professor Michael Kidd AM
Member
31/12/2010

Signed for and on behalf of the HPC by



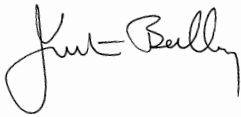
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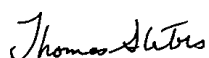


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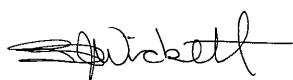


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Health Performance Council

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Secretariat	Ms Barbara Power – Director Ms Marcela Perez – Senior Project Officer Ms Julie Edwards – Administration Officer Mr Ian Brownwood – Principal Consultant, Performance Management, SA Health (seconded April to September 2010)

Review Terms of Reference

The Health Performance Council's review of the SA public health system was undertaken in accordance with its mandate under the *Health Care Act 2008*. Part 3, Section 11 of the Act, specifies that:

- (1) The functions of HPC are:
 - (a) to provide advice to the Minister about:
 - (i) the operation of the health system; and
 - (ii) health outcomes for South Australians and, as appropriate, for particular population groups; and
 - (iii) the effectiveness of methods used within the health system to engage communities and individuals in improving their health outcomes; and
 - (b) to provide reports to the Minister in accordance with the requirements of the Act; and
 - (c) to provide advice to the Minister about any matter referred to it by the Minister or any matter it sees fit to advise the Minister about in connection with its responsibilities under the Act; and
 - (d) such other functions assigned to HPC under this or any other Act, or assigned to HPC by the Minister.
- (2) HPC should, in the performance of its functions, seek to obtain, to such extent as is reasonable and relevant in the circumstances, the views of:
 - (a) Health Advisory Councils; and
 - (b) advisory committees established by the Minister to assist HPC in the performance of its functions.
- (3) HPC must, in the performance of its functions, take into account the strategic objectives that have been set or adopted within the Government's health portfolios.
- (4) Without limiting subsection (3), HPC must, in providing any advice with respect to the provision of any health services (including proposed services), take into account:
 - (a) the net benefit provided by the services, the cost effectiveness of services, and available resources; and
 - (b) the net impact that the adoption of the advice would have on other services, or on the community more generally; and
 - (c) the value placed on any relevant services by members of the public who use those services.
- (5) The Minister must establish arrangements to meet with HPC on a regular basis.
- (6) HPC cannot, in the performance of its functions, give directions to the Chief Executive, the Department, a hospital or a HAC.
- (7) HPC may request the Chief Executive to provide it with specified information in order to assist it in the performance of its functions.
- (8) The Chief Executive may impose conditions that HPC must observe in relation to the receipt, use or disclosure of information provided under subsection (7).

Part 4, Section 13 outlines the content of the four-yearly reports as follows:

- (1) HPC must, on a four-yearly basis, furnish to the Minister a report that assesses the health of South Australians and changes in health outcomes over the reporting period.
- (2) This report must:
 - (a) identify significant trends in the health status of South Australians and consider future priorities for the health system having regard to trends in health outcomes, including trends that relate to particular illnesses or population groups; and
 - (b) review the performance of the various health systems established within the State in achieving the objects of the Act; and
 - (c) identify any other significant issues considered relevant by HPC; and
 - (d) conform with any requirements of the Minister as to the form of the report and other matters to be addressed by the report.
- (3) The Minister must, within 12 sitting days after receipt of a report under this section, cause a copy of the report to be laid before both Houses of Parliament.
- (4) The Minister must, within six months after receipt of a report under this section, cause a formal response to the report to be laid before both Houses of Parliament.
- (5) The first report under this section must be completed by a day to be fixed by the regulations.

*NB. The date set for the first report was the **31 December 2010**.*

Executive Summary

Reflecting on Results is the inaugural Health Performance Council (HPC) 2010 report to the South Australian Minister for Health and the Parliament. This report outlines and comments on the recent performance of the public health care system managed by SA Health.

The HPC was established in 2008 by the South Australian Government to independently monitor the health system's performance and thereby provide greater public accountability and support to maintain a quality health care system.

This report is the culmination of the HPC's discussion, targeted consultation, research and deliberation on the evidence provided by SA Health and key stakeholders. From 2014, the HPC expects to report every four years on both the public and private sectors of the health system.

For its first report the HPC reviewed key aspects of SA Health's performance from 2008-2010. The review focused on the *SA Health Strategic Plan 2008-2010* (SAHSP), which explicitly states that this is SA Health's public statement on where they are headed and what people can expect from them.

During 2008-2010, SA Health committed to:

- > Strengthen primary health care
- > Enhance hospital care
- > Reform mental health care
- > Improve the health of Aboriginal people.

In undertaking its review, the HPC became aware of many valuable and essential health services and functions undertaken by SA Health that were not specifically in the SAHSP and were therefore outside the review scope. For example during 2009-10:

- > 169 788 courses of dental care were commenced by SA Dental Service
- > 5 513 207 tests were performed by SA Pathology
- > 19 575 women gave birth to 19 872 babies
- > 1 468 231 doses of vaccine for childhood, adolescent and adult vaccination programs were distributed
- > SA Ambulance Service responded to an average of 733 incidents every day.

This report details the HPC findings on how SA Health is meeting the key objectives and targets it has set within its strategic directions to improve health outcomes for South Australians.

The HPC was able to obtain and analyse sufficient evidence to complete this initial review. Specific findings for each of the objectives are described at the end of this executive summary. In reflecting on the overall results of the review, the HPC makes the following points:

There are good results in many areas...

1. The majority of South Australians are living longer in good health

The general health of the South Australian population compares favourably with the rest of Australia and many other countries. Both life expectancy and the length of life lived in good health, are increasing.

While the health of South Australians is improving, significant areas of premature and chronic disease, injury and mortality remain in the community. Considerable disparities in health status persist across population groups, particularly Aboriginal people. Chronic conditions including asthma, chronic obstructive pulmonary disease, renal disease, diabetes and heart failure are creating increasing health burdens in the community and present major challenges for the health system.

As it is estimated that nearly a third of all causes of deaths in Australia are amenable to health care interventions, there is clearly further scope for the health system to generate improvements in the health status of South Australians.

2. The SA health system is changing to meet future health needs

SA Health is continuously improving the public health system to respond to future health care needs. While the SA public health system has much strength, like other health systems worldwide, it is under pressure to respond to increasing demands arising from significant demographic, cultural, economic and social changes as well as changes in health care delivery and technology.

SA Health is tackling these challenges by undertaking major reforms to the health system. During 2008-2010, there has been significant activity across the whole system to support the achievement of these strategic objectives. These reform initiatives are being implemented in the challenging context of increasing demand for services, health workforce shortages, efficiency reviews, regional governance restructures and the emerging national health care reforms.

In addition to the SAHSP, four other documents define key elements of the SA Health reform approach: *South Australia's Health Care Plan 2007-2016 (SAHCP)*, *GP Plus Health Care Strategy 2007 (GP Plus)*, *the Strategy for Planning Country Health Services in SA* and *the Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012 Report (Stepping Up)*.

3. SA Health is making progress in improving services to the SA community

On any day in 2009-10, on average 1049 people were admitted to public hospitals, 1515 people were treated in accident and emergency departments, while 5412 people were seen in outpatient clinics. Against this backdrop of increasing activity, SA Health has undertaken the following service improvements. It has:

- > Strengthened its focus on health protection and promotion through its efforts in tackling health risk factors as early as possible, and improving the services outside the hospital setting
- > Increased avenues for illness prevention and early intervention that improve early childhood health outcomes by targeting risk factors in pregnant women
- > Developed new models of mental health care in line with Social Inclusion *Stepping Up* recommendations
- > Worked to improve the safety culture and monitored adverse events within the public hospital system
- > Invested in capital projects to improve hospital and health service infrastructure.

4. Health services in the community are taking shape

There is evidence of substantial activity and commitment in the development of a wide range of plans, strategies and programs to strengthen primary health care. SA Health has taken a strategic approach in concentrating its focus on major health risk factors and chronic disease management to provide continuity of care within the system, thereby achieving alignment with the *South Australia's Strategic Plan 2007 (SASP)* targets. SA Health's efforts to strengthen primary health care rely heavily on *GP Plus*. This is seen as a 'linchpin' in the development of a better-integrated and responsive health system that aims to reduce the need for hospitalisation, increase client self-management and improve health outcomes.

Some new programs are in the early stages of implementation and have not yet demonstrated significant health outcomes or system improvements, including linkages across primary health care and other parts of the system.

The total public hospital separations (metropolitan and country hospitals) were up 2.27% in 2009-10, which is just over the statewide target of holding growth to 2%. This is comparable with an average annual increase of 3.5% for the previous three years. SA Health attributes this result to the impact some *GP Plus* programs are having in reducing hospital separations across a number of service areas for some selected conditions.

SA Health has demonstrated a commitment to achieving mental health reform with its infrastructure programs and the introduction of a recovery focused stepped model of care that seeks to strengthen community care and support.

5. A strong focus on maintaining a sustainable and safe hospital sector

SA Health is focused on achieving greater sustainability in the delivery of health services. It has made specific progress with improved access to elective surgery, emergency care and reduced length of stay in acute care.

There have also been significant efforts to enhance hospital care through capital infrastructure programs such as the planned new Royal Adelaide Hospital and Glenside projects, and new consumer focused models of care. Other initiatives focused on strengthening the safety and quality of services, and workforce reform.

SA Health has focused on measuring safety and activity in the hospital sector. Whilst this is important, the perspectives and experiences of consumers are equally important in determining the impact and quality of health care services.

...While achieving results in other areas remains a challenge

It would appear there is less focus on developing incentives to improve service delivery through reflection on measured patient outcomes or processes of clinical care. The HPC considers that the systematic collection and analysis of client data and information on the client/patient's experience and quality of care outcomes in the health system are not well developed.

6. A greater focus on continuity of care needed

Continuity of care is a challenge that all Australian health care systems are dealing with. An efficient and effective health system needs to create a model of integrated care if optimum health outcomes are to be achieved in an efficient manner. The lack of integration and communication with providers, within and across services in both the public and private sectors, has resulted in service gaps, duplication and delays in care. Service efficiency, safety and consumer satisfaction are all at risk of compromise.

The HPC notes that there are some early signs that hospitalisation for some chronic conditions is decreasing (for example, diabetes complications) suggesting continuity of care might be improving for people with these conditions.

Whilst individual episodes of care might generally be well handled, it is at points of clinical handover and at interfaces with different services in the system, that continuity of care is not monitored well. The HPC found information technology connectivity was underdeveloped, and stakeholder feedback suggested that effective communication was regularly hampered by delays in transfer of information.

7. Inadequate alignment between strategic intent and performance monitoring

A strong performance reporting and review culture at the executive level is noted. However, the HPC found that the majority of performance measures reviewed at this level were more focused on activity and outputs, rather than the effectiveness and outcomes of the system.

In addition, the HPC considers that the existing measures are not well aligned with the strategic intent of SA Health. This made it difficult to obtain relevant data and information that demonstrated progress attributable to the strategic intent of SAHSP during the timeframe under review.

The HPC found an indirect connection between the long-term targets established under the SAHSP and the operational targets routinely monitored.

The amount of available data is significant but is not sufficient for determining the quality of health care outcomes.

The development of performance measures that demonstrate effectiveness and system outcomes is challenging, however in the HPC's view, this is essential to the achievement of greater public accountability and system improvement.

8. More dynamic community relationships needed

SA Health has established Health Advisory Councils in country regions and continues to support the Health Consumers Alliance. The Chief Executive meets regularly with key stakeholders and there are examples of individual regions, units and services having implemented community engagement processes.

However, there was limited evidence of SA Health developing an overall strategic approach to its relationships with key stakeholders, community organisations and consumers.

While the release of the Consumer and Community Participation Guideline and Policy in late 2009 is a positive step, it is important that implementation be regularly monitored as part of the overall evaluation of its effectiveness in achieving improved public participation. Achievement of planned health reforms (including those focused on 'at risk' populations) will require effective community engagement by SA Health in service development, delivery and evaluation.

9. 'One size does not fit all' for South Australia's diverse population

South Australia has a diverse population with a range of health care needs. SA Health is progressively implementing statewide clinical service plans that include specific strategies to meet the different health care needs of diverse populations within SA.

This is a positive development, as information provided by some stakeholders suggests that SA Health's services have not been adequately responsive to the differing needs of particular population groups. They include individuals from low socioeconomic backgrounds, culturally and linguistically diverse (CALD) communities, refugees, people with disabilities, people living in remote and rural communities, the aged, individuals with mental health illnesses and Aboriginal people.

SA Health's 2008-2010 performance target of improving Aboriginal health lacked an effective plan; hence, implementation appeared spasmodic and was devoid of evidence relating to evaluation and significant achievements. The HPC views the release in November 2010 of the *Aboriginal Health Care Plan 2010-2016* (AHCP) as a promising development.

Aboriginal health outcomes remain unacceptable and there is limited access to services perceived by Aboriginal people to be culturally appropriate and relevant to their needs. While there were some encouraging instances of program successes, the overall achievement of improved health outcomes for Aboriginal people was not demonstrated.

SA Health has indicated that it expects its involvement in the *National Indigenous Reform Agreement (Closing the Gap)* partnerships to deliver improvements in the future.

There is also need for additional focus on addressing mental health issues for young people, CALD communities, refugees and Aboriginal people, if significant health outcomes are to be achieved.

During the next four years the HPC expects to see a strong, coordinated system for mental health care established that implements the *Stepping Up* principles for all people with mental illness.

There was some evidence that SA Health has been developing statewide clinical service plans for specific health conditions designed to be more responsive to the needs of the specific populations mentioned earlier.

Next Steps

Over the next four years, the HPC will actively build on this baseline review and the lessons learnt from ongoing analysis.

The most important priority for the HPC, in its role as special adviser to the Minister for Health is the usefulness of its reports in contributing to improvements in the health system and health outcomes for South Australians.

The HPC will continue to refine its review processes so that it provides robust and coherent evidence based analysis of the health system's performance to South Australians every four years.

Summary of Findings

Strengthen Primary Health Care

Focus on health protection and promotion (Objective 1.1)

1. SA Health has strengthened its focus on health protection and promotion through its efforts in tackling health risk factors as early as possible and improving services provided outside the hospital setting. The HPC notes the ongoing monitoring of many of these initiatives and acknowledges SA Health has plans to evaluate their impact on population health outcomes.

Provide effective avenues for prevention and early intervention (Objective 1.2)

2. SA Health has increased avenues for illness prevention and early intervention that improve early childhood health outcomes by targeting risk factors in pregnant women through the Universal Contact Visit and Family Home Visiting Programs. Whilst significant efforts have been noted, it is too early to determine the effectiveness of these programs in producing improved health outcomes.

Facilitate effective coordination and continuity of care (Objective 1.3)

3. Although a variety of programs are operating across the health system to improve continuity of care, particularly for those suffering from a chronic disease, the HPC considers performance measures currently available to assess performance in this area to be insufficient. A greater focus on measuring patient experiences across the continuum of care is needed.

Minimise the burden of disease on the health system (Objective 1.4)

4. The investment in *GP Plus* strategies over the last three years represents a significant commitment to strengthening primary health care in South Australia. Sound evaluation of these strategies will be required.
5. There are signs and early trends that some of the *GP Plus* strategies are having an impact on service utilisation for selected chronic conditions, with preliminary evidence that they are reducing pressure on the public hospital system.

Provide appropriate services closer to where people live (Objective 1.5)

6. While the development of hospital networks, Intermediate Care Centres for mental health clients, *GP Plus* centres and related services and programs are progressively strengthening services in metropolitan areas, planned service developments in rural and remote communities are in their formative stages and not ready for evaluation at this point.

Enhance Hospital Care

Provide a coordinated hospital system across metropolitan and country regions (Objective 2.1)

7. Initial steps have been taken toward the planned clinical service reconfiguration across the hospital system, with a number of the remaining changes dependent on future capital developments. The Statewide Clinical Networks offer significant potential for clinical service improvements and enhanced collaboration; however, some are still in their formative stages.
8. Although ongoing efforts to improve continuity of care across and within health services are noted, their overall effectiveness is not demonstrated at this stage. The timely transfer of client/patient information requires greater rigour, as consulted stakeholders indicated that information was not provided when required, which affected the ability to provide optimal care. A strategic review of information exchange at points of clinical handover would be valuable.

Improve health outcomes and safety and quality for people in hospital care (Objective 2.2)

9. While substantial work is underway to improve the safety culture and to monitor adverse events within the public hospital system, further work to both understand and improve patient experiences and clinical effectiveness of in hospital and out of hospital care is indicated.
10. Structural incentives to improve hospital service quality, based on measured patient outcomes or processes of clinical care, were not clearly demonstrated.

Improve efficiency and effectiveness of hospital care (Objective 2.3)

11. The focus on improved efficiency has resulted in SA Health having the lowest *Cost per Casemix-Adjusted Separation* in Australia. In part, this is attributable to reduced lengths of stay and increased day of surgery rates. This significant achievement does however require evaluation in the context of relatively high public hospital bed utilisation and out of hospital care provided by carers.
12. Continued efforts to improve effectiveness were difficult to assess, particularly in relation to the quality of care and patients' outcomes for priority population groups.

Reduce dependency on hospitals (Objective 2.4)

13. The evidence suggests a containment of demand escalation and more appropriate treatment outcomes, significantly in access to primary health care and out of hospital services. However, it is important that in the face of escalating demand for hospital services, investment continue in primary health care and out of hospital services, notwithstanding the long lead times for demonstrable success.

Provide an attractive learning environment for health professionals (Objective 2.5)

14. There is evidence that alignment of workforce development with health care reforms has commenced with the introduction of new roles (for example, nurse practitioner, allied health assistant and physician assistant) now underway.
15. While significant improvements in professional development opportunities for hospital medical staff are noted, indications of providing similar opportunities to nursing and allied health staff are less apparent.
16. The development of a new medical research facility should further strengthen overall research in South Australia.

Reform Mental Health Care

Provide integrated services to mental health clients in community, residential and hospital settings (Objective 3.1)

17. New models of care were developed in line with *Stepping Up* recommendations. Plans to establish community mental health centres as hubs for mental health integration are progressing with the aim of improving access to appropriate care.
18. It is unclear how SA Health plans to measure and evaluate the system wide access improvements and delivery of recovery outcomes achieved because of implementing integration strategies.

Improve access to appropriate care at an early stage (Objective 3.2)

19. The information provided by SA Health underpins the priority given to early identification and provision of services particularly in relation to young people and people in aged care. There is evidence to indicate a priority focus on improving capacity for country services to manage the broad spectrum of mental health presentations locally. These are in line with the *Stepping Up* recommendations and the focus of SAHSP.

Improve mental health services through better systems of care (Objective 3.3)

20. Many activities were developed to improve systems of care, and in some cases, these were implemented. However, it is difficult at this early stage to assess the impact of these initiatives. The focus thus far has been on capital infrastructure development and the HPC received minimal evidence to indicate access to services for consumers and carers has improved.

Improve inter-agency coordination of service delivery to people with a mental illness who have high needs (Objective 3.4)

21. Based on the information provided, it is difficult to assess how current inter-agency coordination initiatives have affected clients, in particular those with complex and chronic needs.

Increase community understanding of mental health (Objective 3.5)

22. It is not clear how the outcomes of mental health promotional programs are assessed, particularly the objective of stigma reduction. However, the HPC noted positive community feedback on SA Health's efforts to build community knowledge and skills regarding a number of mental health conditions.

Improve the Health of Aboriginal People

Reduce Aboriginal ill health (Objective 4.1)

23. Reducing the health outcomes gap in mental illness, injury, diabetes, renal and heart disease remains a significant challenge for the health system.
24. SA Health's 2008-2010 performance lacked an effective strategic planning and evaluation focus; therefore, implementation appeared spasmodic, lacked evidence of evaluation and significant achievements.
25. Although ongoing efforts to reduce Aboriginal ill health were noted, their overall effectiveness is unclear at this stage.

Develop culturally responsive health system (Objective 4.2)

26. Community engagement is sporadic. More effort is required to achieve a culturally responsive service connected to Aboriginal communities and their health and wellbeing organisations.
27. Efforts were made to increase the cultural competence of the workforce, but outcomes are unclear and more needs to be done to ensure competence levels are achieved and maintained across the workforce.
28. Although there is evidence of some performance monitoring a more robust suite of key strategic performance measures relating to improving Aboriginal health are required.

Promote Aboriginal community health and wellbeing (Objective 4.3)

29. SA Health is actively engaged in a whole of government (COAG) response to reduce the health outcomes gap by 2031.
30. The main focus has been on a healthy start to life for children, with a secondary focus on reducing risk factors and improving chronic disease management for adults.

Community Engagement

31. The release of SA Health's Consumer and Community Participation Guideline and Policy in late 2009 marked a positive step towards increasing system wide public participation in health. To-date, SA Health's pursuit of community engagement as a core method of achieving all four strategic directions has not been robust or effective.
32. Stakeholders involved in engagement activities reported limited access to relevant information and data on how the system reviews and improves its services and systems.
33. There are examples of individual regions, units and services that have implemented community and stakeholder engagement processes. There is little evidence of SA Health developing an overall strategic approach to its relationships with community organisations and others, for the purpose of achieving its goals and demonstrating its accountability.
34. SA Health's support for the Health Consumers Alliance is acknowledged, but is insufficient. Representation is only one part of and one indicator of engagement. It is possible to have substantial representation and limited engagement. Engagement does not appear to be a core enabler for health.

Introduction

The Health Performance Council

The Health Performance Council (HPC) was established in July 2008 under the *Health Care Act 2008* to provide increased public accountability of the health system's performance.¹ With its formation, South Australia became the first state in Australia with an independent body that regularly reviews the performance of its health system.

The role of the HPC is to undertake, on a four-yearly basis, a performance review of South Australia's health system to provide independent advice to the Minister for Health. The reporting process involves periodically reviewing the performance of the sectors involved in the provision of health services, whilst taking into account the strategic objectives that have been set or adopted within the Government's health portfolios. The report's overall aim is to identify significant trends, health outcomes and future priorities for South Australia's health system.

The South Australian Health System

South Australia's health system comprises a mix of public, private, and non-government sector providers that work independently and collaboratively at a national or state capacity, for the achievement of health outcomes. The services provided to individuals across the health care continuum range from health protection and promotion through to end of life care, within diverse settings, geographical locations and service delivery models.

The health system is supported by other agencies (for example, research and central statistical agencies, consumer, volunteer and advocacy groups, professional organisations and educational and training institutions) and other organisations that contribute to the broader health and wellbeing agenda.

Over the past few years, there has been significant reform activity across the whole system. These reform initiatives are being implemented in a challenging context of increasing demand for services, health workforce shortages, efficiency reviews, regional governance restructures and the emerging national health care reforms.² For example, from 1 July 2010 the Central Northern Adelaide Health Service (CNAHS) and Southern Adelaide Health Service (SAHS) were amalgamated to form the Adelaide Health Service.

Review Scope

For its first report the HPC reviewed key aspects of SA Health's performance from 2008-2010. The review scope was limited to the priorities within the *SA Health Strategic Plan 2008-2010* (SAHSP) which explicitly states that this is SA Health's public statement on where they are headed and what people can expect from them.³

During 2008-2010, SA Health committed to:

- > Strengthen primary health care
- > Enhance hospital care
- > Reform mental health care
- > Improve the health of Aboriginal people.

This report details the HPC findings on how SA Health is meeting the key objectives and targets it has set itself within these strategic directions. It does not comment on health services and functions that were not specifically identified in the SAHSP.³

SA Health's overall performance was evaluated in relation to:

- > Its policies and strategies to achieve the South Australian Government's key health outcomes
- > State health system performance measures, standards and benchmarks (SA Health was assessed against its own measures, not new ones established by the HPC)
- > Significant trends, health outcomes and future priorities of importance to the State Government
- > Community and individual engagement strategies and outcomes.

Review Limitations

The HPC did not review the whole public health system functions and services. Many essential SA Health services and functions were not specifically identified in the SAHSP and were therefore outside the review scope.³

The 2010 HPC Report did not include a review of South Australia's private health system.

The HPC based its findings on available information and data gathered during 2008-2010. It accepted information and data provided by SA Health and particular stakeholders at face value.

The HPC acknowledges the information and data provided might not have always reflected the most recent changes in the health care system as these can occur at a faster rate than information systems can reveal.

Review Methodology

The review process comprised the following steps:

1. The HPC submitted review questions (based on SAHSP strategic directions and key objectives) to SA Health that sought written responses on the following:³
 - > Relevant key performance indicators, targets and expected outcomes
 - > Monitoring results relating to:
 - Health status improvements
 - Health system improvements
 - Regional variations in health status outcomes and system improvements
 - Relevant trends from monitored key performance indicators.
 - > Improvements in health status and service delivery for:
 - Aboriginal and Torres Strait Islander people
 - People living in rural and remote communities
 - People with mental health issues.
 - > Contribution of individual/community engagement approaches to health service improvements
 - > Monitoring and data limitations
 - > Service delivery challenges/future directions.
2. The HPC consulted with key stakeholders on their views of how SA Health performed in achieving the SAHSP objectives.³
3. Formal meetings were held with SA Health executives to discuss themes developed from stakeholder feedback and complete the information gathering process.
4. The HPC considered data provided by SA Health on achievements made against the key SAHSP objectives.³
5. The HPC developed its findings based on the available evidence and prepared a draft report.
6. The draft report was provided to SA Health for consideration and response to ensure the HPC had fairly represented the situation for SA Health over the past two years.
7. The final report was submitted to the Minister for Health in December 2010. The report will be available to the public on the HPC's website when it has been submitted to Parliament.

HPC Stakeholder Engagement

The importance placed by government on community engagement to foster sustainable, inclusive and involved communities, was demonstrated under the *Health Care Act 2008*.¹ Within this the HPC is tasked with the responsibility of assessing the effectiveness of methods used within the health system to engage communities and individuals in improving their health outcomes.

In performing the statutory obligations under the *Health Care Act 2008*, the HPC identified and defined 'effective', in relation to community/stakeholder engagement, and agreed that:¹

'In its broadest sense, community/stakeholder engagement refers to the opportunities, processes and mechanisms made available to members of the South Australian public, regardless of status, culture, gender, sexuality or age, to have a say in the development, delivery, planning and evaluation of health services and health system priorities.'

The HPC actively consulted with informed health sector stakeholders and sought their views on SA Health's performance against its 2008-2010 strategic directions. Represented stakeholders included the Health Advisory Councils, Ministerial Advisory Councils, non-government sector peak bodies, health professional bodies, local government bodies, the universities and advocacy groups. The stakeholders consulted by the HPC are listed in Appendix 4.

The HPC's community engagement process was guided by the following principles:

Effective	The outcomes of community engagement would inform HPC's decision-making and advisory service to the Minister for Health.
Appropriate	Engagement was undertaken with the relevant sections of the community as required and duplication would be avoided.
Inclusive	To ensure the HPC's advice to the Minister remained balanced and broadly representative of the views of the South Australian community, the HPC engaged community groups representing the disadvantaged and socially excluded.
Coordinated	The HPC adopted community engagement best practice mechanisms to ensure a consistent and coordinated approach to its community engagement activities.

Consultation methods included questionnaires, face-to-face forums, interviews, written submissions and meetings. Information gathered via questionnaires was categorised using SA Health's strategic objectives and emerging themes identified. A summary of the information collected was reviewed, discussed and validated, at every community/stakeholder engagement forum hosted by the HPC.

The stakeholder forums sought participants' views about how SA Health was performing in the areas committed to in the SAHSP.³ Forums were held as follows:

- > On 4 and 5 February 2010, the HPC met with a number of key stakeholders representing remote Aboriginal communities and the organisations providing Aboriginal health services throughout South Australia.
- > On 8 and 9 February 2010, the HPC held separate forums with the following stakeholder organisations:
 - Non-government health service providers (8 February 2010)
 - Consumer advocacy groups (8 February 2010)
 - Professional bodies and universities (9 February 2010).
- > On 21 April 2010, the HPC met with representatives of the Country Health Advisory Councils.

The engagement of key consumer advocacy groups and professional bodies, who have long established relationships with the South Australian public health system, resulted in the collection of valuable feedback. This was used by the HPC to identify the priority areas requiring improvement that fell within the scope of this review, and has informed the findings in this report.

Report Structure

The report does not cover every aspect of the SAHSP, but rather is organised around the HPC's three broad reporting themes, each detailed in a separate chapter.³ They are:

1. Update on the health status of South Australians
2. SA Health's performance during 2008-2010 against its strategic directions and key objectives
3. SA Health's Community Engagement.

Information relevant to SAHSP is discussed within each of these chapters.³

The *Update on the health status of South Australians* chapter provides a snapshot on health trends and outcomes for South Australians and, as appropriate, for particular population groups.

The *Health System Performance* chapter includes a separate section on Primary Health Care, Hospital Care, Mental Health Care and Aboriginal Health. Each section begins with a description of SA Health's commitments. This is followed by a brief outline of their key objectives and performance measures and concludes with the HPC's findings and associated discussion.

The *Community Engagement* chapter also begins with a description of SA Health's commitments and concludes with the HPC's findings and associated discussion.

Finally, this report outlines the HPC's conclusions and sets the stage for continued discussion over the next four years with SA Health, in preparation for the HPC's 2014 health system performance review.

Chapter 1: Update on the Health Status of South Australians

Introduction

This chapter of the report seeks to provide a snapshot of the health status of, and key trends for, the population of South Australia. This lays down some of the key parameters that guide health service planning and ultimately provide evidence about how well South Australians are doing. Central to this chapter is the presentation of the most recent data on the relevant targets being pursued under the *South Australia's Strategic Plan 2007 (SASP)*.⁴

The HPC concluded that the general health of the South Australian population compares favourably with other Australians and many other countries. Both life expectancy and the length of life lived in good health are increasing.

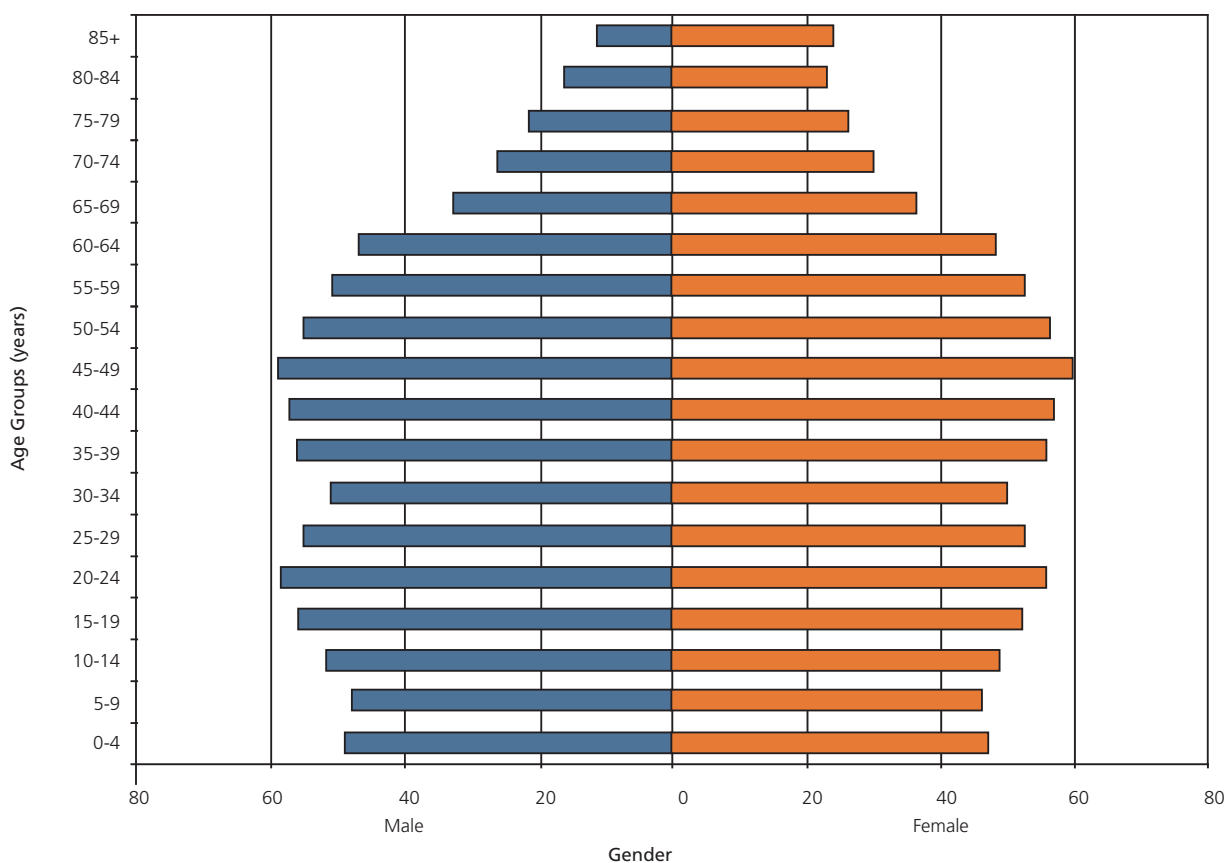
While the health of South Australians is improving, there remain significant areas of premature and chronic disease, injury and mortality in the community and large disparities in health status that persist across population groups, particularly Aboriginal people. Chronic conditions including asthma and chronic obstructive pulmonary disease, diabetes and heart failure are creating increasing health burdens in the community and presenting major challenges for the health system.

Given it is estimated that nearly a third of all causes of deaths in Australia are amenable to health care interventions there is clearly further scope for SA Health to generate health improvements in the health status of South Australians.

Population Profile

South Australians accounted for 7.4% of the Australian population in 2009 (see Chart 1.1).

Chart 1.1 Age and gender profile, South Australia, 30 June 2009

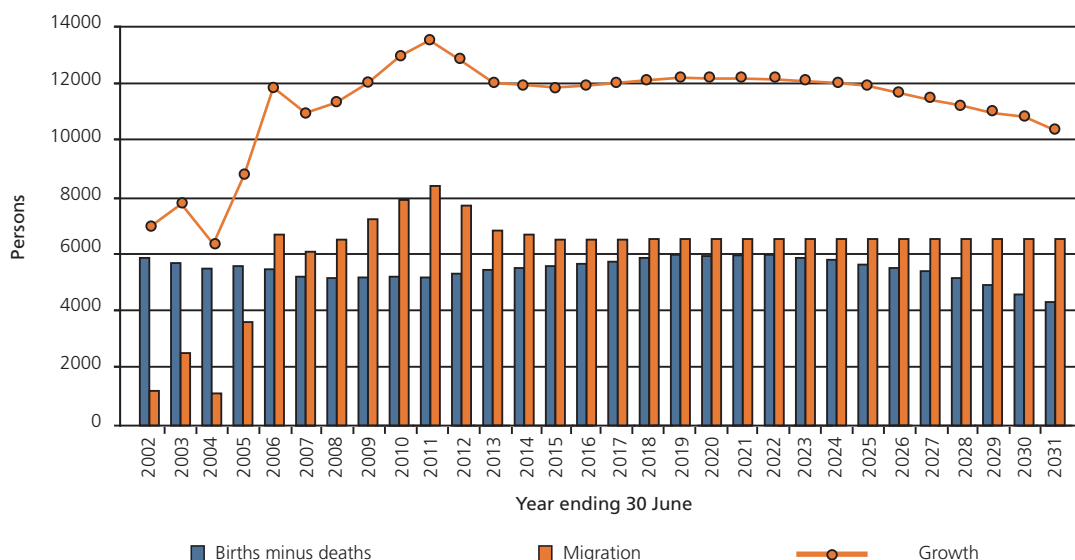


Sources: Australian Bureau of Statistics (2010) Australian Demographic Statistics, December 2009 (Cat. No. 3101.0)

While the rate of growth has been increasing in recent years, South Australia's population continues to grow at a slower pace than Australia as a whole with growth of 1.2% compared with 2.1% nationally in June 2009 (see Chart 1.1).

The South Australian Government has a population policy that, if successful, will result in a total population of two million by the end of 2050, with an average rate of growth of 0.7% per year (see Chart 1.2).

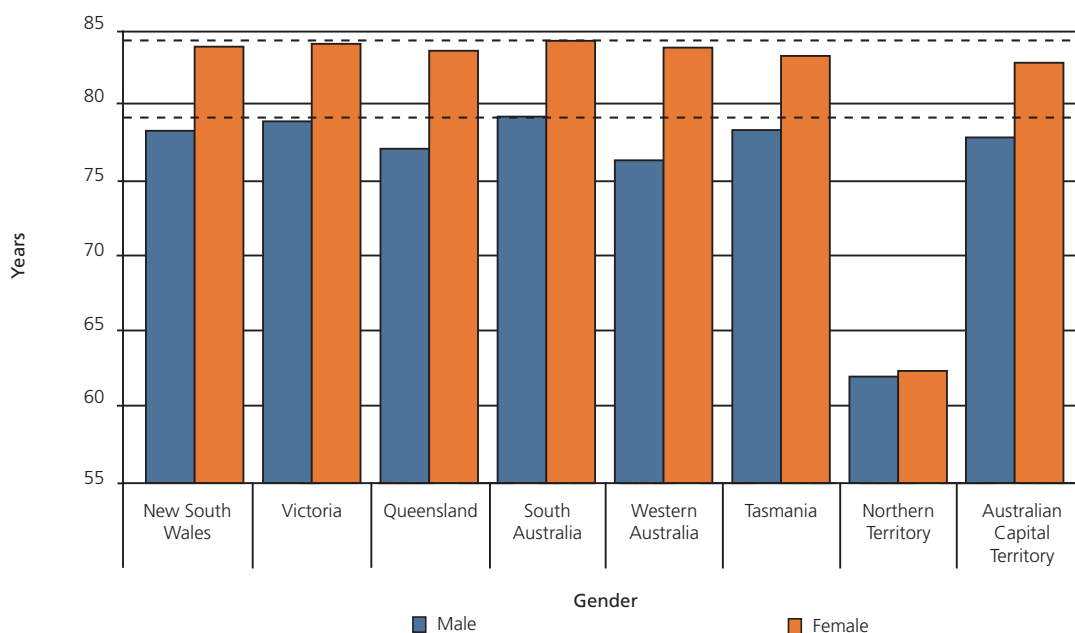
Chart 1.2 Projected population growth (2 million by 2050 series), South Australia



Source: Planning SA (2007) *Population projections for South Australia, 2001-31, June 2007*.

The proportion of the population over 65 years of age in June 2009 was 15.4% (as compared with 13.1% across the other states and territories) confirming that South Australia still has the oldest population in Australia (see Chart 1.3).

Chart 1.3 Median age at death, Australia, 2008

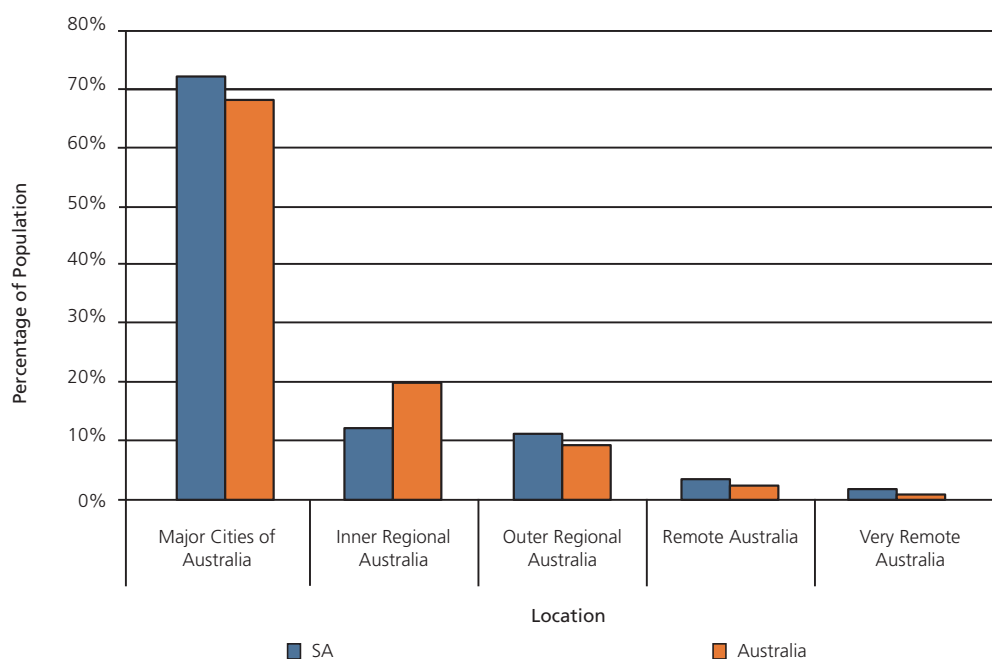


Source: Australian Bureau of Statistics (2009) *Deaths, Australia, 2008* (Cat. No. 3302.0)

In general, South Australians live longer than their counterparts in other parts of Australia, with the median age at death for both males and females being higher than any other state or territory in 2008.

The geographic distribution of the population in South Australia is more concentrated in Adelaide than in other capital cities. While in other states a greater proportion of the population live in inner regional areas, rural and remote communities in South Australia are more populous (see Chart 1.4).

Chart 1.4 Geographical population distributions, SA and National, June 2009



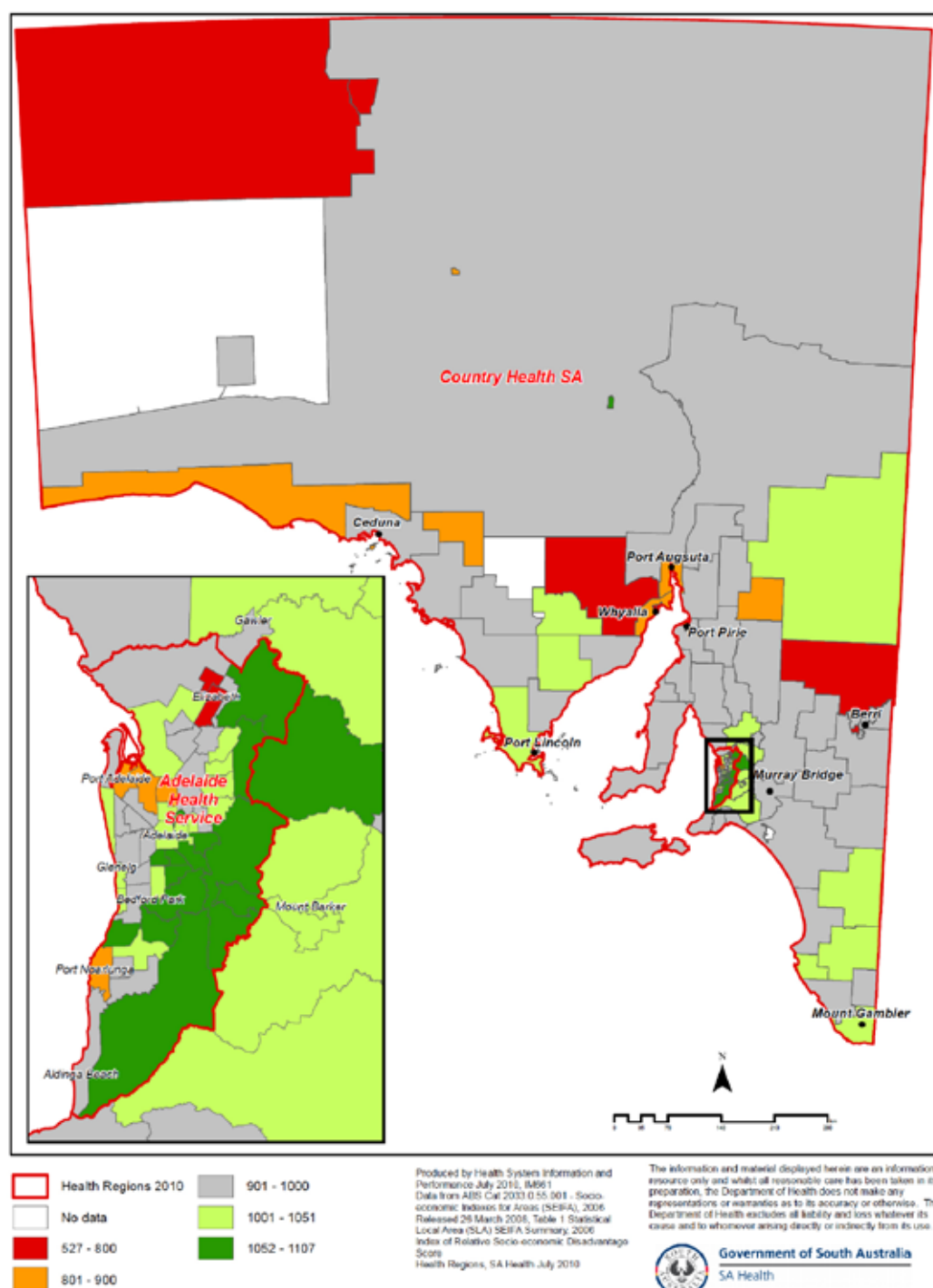
Source: Australian Bureau of Statistics (2010) *Regional Population Growth, Australia, 2008-09* (Cat. No. 3218.0)

Socioeconomic Profile

Research has established that there is a link between the socioeconomic status of people and their health-related behaviour and health status. For example, people with low socioeconomic status in South Australia are more likely to smoke and consume unhealthy amounts of alcohol and less likely to be physically active and consume healthy food.

The Index of Relative Socioeconomic Disadvantage (SEIFA Index of Disadvantage) is one of the Socioeconomic Indexes for Areas developed by the Australian Bureau of Statistics based on Census data⁵. This index enables an appreciation of the geographic distribution of disadvantage across South Australia and can help identify communities with additional health related needs (for example, areas in and around Elizabeth, Berri, Whyalla and the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands (see Figure 1.1).

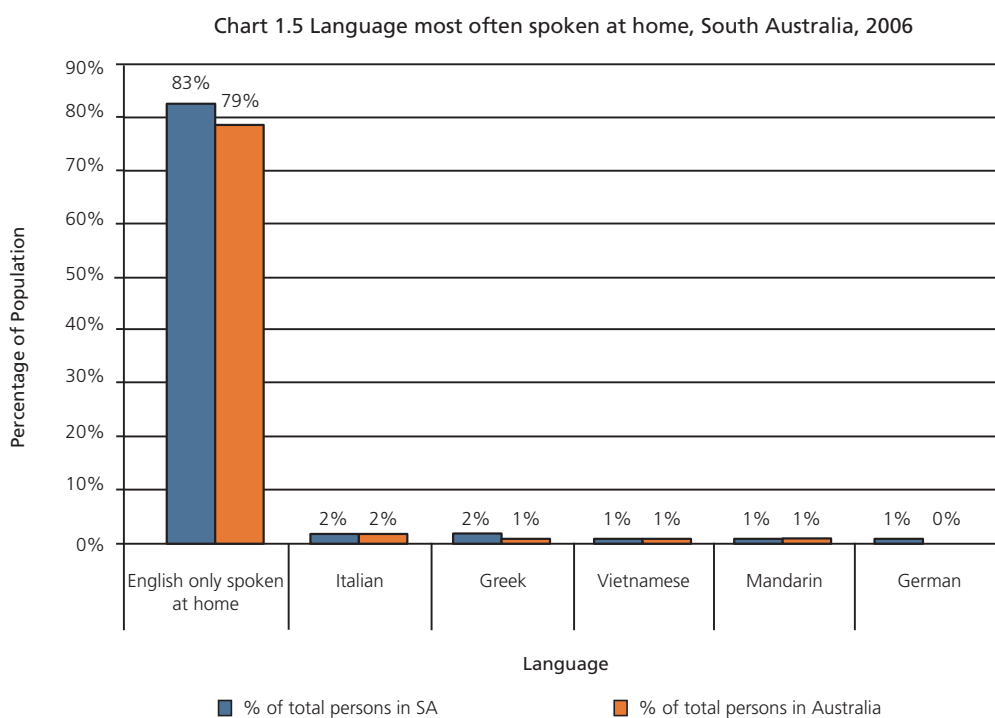
Figure 1.1 Geographic Distribution of Socioeconomic Status (SEIFA Index of Disadvantage), South Australia, 2006



Multicultural Population

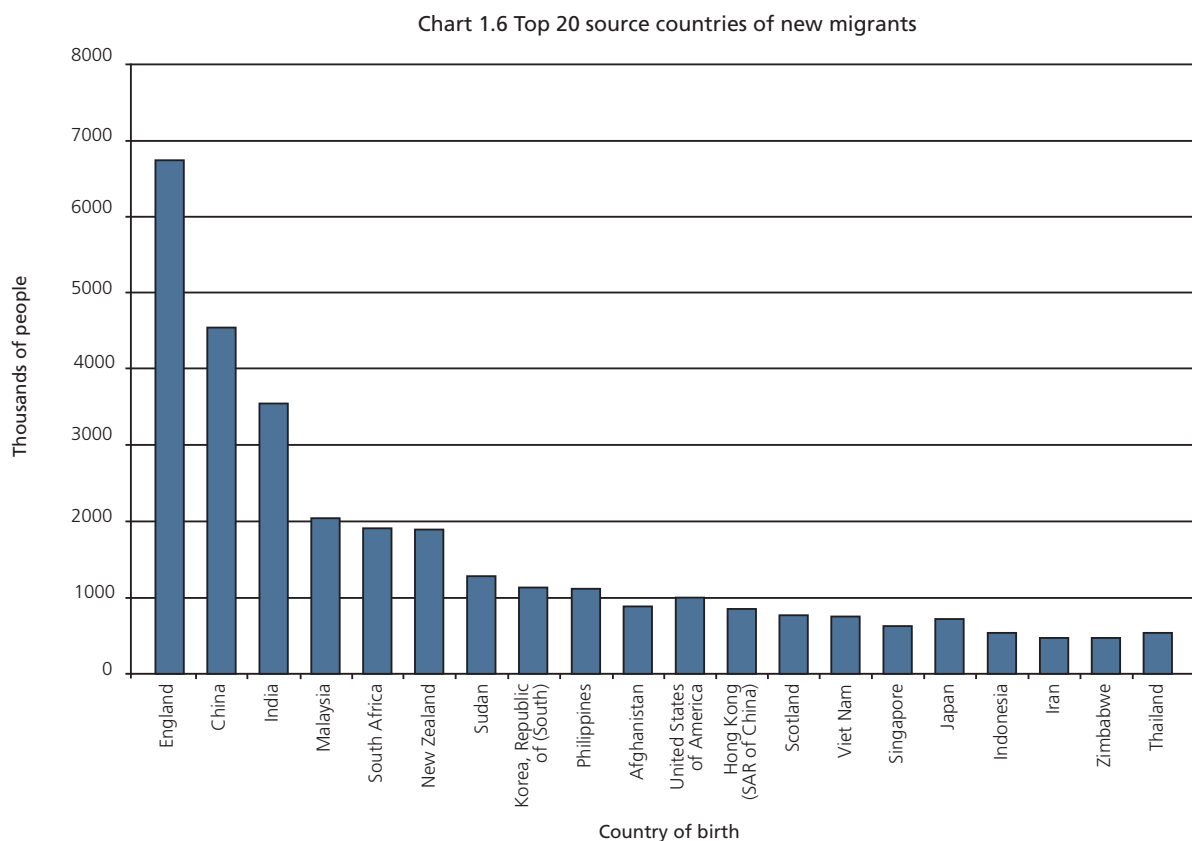
The latest census revealed that there were 1 514 337 South Australians in 2006, 79% of whom were born in Australia and 21% of whom were born overseas, (10% in English speaking countries and 11% in non-English speaking countries). Of those born overseas from non-English speaking countries, people from Italy, Germany, Greece and Vietnam are the most populous.

There are indications that the relative proportion of people from culturally and linguistically diverse backgrounds living in South Australia varies to the rest of Australia, with a higher proportion of South Australians speaking English (only), Italian and Greek and a lower proportion speaking standard Chinese at home in 2006 (see Chart 1.5).



Source: ABS (2007) 2006 Census QuickStats: South Australia

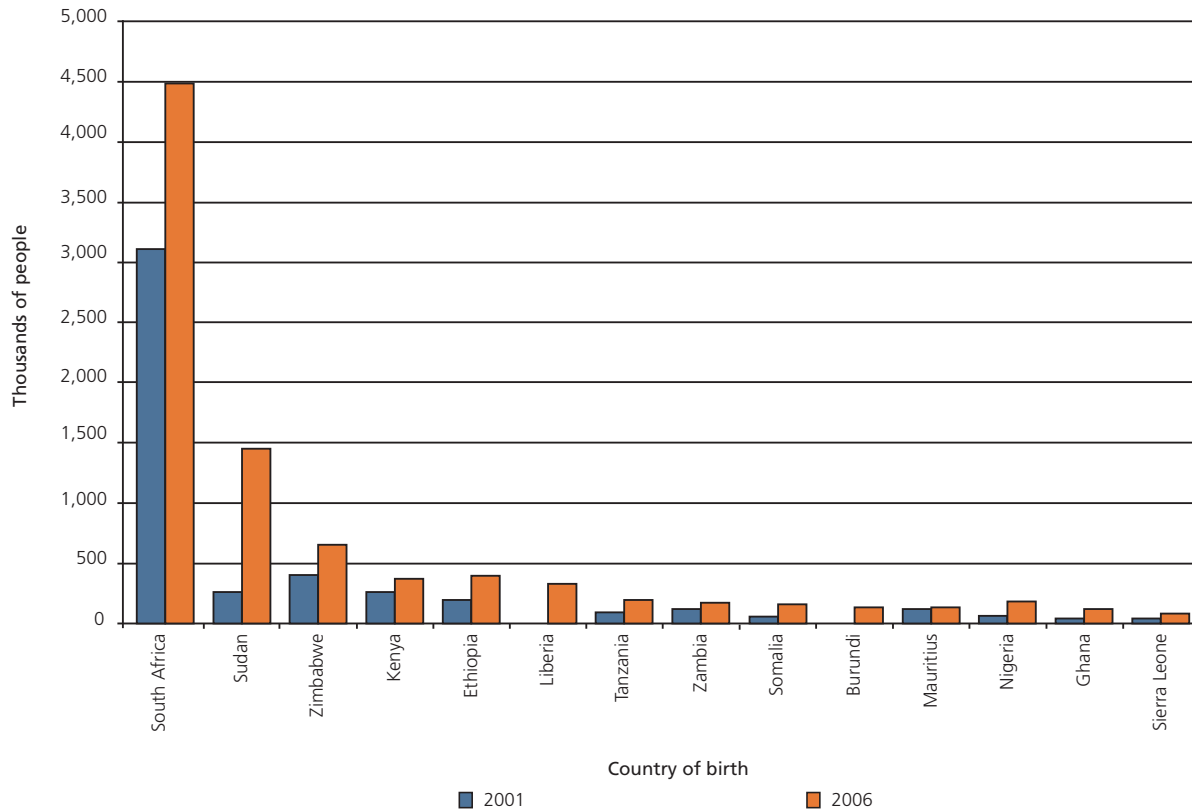
The profile of the more recent migrants to South Australia reflects a shift from the 'tradition' source countries (for example, Italy, Greece) and provides an indication of the potentially bigger communities to become established in the future, including Chinese, Indian, Filipino, Malaysian and South African (see Chart 1.6).



Source: Multicultural SA (2008) *Multicultural Life*, Autumn 2008 Edition

It is noted that African communities have been growing in South Australia due to humanitarian (refugee) efforts and while there has been significant growth in the number of households where African languages are spoken, the increase is not large in terms of absolute numbers (see Chart 1.7).

Chart 1.7 South Australia's growing African communities



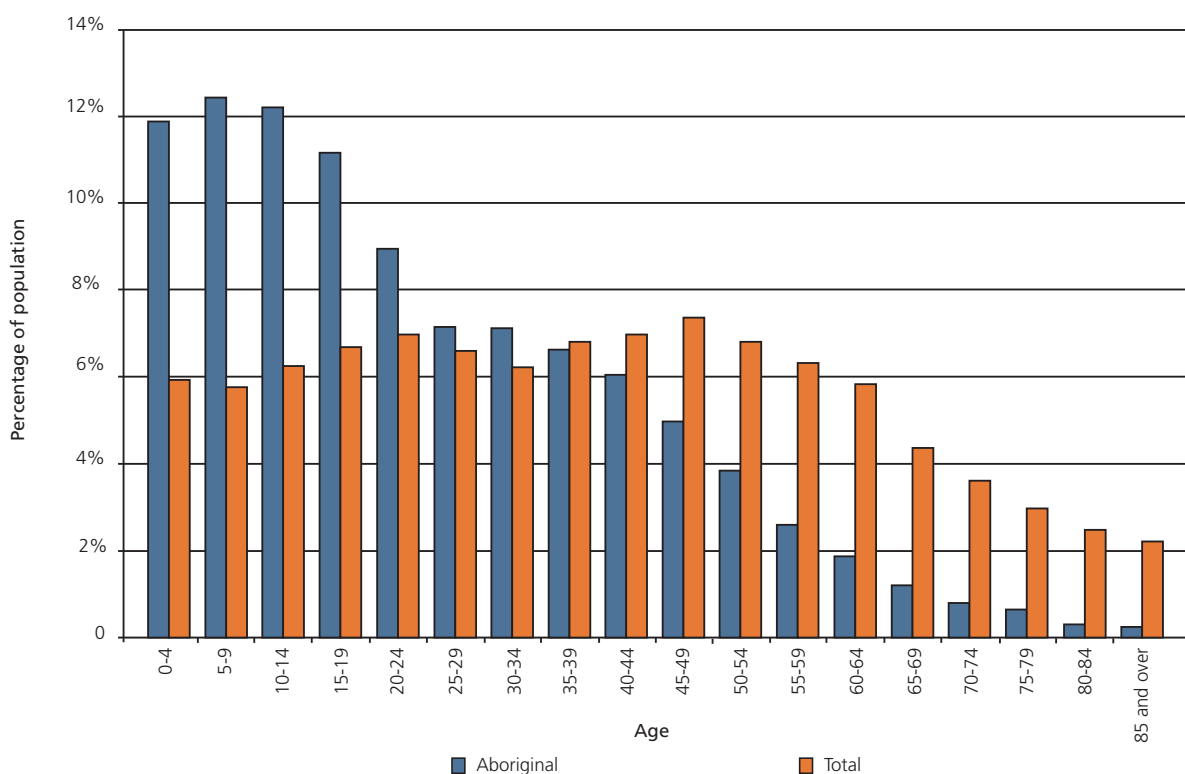
Source: Multicultural SA (2008) *Multicultural Life*, Autumn 2008 Edition

The implications of these demographic changes for the health system are important to consider, including the ageing of the Greek, Italian and Yugoslav communities and the specific health profile of recent migrants.

Aboriginal People

Just over 28 000 Aboriginal people were estimated to be living in South Australia in June 2006, which represented about 1.7% of the total population in the state. The age distribution of the Aboriginal population is markedly different from the general population in South Australia. This is reflective of the overall lower life expectancy and higher mortality rates in Aboriginal communities (see Chart 1.8).

Chart 1.8 Age Profile, Aboriginal and Non Aboriginal, South Australia, June 2006



Source: Australian Bureau of Statistics (2008) *Experimental Estimates of Aboriginal and Torres Strait Islander Australians, June 2006* (Cat. No. 3238.0.55.001)

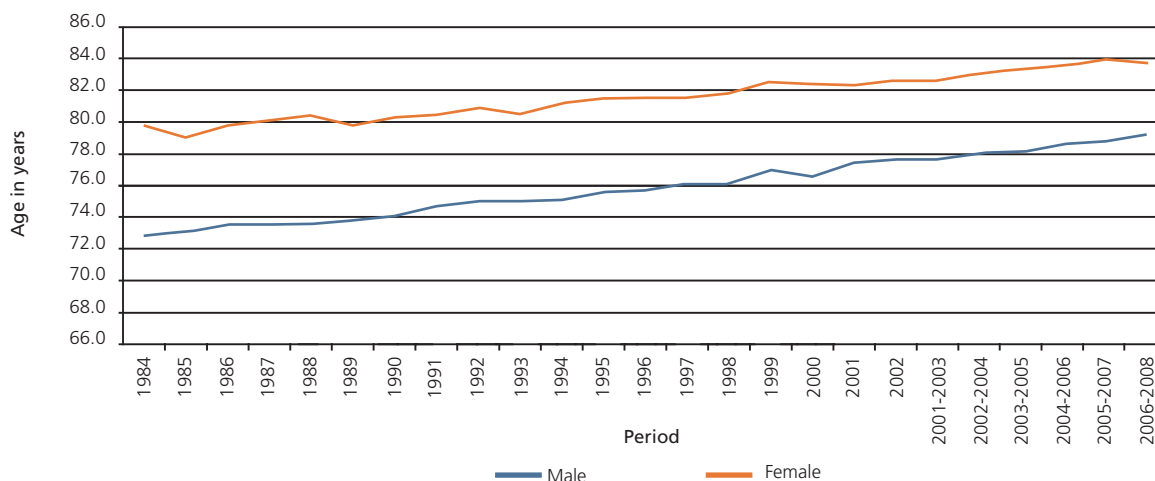
The specific characteristics and trends in the South Australian population have clear implications for health service planning by affecting the magnitude and nature of services provided in South Australia over time. The differences in geographical distribution, age structure and cultural diversity of the South Australian population, compared with Australia as a whole, are noted, as is the stark difference between the Aboriginal and non-Aboriginal people living in the state.

Health Status

Summary measures of the status of the South Australian population reflect how long people live, how long they live in good health, and the proportion of their lives they live with a disease or injury related illness.

Life expectancy of South Australians at birth has been increasing over the last quarter of a century. While females have a higher life expectancy than males, the gap appears to have narrowed marginally over this period (see Chart 1.9).

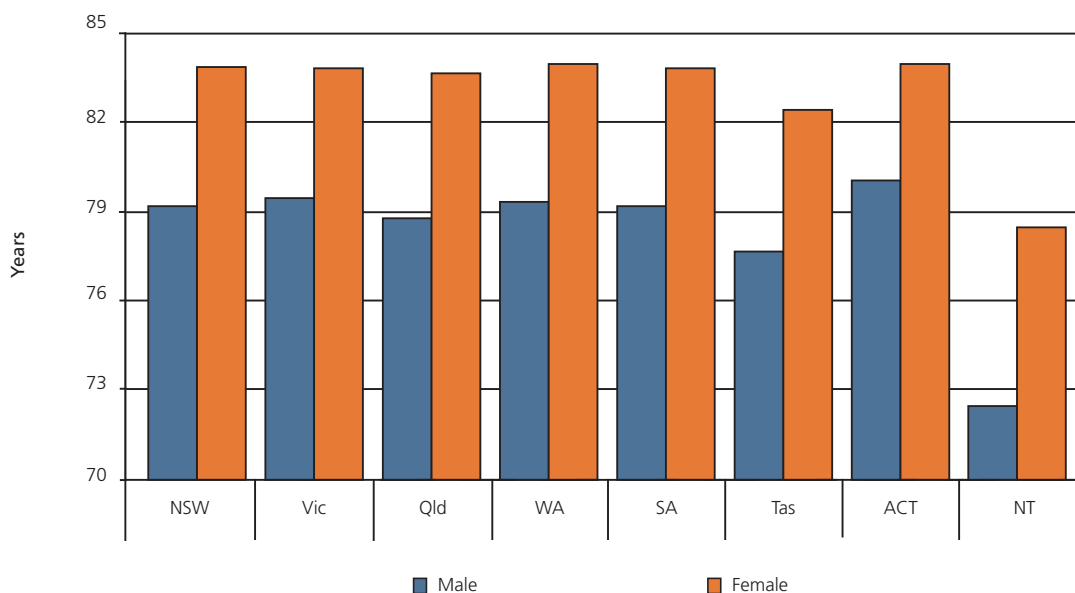
Chart 1.9 Life expectancy at birth by gender, South Australia



Note: Australian Bureau of Statistics figures are drawn from full period life tables. Latter periods are three-year averages.
Source: Australian Bureau of Statistics Cat 3302.4.55.003 and by consultancy in May 2006.

The life expectancy of South Australians compares relatively well to that of other states and territories, with a life expectancy of 83.4 years for females and 78.1 years for males over 2003-2005 (see Chart 1.10).

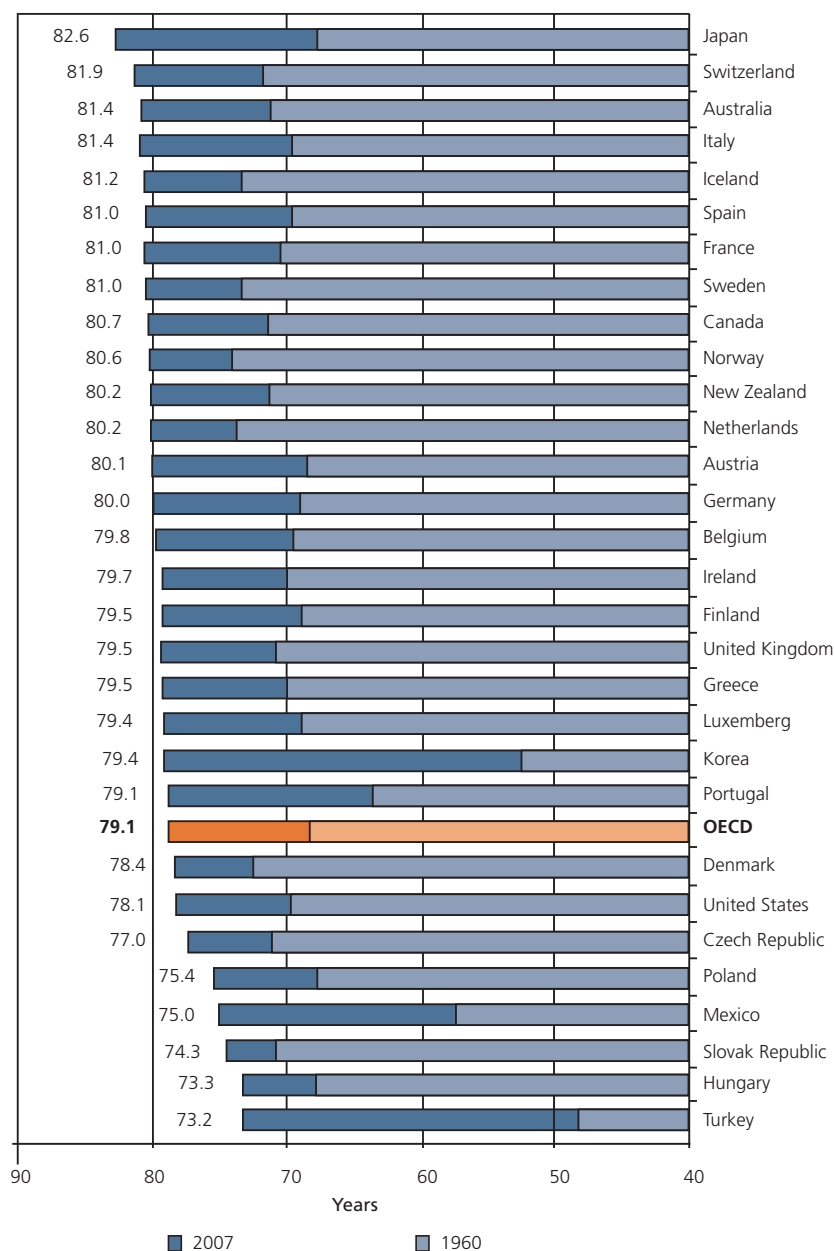
Chart 1.10 State and Territory average life expectancy at birth, 2006-2008



Source: Australian Bureau of Statistics (2009) *Life Tables 2006-2008* (Cat No. 3302.1.55.001 etc)

Furthermore, the HPC notes that Australians have an enviable life expectancy when compared with other Organisation for Economic Cooperation and Development (OECD) countries, with only Japan and Switzerland recording a higher life expectancy in 2007 (see Chart 1.11).

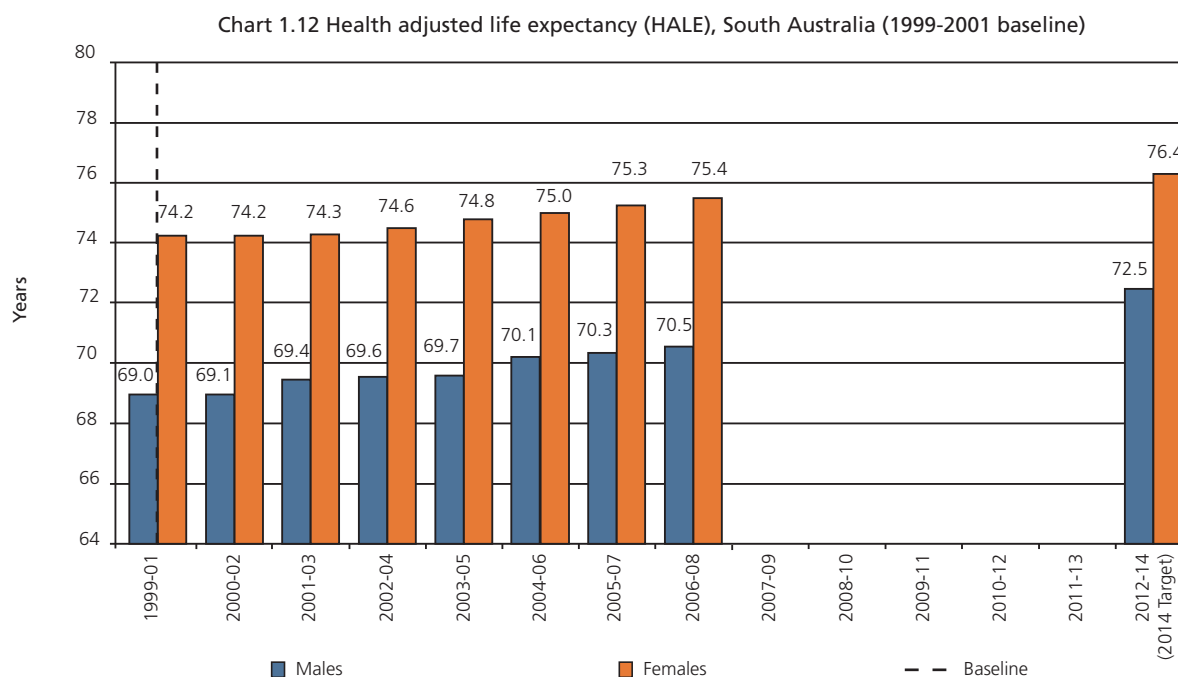
Chart 1.11 Life expectancy at birth in OECD Countries, 1960 and 2007 (or latest year available)



Source: OECD (2009) *Health at a Glance 2009*

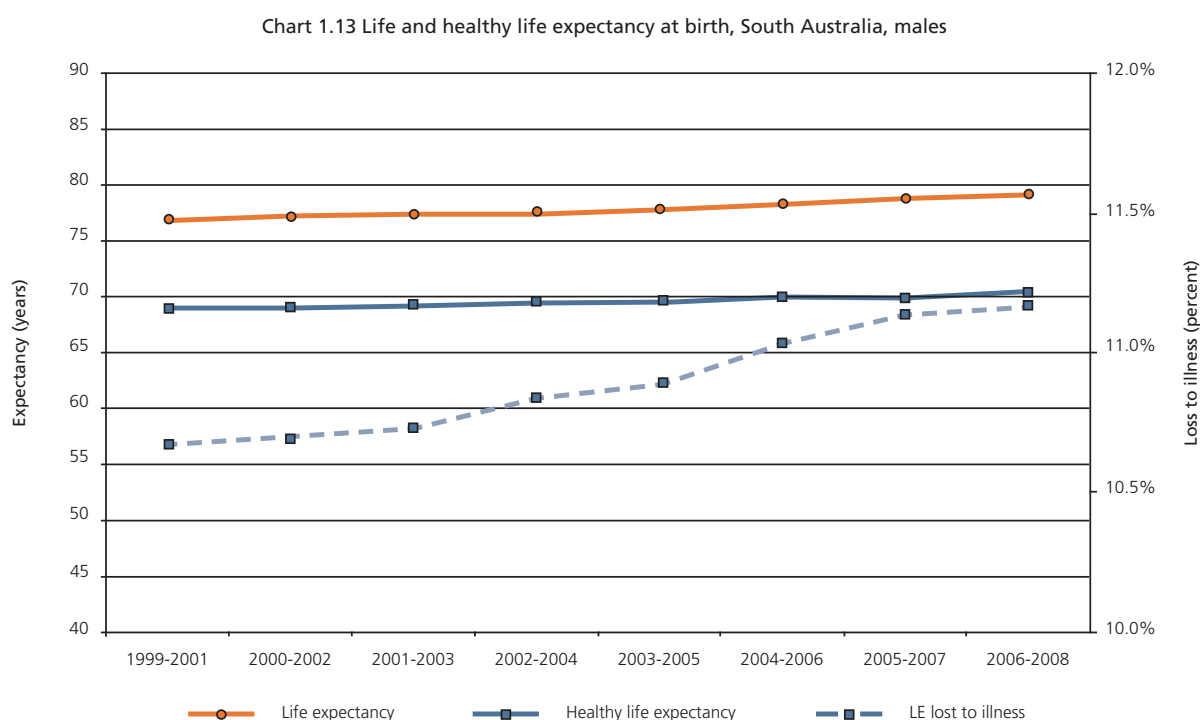
SA Strategic Plan Target 2.4: Healthy South Australians: Increase the healthy life expectancy of South Australians by 5% for males and 3% for females by 2014.⁴

The average years of life of South Australians lived in good health is improving. SA Health has indicated it anticipates that with further reconfiguration of the system to allow an improved focus on prevention, early intervention and improved management of people with a range of chronic diseases; this improvement will be sustained (see Chart 1.12).

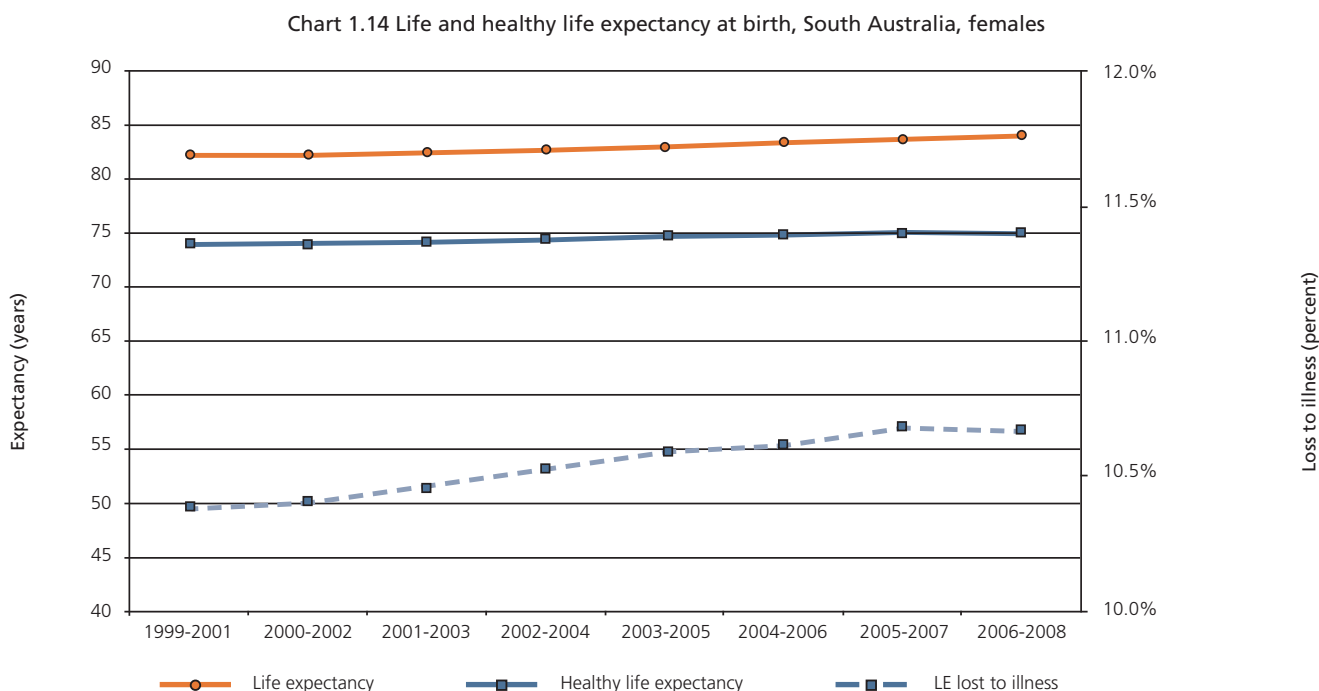


Source: SA Health, South Australian Burden of Disease Study at www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx

However, when life expectancy is compared with healthy life expectancy, it is clear not all life expectancy gains are lived in full health, some is lost to disease and injury related illness. Given the rate of increase in total life expectancy is greater than that of healthy life expectancy, the percentage of life expectancy lost to severity-weighted illness increased over time for both sexes. For men, life expectancy lost to severity-weighted illness increased from 10.7% to 11.2% (a relative increase of 4.7%). (See Chart 1.13). The corresponding figures for women were 10.4% to 10.7% (a 2.8% relative increase) (see Chart 1.14).



Source: SA Burden of Disease site at <http://www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx>



Source: SA Burden of Disease site at <http://www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx>

The trends in life expectancy lost to illness will continue to impact on the overall health burden in the community and demand on services.

Health Priorities

Mortality Burden

While significant gains in life expectancy are occurring, a significant number of years of life are being lost in the South Australian population from premature mortality. In the period 2005-2007, it is estimated that over 136 years per 1000 people are lost to premature mortality in South Australia's Aboriginal communities. This compares to just under 59 years (2.3 times the rate) in the non-Aboriginal population in South Australia.

The top 10 causes of mortality burden for the total population in the 2006-2008 period, in terms of years of life lost through premature death, account for over 50% of the total mortality burden in South Australia (see Table 1.1).

Table 1.1 Top 10 causes of mortality burden by gender and condition, South Australia 2006-2008 (3-yearly annual averages).

Males			Females		
Rank	Condition	YLL	Rank	Condition	YLL
1	Ischaemic heart disease	10024	1	Ischaemic heart disease	6989
2	Lung cancer	4317	2	Stroke	4109
3	Suicide and self-inflicted injuries	3191	3	Breast cancer	3403
4	Stroke	2879	4	Lung cancer	2921
5	Colorectal cancer	2353	5	Dementia	2318
6	Prostate cancer	2026	6	Colorectal cancer	1928
7	Road traffic accidents	1949	7	Chronic obstructive pulmonary disease (COPD)	1672
8	Chronic obstructive pulmonary disease (COPD)	1876	8	Type 2 diabetes	1113
9	Type 2 diabetes	1305	9	Nephritis and nephrosis (excluding diabetic, congenital and poisoning related renal failure)	1107
10	Nephritis and nephrosis (excluding diabetic, congenital and poisoning related renal failure)	1096	10	Lower respiratory tract infections	1022

Note: Years of life lost (YLL) are uniform age weighted and 3 per cent per annum discounted.

Source: SA Burden of Disease site at <http://www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx>

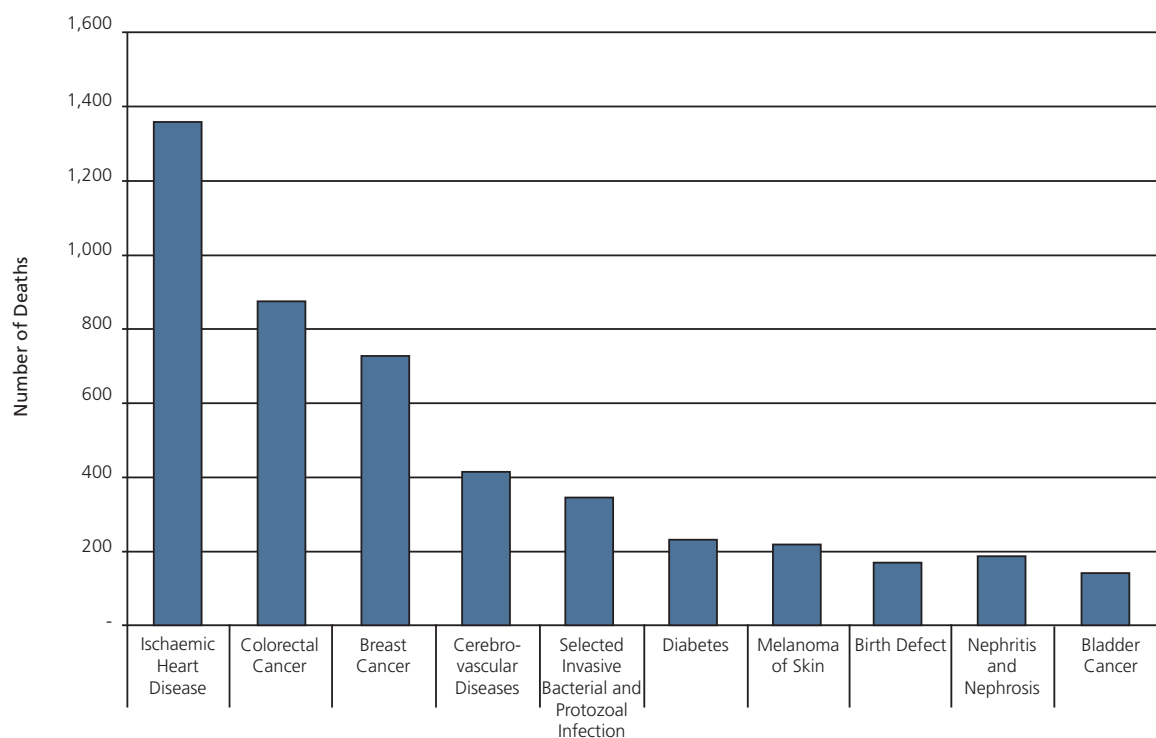
The ranking and mix of causes for Aboriginal people are markedly different, most notably lower respiratory tract infections, cirrhosis of the liver (excluding alcoholic and hepatic cirrhosis) and low birthweight are all in the top 10 causes for Aboriginal people but not for non-Aboriginal people.

Research undertaken over recent years has identified a number of causes of death that are currently considered potentially avoidable given the available knowledge about social and economic policy impacts, health behaviours, and health care. Of these deaths, a subset has been identified that is considered as being particularly amenable to health care interventions and therefore potentially more responsive to actions that are within the direct authority and responsibility of health portfolios, including SA Health.

Overall, almost three quarters of all deaths at ages 0 to 74 years in Australia for the period 1997 to 2001 were considered avoidable, and 40.2% of these deaths (or nearly 30% of all deaths) were considered amenable to health care.

The top 10 causes of amenable mortality for 2003-2007 accounted for 86% of total amenable deaths and were reflective of the highest causes of mortality burden in Australia, including heart disease, diabetes, kidney disease and cancer (see Chart 1.15).

Chart 1.15 Top causes of amenable mortality (0-74 years), South Australia, 2003-2007



Source: Data produced by PHIDU from deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2003 to 2007

These conditions and their chronic manifestation in the patient populations affected are shaping health service planning and delivery systems across many countries. They reflect the priorities of SA Health, most notably through the Statewide Cancer Clinical Network and the *GP Plus* Strategy and related initiatives.⁶

Morbidity Burden

The top 10 causes of morbidity burden for the total population in the 2006-2008 period, in terms of years of life lost through disease or injury related illness, account for nearly 50% of the total mortality burden in South Australia (see Table 1.2).

Table 1.2 Top 10 causes of morbidity burden by gender and condition, South Australia 2006-2008 (3-yearly annual averages)

Males			Females		
Rank	Condition	YLD	Rank	Condition	YLD
1	Type 2 diabetes	5723	1	Anxiety and depression	9519
2	Anxiety and depression	4969	2	Type 2 diabetes	5261
3	Adult-onset hearing loss	4402	3	Dementia	5185
4	Dementia	3104	4	Ischaemic heart disease	2811
5	Chronic obstructive pulmonary disease (COPD)	3031	5	Asthma	2672
6	Ischaemic heart disease	2492	6	Adult-onset hearing loss	2284
7	Asthma	2488	7	Chronic obstructive pulmonary disease (COPD)	2177
8	Prostate cancer	2271	8	Migraine	1989
9	Schizophrenia	1710	9	Breast cancer	1961
10	Stroke	1602	10	Osteoarthritis	1842

Note: Years Lost to Disability/Illness (YLD) are uniform age weighted and 3 per cent per annum discounted.

Source: SA Burden of Disease site at <<http://www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx>>

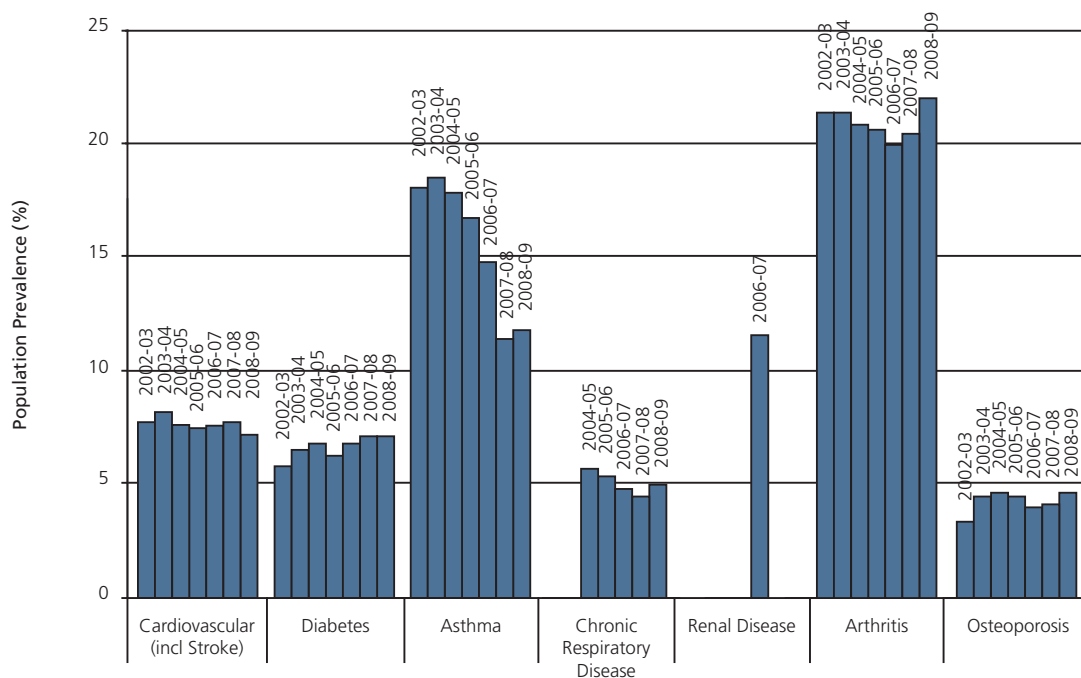
As with mortality, the top causes of morbidity burden reflect the impact of chronic conditions (for example, COPD, diabetes, heart disease) on the health of the South Australian population. Of particular note is the predominance of the mental health related causes of anxiety and depression, dementia, and schizophrenia.

Observations based on chronic disease prevalence estimates generated from the South Australian Monitoring and Surveillance System and the Northwest Adelaide Health Study indicated that the prevalence in South Australia of:

- > Respiratory and to a lesser extent cardiovascular conditions is falling
- > Diabetes and to a lesser extent muscular-skeletal conditions is rising.

The trend in asthma prevalence seems counterintuitive. However, changes in diagnostic practices in Australia over this period could have resulted in fewer people with lower level respiratory symptoms diagnosed with asthma in recent years as compared with the previous years (see Chart 1.16).

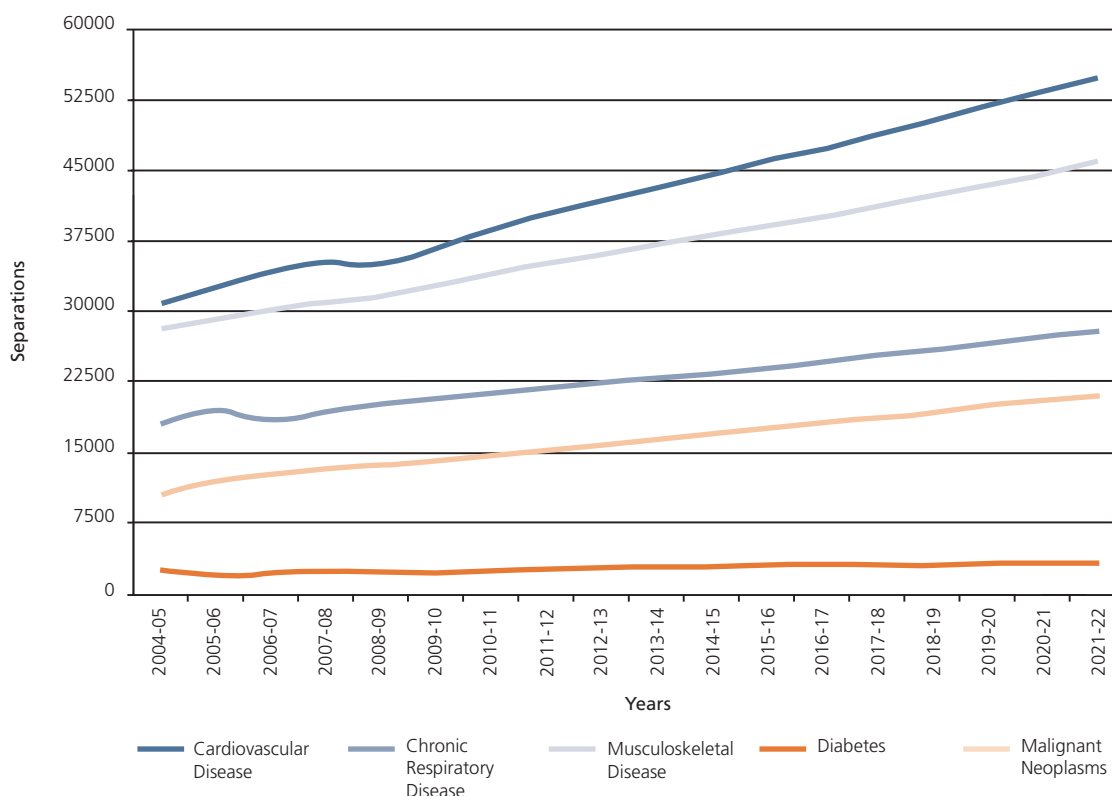
Chart 1.16 Estimated prevalence of chronic disease, South Australia, 2002-03 to 2008-09



Source: South Australian Monitoring and Surveillance System (SAMSS) and Northwest Adelaide Health Study, 2007

Notwithstanding the estimated prevalence for selected chronic conditions, the number of people requiring treatment for chronic conditions is expected to rise in South Australia, driven partly by the ageing population and partly through increased risk factors. The following graph shows the projected growth in hospital demand for patients with chronic conditions if additional steps are not taken to prevent people from developing chronic disease, or if those people with chronic conditions are not better managed (see Chart 1.17).

Chart 1.17 Estimated growth in chronic disease hospitalisations, South Australia



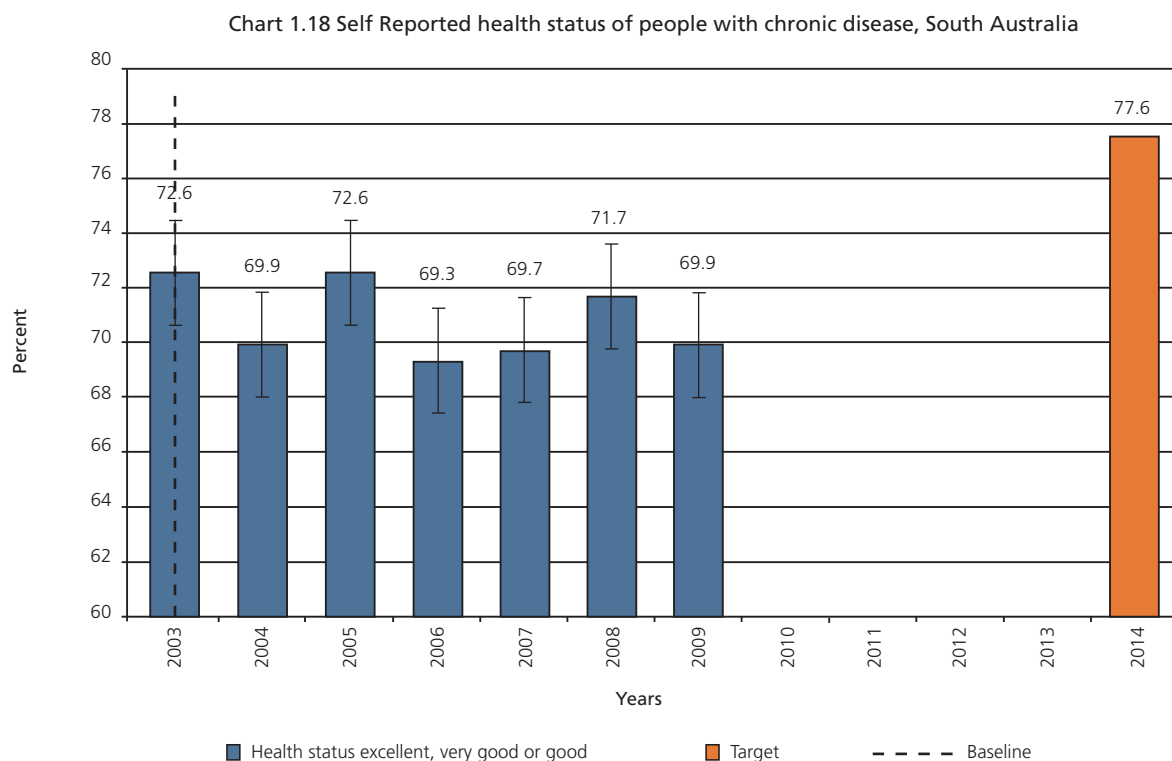
Note: The 2008/09 base year model uses the Planning SA High Series population projections. SA Health moved to using the high series on advice from Planning SA that the 2006 Census outcome revealed higher than expected population growth in SA so that the medium stable population is known to be too low. The 2005-06 HARDS model used the medium stable population and accounts for the difference between the two versions of data.

Source: SA Health, Integrated South Australian Activity Collection

SA Health is focusing on ways to further prevent and better manage chronic disease in the community.

SA Strategic Plan Target 2.6: Chronic Diseases: Increase by five percentage points, the proportion of people living with a chronic disease whose self-assessed health status is good or better.⁴

SA Health considered the data for this target showed no clear or significant trend to-date. The 2009 data indicated a static trend since the baseline, and SA Health indicated that it is not likely the target will be reached (see Chart 1.18).



Note: Black I-shaped bars on these graphs represent 95% confidence intervals.
Source: SA Health, South Australian Monitoring & Surveillance System (SAMSS)

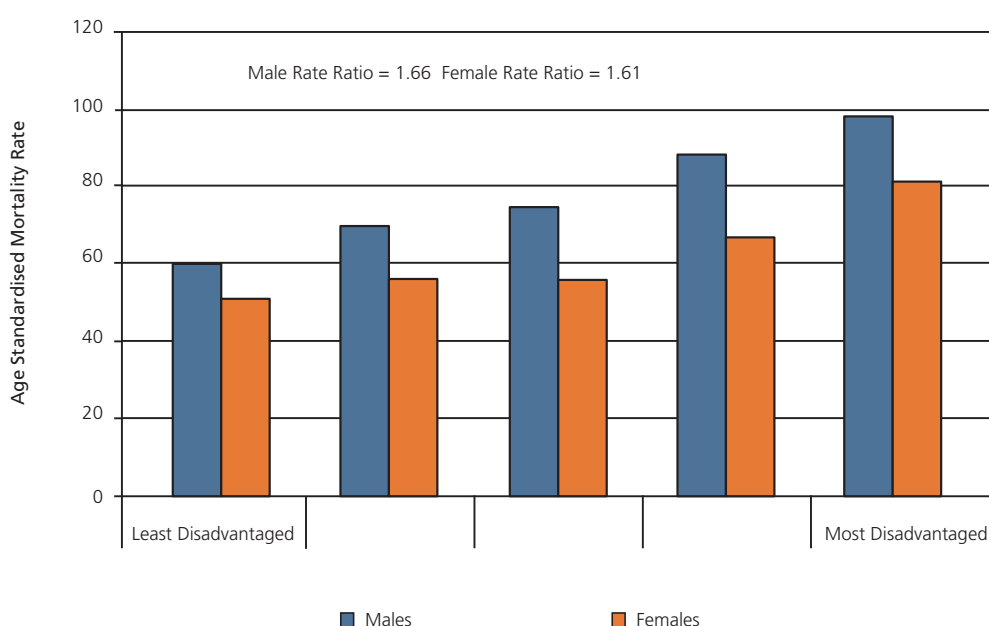
SA Health reported that its effort is targeting the needs of people with chronic or multiple and complex conditions to reduce hospital admissions and to deliver high quality care in a more convenient, efficient and appropriate way. In order to meet the target, a wide range of activities have continued to be developed and/or initiated and will continue to be progressed.

Health Equity

In South Australia, as is the case nationally, amenable mortality rates display a socioeconomic gradient whereby the least disadvantaged areas exhibit the lowest rates and the greatest disadvantaged areas the highest rates. The rate of amenable mortality in the most disadvantaged areas is over 1.6 times higher than in the least disadvantaged areas (see Chart 1.19).

South Australia's amenable mortality rate of 70.4 is higher than the rates for Victoria, Australian Capital Territory and Western Australia and comparable to the rates for New South Wales and Queensland. SA has a lower rate than the rates for Tasmania and Northern Territory.

Chart 1.19 Amenable mortality (0-74 years) by socioeconomic status, South Australia, 2003-07



Source: Data produced by PHIDU from deaths data supplied by ABS on behalf of State and Territory Registrars of deaths for 2003 to 2007

The factors contributing to this situation are many and complex and often reflect fundamental differences in opportunity and capacity across groups of people in our society. This measure indicated there is further scope for SA Health to address health inequalities by continuing to encourage and target improved access to effective health programs and services for the less advantaged in South Australia.

Risk Factors

Data from the South Australian Monitoring and Surveillance System indicated that in South Australia there are approximately 400 000 adults with a single risk factor, over 200 000 adults with two or more risk factors, and over 90 000 adults with three or more risk factors for chronic disease (see Table 1.3).

Given the risk factors for one chronic disease can overlap with those for another, health strategies aimed at reducing common risk factors can have a simultaneous impact on a number of chronic conditions.

Table 1.3 Chronic Disease Risk Factors

Disease	Poor diet	Physical inactivity	Tobacco use	Alcohol misuse	Excess weight	High blood pressure	High cholesterol
Heart disease	X	X	X	X	X	X	X
Stroke	X	X	X	X	X	X	X
Lung cancer			X				
Diabetes	X	X			X		
Asthma			X		X		

Source: Australian Institute of Health and Welfare (2002), Chronic diseases and associated risk factors in Australia, 2001 (Cat No PHE 33).

Longitudinal Data

Observations from longitudinal data on risk factors include: (see Table 1.4)

- > Reduced smoking and underweight
- > Increased obesity, blood pressure, cholesterol, vegetable and fruit consumption
- > Stable risky alcohol consumption.

Table 1.4 Risk Factor Prevalence, South Australia, 2002-03 to 2008-09

Risk factor	2002-03	2003-04	2004-05	2005-06	2006-07	2007-08	2008-09
Current smoker (16+ years)	24.1	23.6	21.9	19.1	20.7	20.6	19.9
Fewer than 5 serves of vegetables per day (19+ yrs)	93	91.9	89.5	88.1	90.7	90.7	88.4
Fewer than 2 serves of fruit per day(19+ yrs)	57.7	60.4	58.8	57.1	58.1	56.3	54.1
Short-term-risky/high-risk alcohol (16+ yrs)	29.1	28.9	29.5	29.9	28.4	29.7	28.7
Long-term-risky/high-risk alcohol (16+ yrs)	4.0	4.0	3.9	3.3	3.7	4.3	4.0
Overweight or obese (18+ yrs)	54.5	54.6	55.1	55.7	56.7	55.8	58.5
Underweight (18+ yrs)	2.5	2.4	2.2	1.8	2.2	2	2.1
Insufficient activity/no activity (16+ yrs)		49.0	50.2	48.7	47.1	46.7	45.9
High blood pressure (16+ yrs)		17.1	18.6	18.1	18.1	18.1	19.4
High cholesterol (16+ yrs)		13.2	14.3	13.5	14.3	14.0	15.7

Source: Smoking data – Tobacco Control Research and Evaluation Program. All other data – South Australian Monitoring and Surveillance System (SAMSS).

Age Cohorts

Observations from age cohort data on risk factors include: (see Table 1.5)

- > Overweight (except for the very elderly), insufficient physical activity, high blood pressure and high cholesterol prevalence all increase with age
- > Healthy vegetable consumption increases with age
- > Healthy fruit consumption peaks in the 30-39 age cohort
- > Risky alcohol consumption is relatively stable across most age cohorts
- > Smoking is most prevalent in people aged between 20 and 50 years
- > Underweight is most prevalent in the young and very elderly.

Table 1.5 Risk Factor Prevalence by Age, South Australia

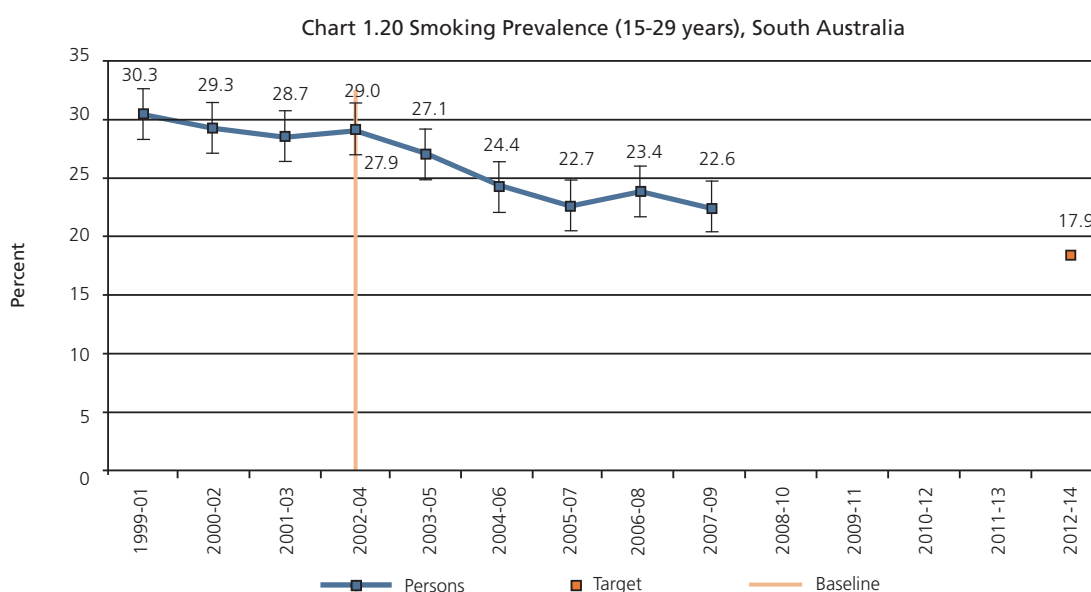
Risk factor	Age group							
	16-19	20-29	30-39	40-49	50-59	60-69	70-79	80+
Current smoker (16+ years)	8.8	32.1	25.3	26.9	18.7	10.6	5.2	4.2
Fewer than 5 serves of vegetables per day (19+ yrs)	100	94.3	91.5	90.2	83.3	83.1	86.2	87.8
Fewer than 2 serves of fruit per day(19+ yrs)	46.7	58	60.9	58.8	53.3	47.4	45.5	46.5
Short-term-risky/high-risk alcohol (16+ yrs)	29.1	28.2	22.7	25.6	31.7	33.2	33.2	28.2
Long-term-risky/high-risk alcohol (16+ yrs)	3.6	6.1	3.4	3.7	4.7	4.9	2.1	1.0
Overweight or obese (18+ yrs)	24.8	46.2	59.4	62.9	67.4	68.6	63.5	40.5
Underweight (18+ yrs)	10.6	4.4	0.5	0.8	0.6	1.0	1.2	6.3
Insufficient activity/no activity (16+ yrs)	25.9	36.9	41	46.6	48.4	47.9	58.3	76.1
High blood pressure (16+ yrs)	0.6	0.3	2.4	12.7	22.4	39.2	54.8	54.3
High cholesterol (16+ yrs)	0.5	1.5	3.7	11	20.4	30.7	39.9	34.9

Source: Smoking data – Tobacco Control Research and Evaluation Program. All other data – South Australian Monitoring and Surveillance System (SAMSS)

Young Smokers

SA Strategic Plan Target 2.1: Smoking: Reduce the percentage of young cigarette smokers by 10 percentage points between 2004 and 2014.⁴

There has been positive progress with this target and SA Health considered it is on track to meet the target by 2012-2014 (see Chart 1.20). A large decline in smoking prevalence was observed in 2005, in line with considerable national expenditure on national and state media campaigns, including the Graphic Health Warnings Campaign.



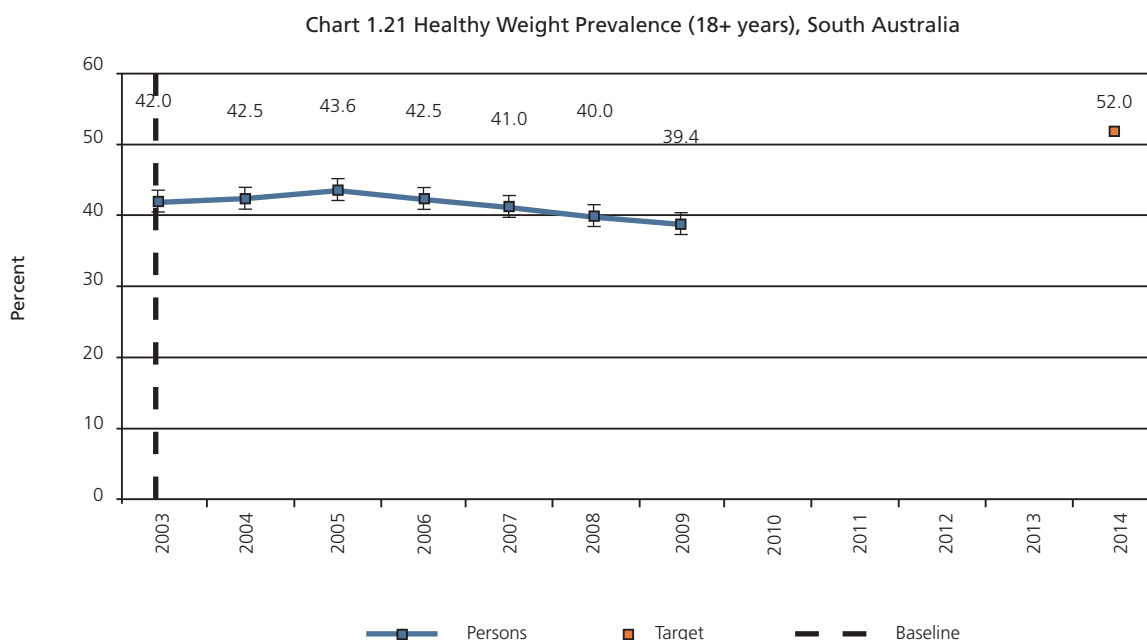
Note: Smoking Prevalence for 15-29 year olds, age standardized to 2001 population, 3 year moving averages. Baseline based on 2004 single year figure. Black I-shaped error bars on these graphs represent 95% confidence intervals.

Source: SA Health, Health Omnibus Survey; The Cancer Council, South Australia

Prevalence of Adult Healthy Weight

SA Strategic Plan Target 2.2: Healthy Weight: Increase the proportion of South Australians 18 and over with healthy weight by 10 percentage points by 2014.⁴

There has not been positive progress with this target since 2005 and SA Health considered it unlikely that the target would be met by 2010 (see Chart 1.21).



Note: Black I-shaped error bars on these graphs represent 95% confidence intervals.

Source: SA Health, South Australian Monitoring and Surveillance System (SAMSS)

In order for the target to be reached, SA Health considered it would be necessary to assist men (in particular) and women, to move from being overweight to being in the healthy weight range. However, weight loss is very difficult with few evidence-based successful interventions. Therefore, the focus of SA Health is to:

- > Prevent men in particular, but also women, from gaining weight and moving into the category of overweight by supporting healthy eating and physical activity.
- > Prevent young people 11-18 years from moving into the adult category with an unhealthy weight.
- > Ensure younger children maintain a healthy weight throughout childhood.

The four key strategies in the SA Health implementation plan for this target apply to each of these groups and are consistent with the *Eat Well Be Active Healthy Weight Strategy (EWBA) for SA 2006-2010*.⁷ South Australia is implementing similar strategies to those being progressed throughout the world. This involves across-government approaches in partnership with individuals and communities.

Mental Health

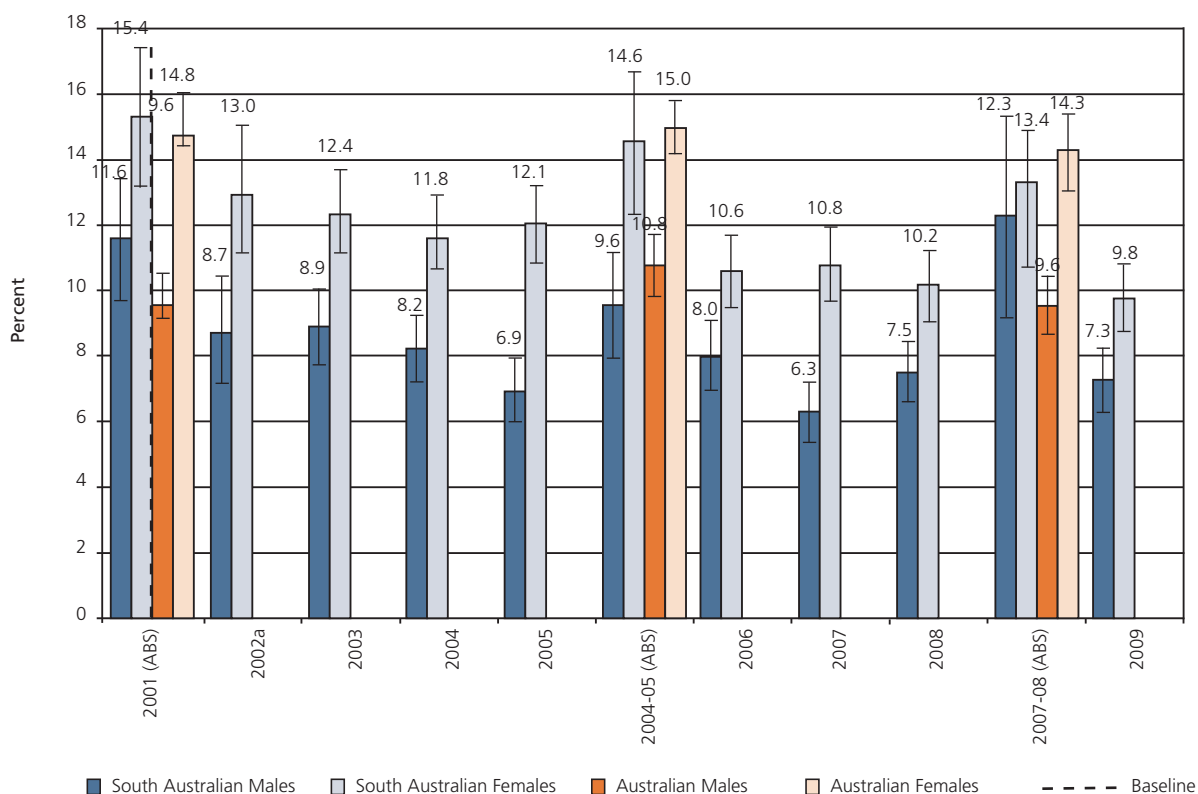
Population Level of Psychological Distress

SA Strategic Plan Target 2.7: Psychological Wellbeing: Equal or lower than the Australian average for psychological distress by 2014.⁴

Self reported levels of psychological distress in the population are being monitored in South Australia, and nationally, to gain an overall appreciation of the mental health status of the community. The South Australian Government set a target for SA Health that required performance to be equal or better than that achieved nationally.

National data is not available annually, hindering SA Health's ability to monitor progress towards the target in South Australia. However, from the longitudinal national data that is available, there are signs that the situation for females is improving. Data from the 2004-05 and the 2007-08 Australian Bureau of Statistics National Health Surveys (ABS/NHS) indicated the level of distress in South Australia might now be lower than that nationally.^{8,9} The situation for males is less clear, where (apart from 2004-05), the data pointed towards South Australian males having a higher level of distress than nationally (see Chart 1.22).

Chart 1.22 Level of Psychological Distress by Gender, South Australia



Note: 2002a data for July to December 2002. Black I-shaped error bars on these graphs represent 95% confidence intervals

Data Source: ABS Cat No. 4364.0 (where specifically indicated) and SA Health, South Australia Monitoring and Surveillance System (SAMSS)

Annual SA Health survey data provided further insights into the trend in the population level of psychological distress, with further indications of a downward trend for females.

Causes of Mental Illness Burden

Mental illness accounted for approximately 9.4 per cent of the total disease burden in South Australia in 2001-2003. The definition of mental illness used by SA Health excluded alcohol and substance illnesses. If these two categories were included, the total burden of disease would have been 12.3%, which is below the national figure of 13.3 %.¹⁰

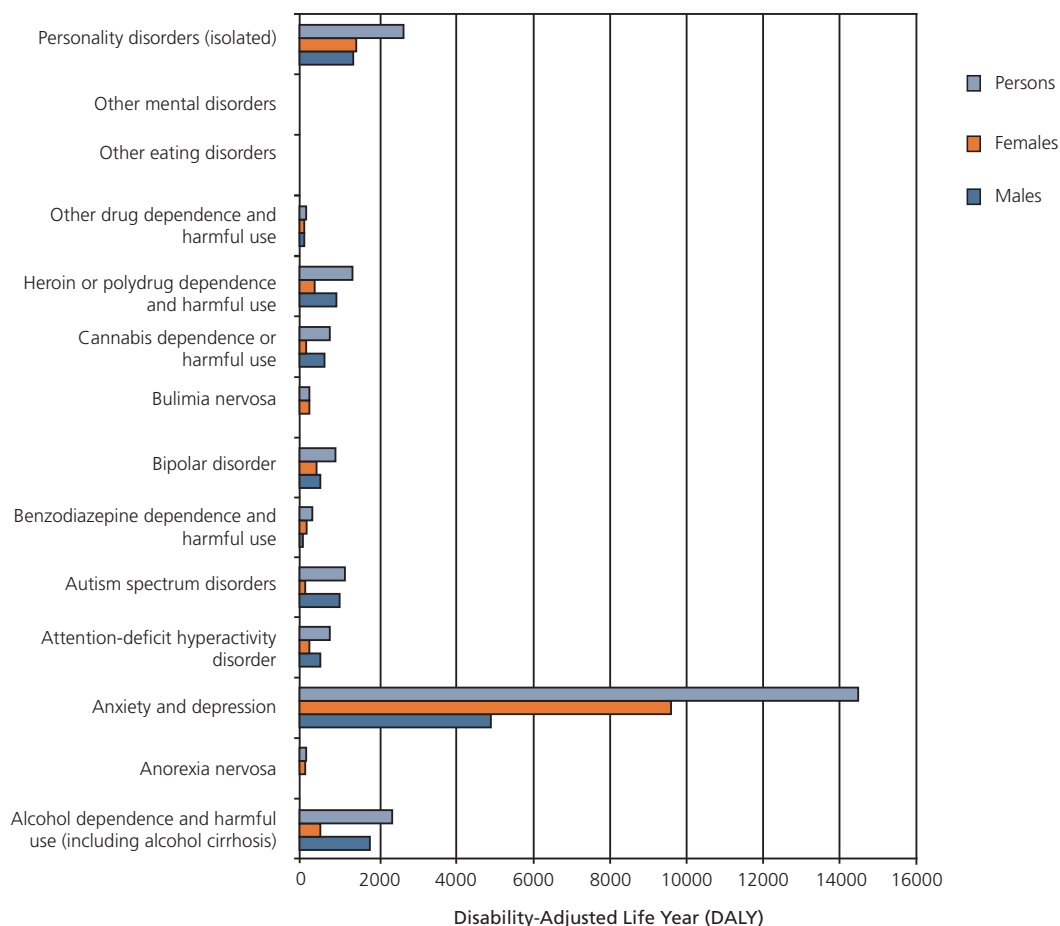
The measure to determine total disease burden is referred to as the 'disability-adjusted life year' (DALY), which describes the number of years of life lost due to premature death coupled with years of 'healthy' life lost due to disability.

During 2001-2003, the total burden of disease for mental illness (excluding alcohol and substance illnesses) for all South Australians accounted for 8000 years for males and nearly 12 000 years for females. Depression and anxiety disorder dominated the burden of mental health disorders.

It also should be noted that, in addition to the mental health illness DALYs, there were over 4000 DALYs recorded for intentional injuries (suicides) of which nearly 3500 were for males and close to 1000 were for females.

The following chart (see Chart 1.23) depicts the most recent burden of disease estimates for both males and females in South Australia. Mental health problems can result in increased exposure to health risk factors, poorer physical health, and death, from causes such as suicide.

Chart 1.23 Burden of mental illness by disorder and gender, South Australia, 2006-08



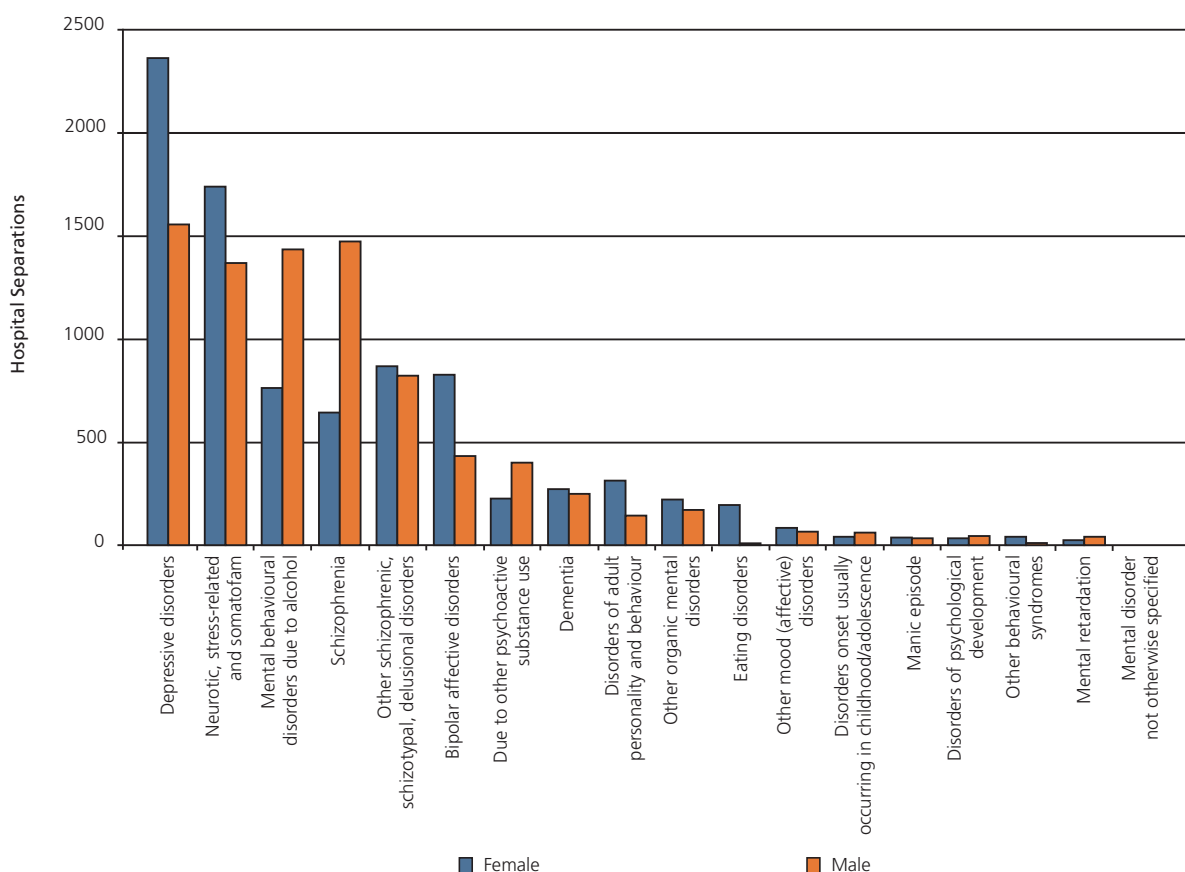
Source: SA Health, South Australian Burden of Disease Study at www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx

Large differences were observed for both disorders and gender. While male years tended to be similar or greater than female years across the disorders, the magnitude and relatively higher level of female years for depression was a noteworthy exception.

Public Hospital Hospitalisation

Understandably, the utilisation of public hospital care is largely reflective of the relative DALY levels across disorders and gender, for example, a disproportionate number of women are admitted for depressive disorders. However, there are a few instances where relative DALY levels are not reflected in the hospitalisation rates, for example, bipolar disorders where it would appear females are over represented (see Chart 1.24).

Chart 1.24 Mental Health Public Hospitalisation by Principal Diagnosis, South Australia, 2008-09

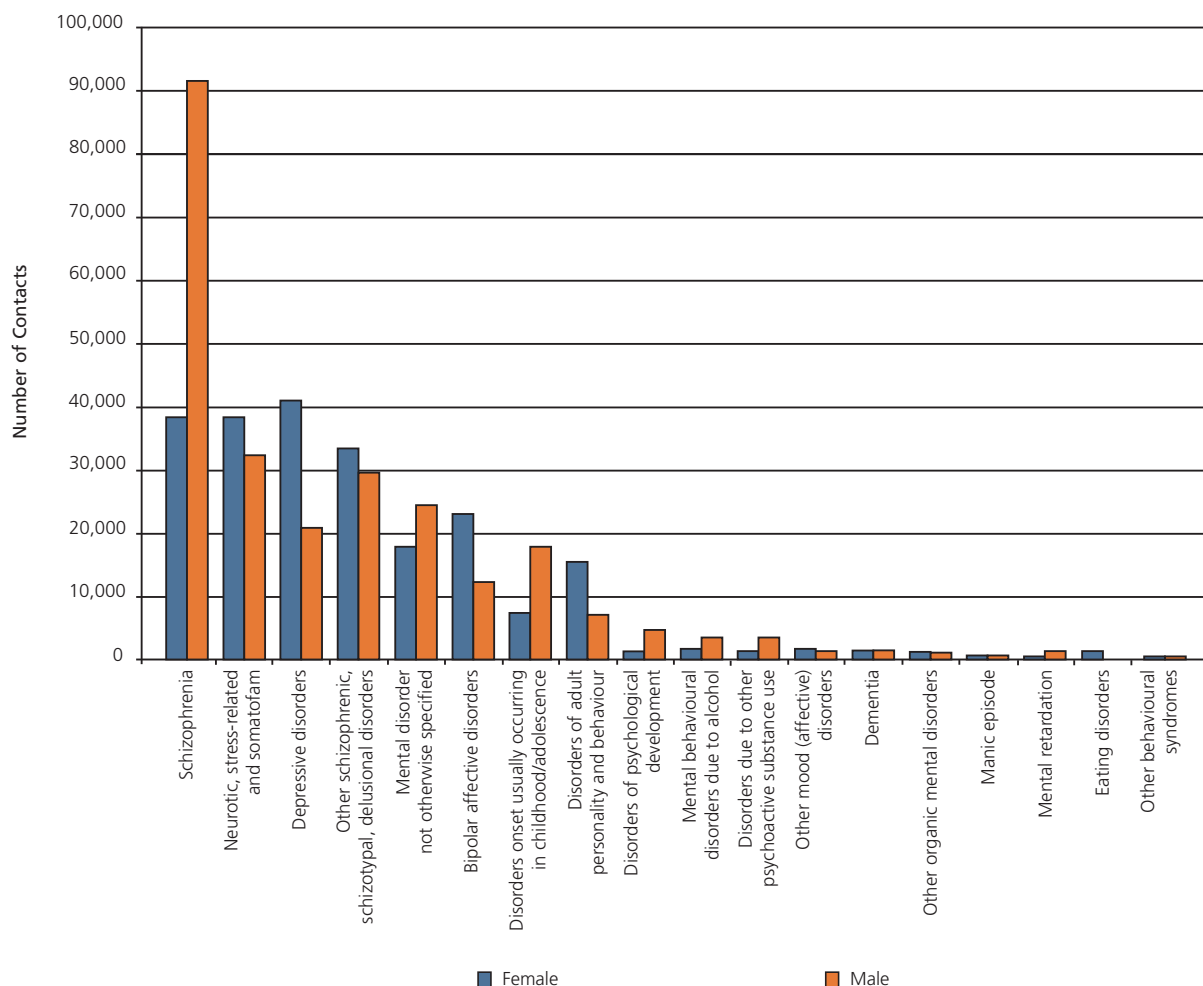


Source: SA Health, Integrated South Australian Activity Collection

Community Mental Health Care Utilisation

Community mental health care utilisation reflected similar patterns to that of the hospital system, with disorders such as schizophrenia; depression and neurotic stress related disorders accounting for the highest utilisation in both hospitals and community care (see Chart 1.25).

Chart 1.25 Community Mental Health Service Contacts by Diagnosis, 2008-09



Note: Includes 28,372 informal contacts and 51 diagnosed contacts where sex is not reported. Informal contacts not reported in 2006-07 Departmental policy is to provide more mental health services in the community.

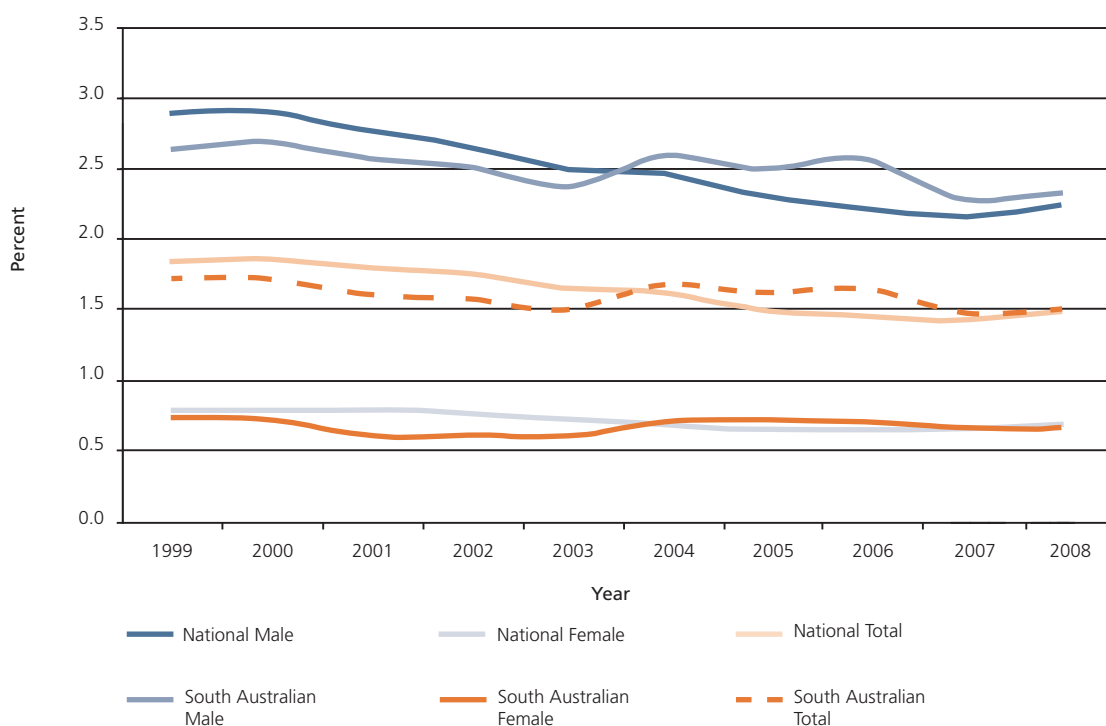
Source: Community Based Information System (CBIS); Country Consolidation CME (CCC); Northern Child Adolescent Mental Health System (NCAMHS)

However, it is noted that the relative utilisation of hospital and community based care for conditions related to alcohol were markedly different.

Suicide

The percentage of deaths attributed to suicide is trending down nationally for both males and females, although it is noted that male suicide rates remain significantly higher than for females. It is noted that while the percentage of total suicides in South Australia was similar to the national level in 2008, the male percentage was higher. This observation would appear consistent with the level of psychological distress in the male community in South Australia, where the results (as noted earlier) from the 2007-08 ABS/NHS indicated a higher level of distress in South Australia.^{8,9} Interestingly, for both males and females the percentage of suicides increased and moved above the national level from 2004. The reason behind this trend is unclear (see Chart 1.26).

Chart 1.26 Suicide as a Percentage of all Deaths by Gender (3 year moving average), South Australia and Australia



Source: Australian Bureau of Statistics (2009) *Deaths, Australia, 2008* (Cat. No. 3302.0) and (2010) *Causes of Death, 2008* (Cat No. 3303.0)

Aboriginal Health

Using the latest data available to the HPC, the following table (see Table 1.6) presents key measures to help identify the 'gap' between Aboriginal and non-Aboriginal people in South Australia and how well South Australian Aboriginal people fare when compared with other Aboriginal people in Australia.

Table 1.6 Selected Aboriginal Health Measures, South Australia and Australia

Indicator	South Australia		National		Ratio	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	SA Indigenous/SA Non-Indigenous	SA Indigenous/National Indigenous
Mortality (2003-2007)						
All ages mortality per 100,000	1447.3	632.1	1400.2	619	2.3	1.0
Perinatal mortality per 1,000 births	11.7	8.2	13.2	9.5	1.4	0.9
Infant mortality per 1,000 live births	8.0	3.9	9.7	4.4	2.1	0.8
Child 0-4 mortality per 100,000	2.0	1.0	2.3	1.1	2.0	0.9
Hospitalisations per 1,000 (2006-07 to 2007-08)						
Hospitalisation (all causes) per 1,000	1097.8	351.6	884.8	338.6	3.1	1.2
Hospitalisation (excluding dialysis) per 1,000	491.3	315.0	425.7	301.1	1.6	1.2
Child under 5 hospitalisation per 1,000	368.2	278.9	308.7	237.5	1.3	1.2
Prevalence of selected health conditions (2004-05)						
Heart/circulatory diseases	22.7%	18.7%	21.7%	17.3%	1.2	1.0
Diabetes	16.0%	4.0%	12.0%	4.0%	4.0	1.3
Disease of the ear/mastoid (children aged 0-14 years)	6.5%	3.6%	9.5%	3.0%	1.8	0.7
Incidence of selected health conditions (2004-2006)						
End stage renal disease per 1,000	0.9	0.1	0.8	0.1	9.0	1.1
Chlamydia per 100,000	7779.2	172	1239.4	202.9	45.2	6.3
Gonorrhoea per 100,000	838.1	9.7	1503.4	21.7	86.4	0.6
Syphilis per 100,000	22.1	1.5	263.4	3.6	14.7	0.1
Hepatitis C per 100,000	32.7	3.4	23.4	3.9	9.6	1.4
Health risk factors (2004-05 except where stated)						
Low birth-weight (2005-2007)	13.5%	4.8%	11.5%	4.5%	2.8	1.2
Tobacco smoking during pregnancy (2007)	60.8%	19.7%	50.6%	15.2%	3.1	1.2
Antenatal care						
Women who attended at least one antenatal visit in first trimester (2007)	40.7%	72.5%	59.4%	76.9%	0.6	0.7
Current daily smoking (2008)	47.0%	20.0%	44.8%	18.9%	2.4	1.0
Alcohol consumption						
Short-term risky/high risk levels at least once a week	17.5%	8.2%	17.0%	8.0%	2.1	1.0
Long term risky/high risk levels	16.0%	14.7%	15.4%	13.5%	1.1	1.0
Physical activity						
Sedentary	53.8%	33.7%	50.9%	33.2%	1.6	1.1
Low	24.3%	38.2%	28.1%	36.1%	0.6	0.9
Moderate	17.5%	22.4%	16.1%	23.8%	0.8	1.1
High	4.3%	5.8%	4.9%	6.9%	0.7	0.9

Note: National rates for child under 5 hospitalisation includes NSW, Vic, Qld, WA, SA & NT only. National data for antenatal care includes NSW, SA & NT for antenatal visits in first trimester; and Qld, SA & NT for number of antenatal visits. Estimates have a relative standard error of between 25% and 50% and should be used with caution.

Source: National Agreement Performance Information 2008-09: National Indigenous Reform Agreement.

Key observations from the data include:

1. While pregnant SA Aboriginal women have lower antenatal care participation and higher smoking during pregnancy rates, and their babies have greater low birthweight rates than other states and territories, the longer-term outcomes for their children would appear better than those of the children of Aboriginal women in other states and territories. Aboriginal perinatal, infant and child (0-4 years) mortality rates are lower in SA than nationally.
2. Hospitalisation rates for Aboriginal people in South Australia are consistently higher than for all Aboriginal people across Australia. This situation is likely to be reflective of the capacity of the hospital system in SA and its overall utilisation, which is around 10% higher than the national average.
3. Large variations in the incidence of infectious conditions (for example, Chlamydia) are likely to be accounted for more by differences in detection and reporting of cases across states and territories rather than the underlying disease profiles in the community.

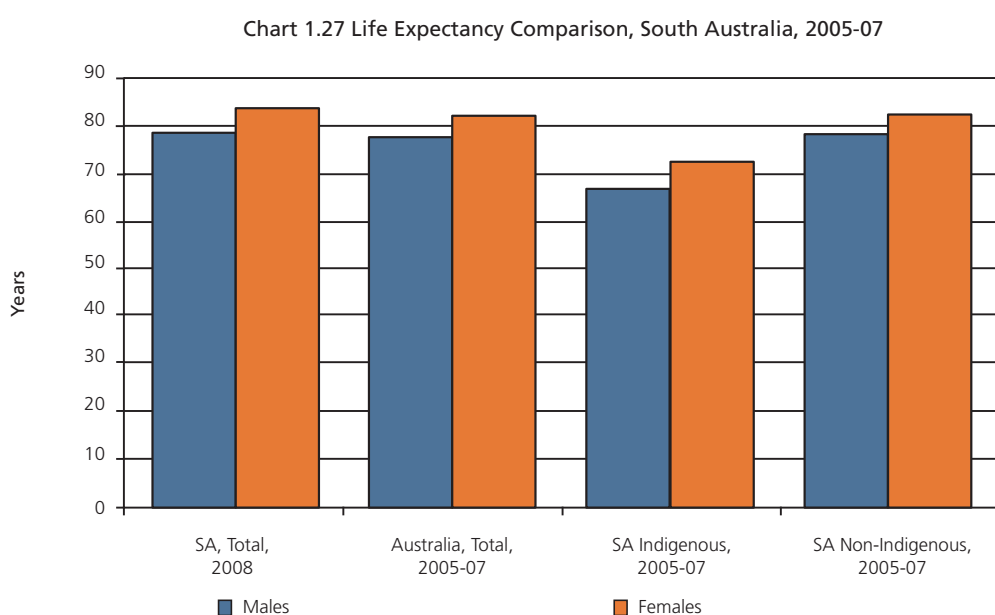
Life Expectancy

The life expectancy of Aboriginal people in Australia is significantly less than the total population.

Through the National Indigenous Reform Agreement (Closing the Gap), the Council of Australian Governments (COAG) have agreed to the following targets:¹¹

- > Closing the life expectancy gap within a generation
- > Halving the gap in mortality rates for Indigenous children under five within a decade
- > Ensuring all Indigenous four-year-olds in remote communities have access to early childhood education within five years
- > Halving the gap for Indigenous students in reading, writing and numeracy within a decade
- > Halving the gap for Indigenous students in Year 12 attainment or equivalent attainment rates by 2020
- > Halving the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade.

The following chart (see Chart 1.27) illustrates the gap in life expectancy between Aboriginal and non-Aboriginal people in South Australia. Both male and female Aboriginal people have a life expectancy of about 10 years less than the total population.



Source: ABS (2009) *Deaths, Australia, 2008* (Cat. No. 3302.0) and (2008) *Life Tables, Australia, 2005-2007* (Cat No. 3302.0.55.001)

Mortality

The total age standardised rate of mortality of Aboriginal South Australians was 2.3 times that of non-Aboriginal South Australians during the period 2003-2007, whereas it was only slightly elevated in comparison with other Aboriginal communities across Australia (see Table 1.7).

Table 1.7 Leading Causes of Mortality, Indigenous and Non-Indigenous Australians, SA and National, 2003-2007

Cause of death (ICD-10 chapter level)	South Australia		National(a)		Ratio	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	SA Indigenous/ SA Non-Indigenous	SA Indigenous/ National Indigenous
Age standardised rate per 100,000						
Diseases of the circulatory system (I00-I99)	582.8	221.7	513.5	216.9	2.6	1.1
External causes of morbidity and mortality (V01-Y98)	115.1	39.3	88.8	37.2	2.9	1.3
Endocrine, nutritional and metabolic diseases (E00-E90)	125.4	23.7	119.6	23.0	5.3	1.0
Diabetes mellitus (E10-E14)	123.8	16.5	113.1	16.2	7.5	1.1
Diseases of the respiratory system (J00-J99)	155.2	57.9	150.4	52.5	2.7	1.0
Neoplasms (C00-D48)	224.1	184.9	247.8	183.9	1.2	0.9
Malignant neoplasms of digestive organs (C15-C26)	44.0	49.6	68.4	50.1	0.9	0.6
Malignant neoplasm of bronchus and lung	57.5	33.2	63.8	34.1	1.7	0.9
Malignant neoplasm of cervix uteri	1.7	1.0	5.0	1.0	1.7	0.3
Diseases of the digestive system (K00-K93)	77.7	21.4	89.7	20.8	3.6	0.9
Kidney Diseases (N00-N29)	52.2	12.1	46.3	10.7	4.3	1.1
Certain conditions originating in the perinatal period (P00-P96)	5.5	2.2	5.7	3.0	2.5	1.0
Certain infectious and parasitic diseases (A00-B99)	20.8	8.1	24.6	8.4	2.6	0.8
Diseases of the nervous system (G00-G99)	49.8	21.3	35.1	22.3	2.3	1.4
Other causes	71.8	39.7	92.7	40.3	1.8	0.8
Total	1477.3	632.1	1400.2	619	2.3	1.1

(a) National rates include all states and territories. These estimates should be interpreted with caution as they are not adjusted for under-identification.

Source: National Agreement performance information 2008-09: National Indigenous Reform Agreement.

While Aboriginal people in South Australia have a higher death rate for such conditions as diabetes and kidney disease, there are indications that Aboriginal people in South Australia have lower cancer mortality rates than other states and territories.

Premature Death

Although there is a degree of overlap in the top 10 causes of premature mortality, the mortality burden from inflammatory heart disease, cirrhosis of the liver and diabetes is of relatively greater significance in the Aboriginal community than the non-Aboriginal community (see Table 1.8).

Table 1.8 Top 10 Causes of Premature Mortality (three-year moving average) Aboriginal and Non-Aboriginal People, SA, 2005-2007

Condition	Aboriginal South Australians			Other South Australians		
	Rank	YLL	Adjusted rate per 1000	Rank	YLL	Adjusted rate per 1000
Ischaemic heart disease	1	412	27.9	1	16645	9.1
Suicide and self-inflicted injuries	2	212	7.6	5	4014	2.6
Type 2 diabetes	3	127	9.4	11	2191	1.2
Road traffic accidents	4	107	3.6	9	2764	1.8
Lower respiratory tract infections	5	100	4.2	15	1888	1.0
Lung cancer	6	93	7.9	2	7088	3.9
Cirrhosis of the liver (excluding alcoholic and hepatic cirrhosis)	7	82	4.8	17	1624	0.9
Stroke	8	68	4.5	3	6889	3.7
Low birth weight	9	67	1.3	44	425	0.3
Nephritis and nephrosis (excluding diabetic, congenital and poisoning related renal failure)	10	65	5.5	10	2254	1.2
Total		2375	136.2		104150	58.8

Notes: ERP by indigenous status estimated using age and sex profile within 3238.0.55.001 – Experimental Estimates of Aboriginal and Torres Strait Islander Australians, Jun 2006 applied to projected state totals in ABS 3238.0 – Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2021, Series B. Age categories of 0-4, then 10-year age groups to 55+. Rates adjusted using direct standardisation with SA ERP for 30 June in relevant years & Australia 2001 population. Deaths processed by year of death rather than year of registration.

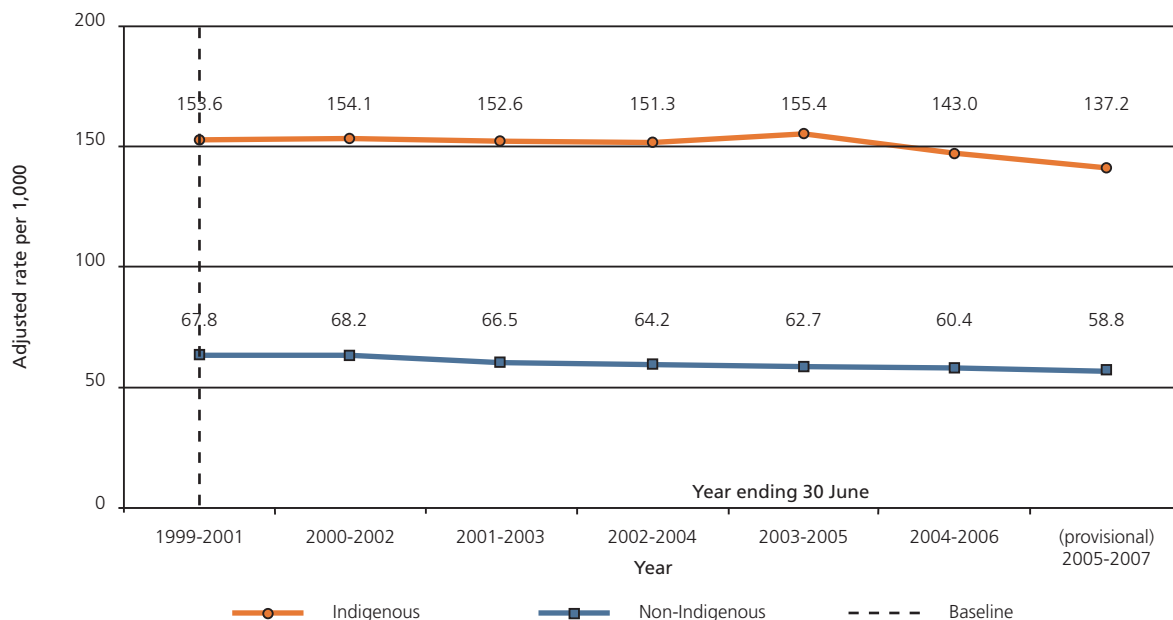
Source: SA Burden of Disease site at <http://www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx>

As mentioned earlier in this chapter, the rate of premature death in the Aboriginal community is much higher than in the non-Aboriginal population. For example, the rate of premature death due to diabetes is nearly 10 times higher.

SA Strategic Plan Target 2.5: Aboriginal Healthy Life Expectancy: Lower the morbidity and mortality rates of Aboriginal South Australians.⁴

Positive progress is being made in relation to this target and SA Health considers it is on track to meet this target by the due date (see Chart 1.28).

Chart 1.28 Premature Mortality (Years of Life Lost), South Australia



Note: ERP by indigenous status estimated using age and sex profile within 3238.0.55.001 – Experimental Estimates of Aboriginal and Torres Strait Islander Australians, Jun 2006 applied to projected state totals in ABS Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians, 1991 to 2009 Cat 3238.0 LOW SERIES. 1999 & 2000 population figures not available so rate calculations use 2001 estimates for 1999-2001 period, then 2001, 2002, 2003, 2004, 2005 for 2000-2002, 2001-2003, 2002-2004, 2003-2005, 2004-2006 respectively Age and sex adjusted to Australia 2001 population so we can determine if there would be any differences in outcomes if the age and sex of the population were the same (used 0-4, then 10 year age groups to 55+.).

Source: SA Health, South Australian Burden of Disease Study www.health.sa.gov.au/burdenofdisease/DesktopDefault.aspx

The COAG reforms are considered to be additional to and supportive of the target, but do not replace the strategic approach to Aboriginal health under the SASP.⁴

Causes of Hospitalisation

Aboriginal people are more than three times as likely to be hospitalised, than other people in South Australia, again reflecting the health differentials that exist in South Australian society. However, it is also noted that Aboriginal people in South Australia have relatively higher access to hospital services when compared with Aboriginal people nationally.

While the admission rate for many of the conditions is 10-20% above the national rate (which is consistent with the finding that South Australia's overall hospital utilisation rate is elevated compared with the national average), even higher access rates exist for such conditions as dialysis, diabetes and mental health (see Table 1.9).

Table 1.9 Leading Causes of Hospitalisation, Indigenous and Non-Indigenous Australians, SA and National, 2006-07 to 2007-08

Principal diagnosis (ICD-10-AM chapter level)	South Australia		National(a)		Ratio	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Non-Indigenous	National
Age standardised rate per 1,000						
Injury and poisoning and certain other consequences of external causes	56.9	23.6	47.2	22.6	2.4	1.2
Diseases of the respiratory system	55.6	19.1	44.5	15.3	2.9	1.2
Diseases of the digestive system	48.3	37.8	40.3	38.3	1.3	1.2
Pregnancy, childbirth and the puerperium	35.2	23.1	36.4	22.5	1.5	1.0
Diseases of the circulatory system	36.6	20.4	36.4	20.4	1.8	1.0
Symptoms, signs and abnormal clinical and laboratory findings	42.5	22.5	35.6	22.3	1.9	1.2
Mental and behavioural disorders	43.2	11.1	27.2	13.4	3.9	1.6
Endocrine, nutritional and metabolic diseases	28	7.1	21.1	6.3	3.9	1.3
Diseases of the genitourinary system	19.4	17.3	20.2	16.5	1.1	1.0
Diseases of the skin and subcutaneous tissue	14.9	7.5	14.4	5.5	2.0	1.0
Certain infectious and parasitic diseases	10.7	4.3	10.3	4.2	2.5	1.0
Other (b)	100	121.2	92.2	114	0.8	1.1
Total excluding dialysis	491.3	315	425.7	301.1	1.6	1.2
Care involving dialysis	606.5	36.6	459.2	37.5	16.6	1.3
Total including dialysis	1097.8	351.6	884.8	338.6	3.1	1.2

(a) National rates include all states and territories and have been adjusted for Indigenous under-identification.

(b) Includes diseases of the musculoskeletal system and connective tissue; neoplasms; diseases of the nervous system; certain conditions originating in the perinatal period; diseases of the ear and mastoid process; diseases of the eye and adnexa; diseases of the blood and blood forming organs and certain disorders involving the immune system; congenital malformations, deformations and chromosomal abnormalities; and factors influencing health status and contact with health services (except dialysis).

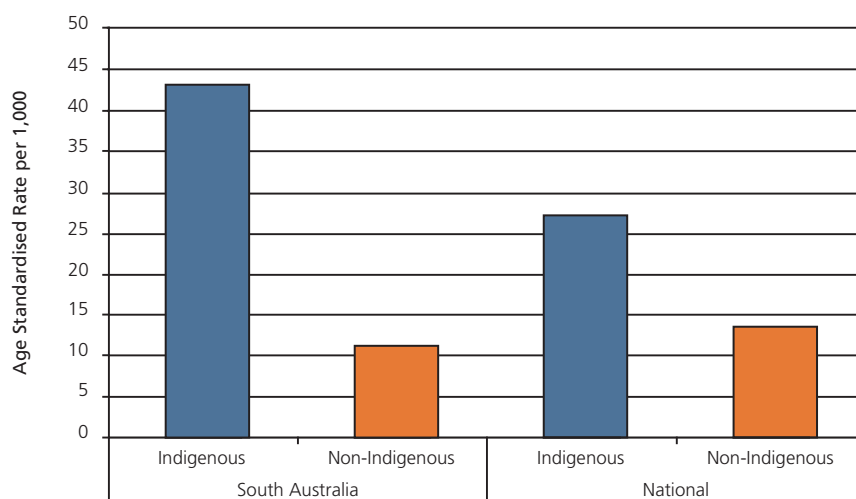
Source: AIHW, National Agreement Performance Information 2008-09: National Indigenous Reform Agreement.

Mental Health

Incidence, prevalence and mortality data presented earlier in this chapter can help provide a reasonable basis for understanding the higher utilisation rates for dialysis and diabetes in South Australia, but the case for mental health is less clear.

The HPC was not provided with a clear indication of what could explain the fact that Aboriginal residents of South Australia were over 1.6 times as likely to be admitted to hospital when compared with other Aboriginal people in Australia during the two-year period 2006-07 to 2007-08. Further data analysis is indicated, including consideration of a longer time trend, metropolitan, rural and remote rates, relative access to community based mental health services and underlying prevalence of mental health conditions in the community (see Chart 1.29).

Chart 1.29 Hospitalisation for Mental and Behavioural Disorders, 2006-07 to 2007-08



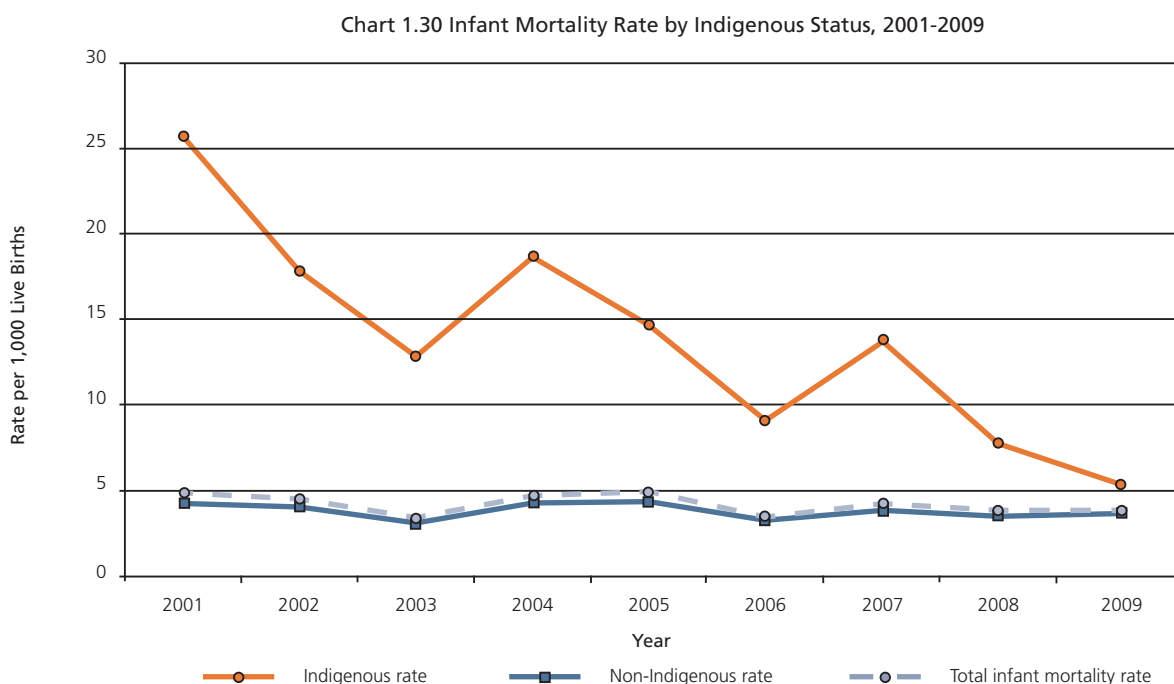
Source: National Agreement performance information 2008-09: National Indigenous Reform Agreement

Birthing Outcomes

Access to effective antenatal care, smoking during pregnancy, low baby birthweight and perinatal and infant mortality rates are often considered together in monitoring birthing outcomes.

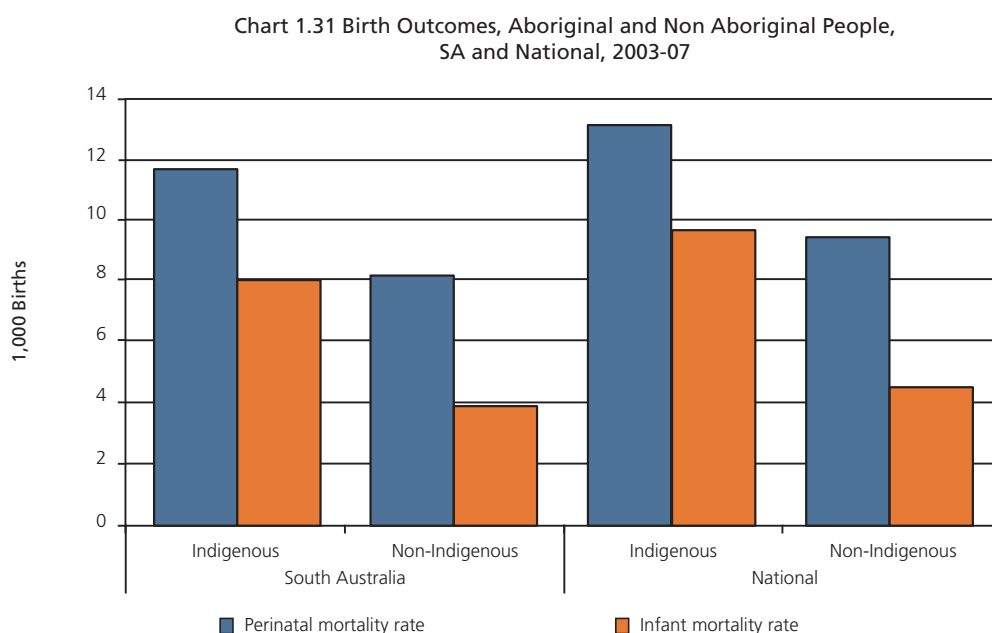
Infant Mortality

SA Health reported that the infant mortality rate (three-year moving average) for Aboriginal people in South Australia has improved from 18.8 per 1000 live births during the period 1999-2001 to 10.2 per 1000 live births during 2006-2008 (see Chart 1.30).



Provisional data for 2009 indicated that the gap between Aboriginal and non-Aboriginal infant mortality rates is being further reduced.

Despite this improvement, data for the period 2003-2007 indicated that the non-Aboriginal rate in South Australia in that period was approximately half that of the Aboriginal population (see Chart 1.31).



Source: National Agreement performance information 2008-09: National Indigenous Reform Agreement.

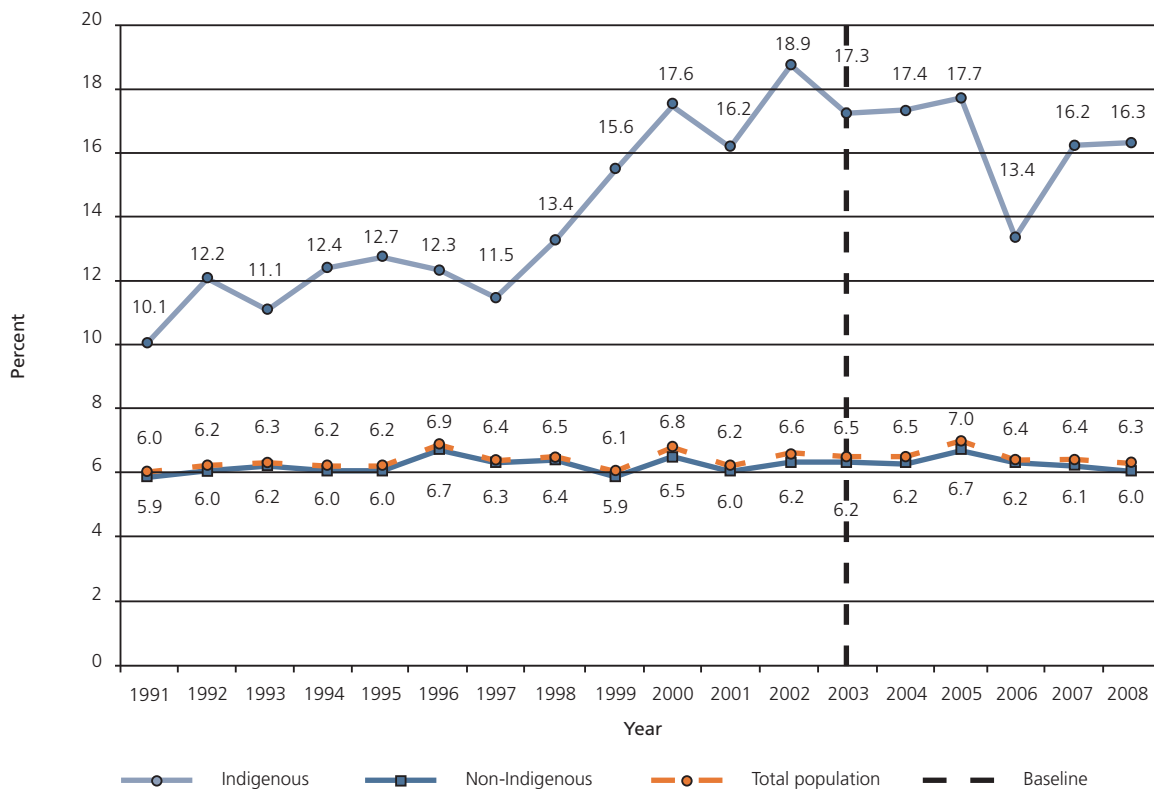
However, this data also indicated that the infant mortality rate for Aboriginal South Australians was approximately 20% lower than in other Aboriginal communities across Australia.

Low Birthweight Babies

South Australia's Strategic Plan Target 6.3: Early Childhood – Birthweight: Reduce the proportion of low birthweight babies.⁴

This target was considered to be on track with a decline since 2006 being maintained for the general population. However, the rate for Aboriginal people remained substantially higher at more than double the total population (see Chart 1.32).

Chart 1.32 Low birthweight infants as a proportion of total live births, Aboriginal and Non Aboriginal, South Australia



Note: Annual rates of Indigenous low birthweight babies can fluctuate due to relatively small numbers.

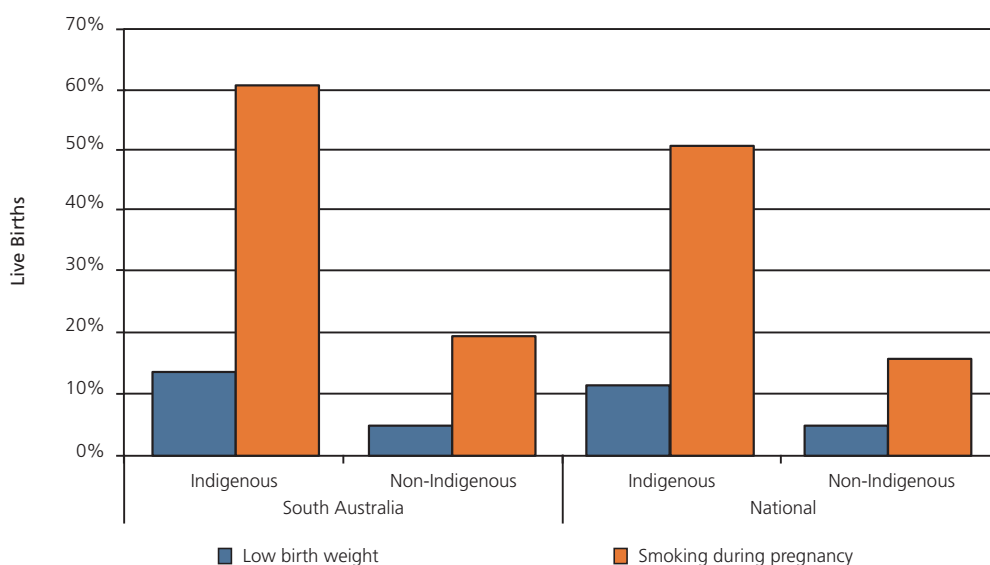
Source: SA Health, Pregnancy Outcomes Unit, Epidemiology Branch

SA Health has indicated it is recognised that one risk factor in isolation is rarely associated with low birthweight. A recent analysis of Australian and international literature indicated that access to care for Aboriginal women has a greater potential to impact on low birthweight where the model of care includes shared care arrangements and Aboriginal Health Workers as part of the health care team. The SA Health implementation plan for this target therefore has a focus on reducing the number of low birthweight babies born to Aboriginal women.

National and international literature indicates the complex nature of the relationships amongst the risk factors might make it difficult to shift the robust population mean for low birthweight babies in South Australia (see Chart 1.33).

Irrespective of relatively favourable birthing outcomes relating to mortality, it is noted that Aboriginal people living in South Australia have a higher percentage of women smoking during their pregnancy and higher percentage of low birthweight babies than Aboriginal people in other states and territories.

Chart 1.33 Birth Outcome Risk Factors, Aboriginal and Non Aboriginal People, SA and National, 2005-07



Source: National Agreement performance information 2008-09: National Indigenous Reform Agreement

SA Health Strategic Direction: Strengthen Primary Health Care

SA Health is committed to a primary health care approach that encompasses the social, economic, cultural, and biological determinants of health, from the well population to individuals with chronic disease – and from birth to old age...SAHSP p.5

1. What did SA Health commit to do?

a. Strategic Position

SA Health Strategic Plan 2008-2010 (SAHSP) presents a commitment to a strengthened primary health care (PHC) approach through the provision of clinical services in the community, improved continuity of care and collaborative action to develop healthy environments and support behaviours that reduce risk factors, enhance health outcomes and reduce health inequalities in the community.³

This approach encompasses both the prevention and treatment of ill health, through the provision of coordinated primary and community care and support to individuals and families, and more broadly based inter-sectoral approaches to promoting and protecting population health.

With its strong focus on reducing health risk factors, by encouraging healthier lifestyles, the strategy has both health outcomes and health system objectives. It seeks to improve the health of South Australians, increase client independence and choice, as well as moving the focus of demand away from the hospital system into the community. The two outcomes are interrelated – the objective is to have improved health by means that reduce the demand on the hospital system and provide more appropriate options for the management of health risk factors and chronic disease.

There are two major strategic areas for strengthening PHC – tackling health risk factors as early as possible and reforming models of care to improve and increase the services that can be provided outside the hospital setting. The HPC noted that this was reflected in the focus of the policies, strategies and programs brought to its attention. *GP Plus* is a major element in the reform of the health system envisaged by the *SA Health Care Plan 2007-2016 (SAHCP)*.^{6, 12}

GP Plus Health Care Strategy – August 2007 (GP Plus) is SA Health's major platform both in terms of tackling health risk factors and for increasing the options for managing the effects of chronic disease outside the hospital system. The HPC would argue that to work effectively it would need to develop excellent communication and whole of system interactions across its different providers and services. As such, *GP Plus* is integral to the achievement of the overall system improvement and improvement in the continuity of care envisaged by the SAHSP.^{3, 6}

b. Key Objectives and Performance Measures

Key Objectives for SA Health for PHC are to:

- > Focus on health protection and promotion (Objective 1.1)
- > Provide effective avenues for prevention and early intervention (Objective 1.2)
- > Facilitate effective coordination and continuity of care (Objective 1.3)
- > Minimise the burden of disease on the health system (Objective 1.4)
- > Provide appropriate services closer to where people live (Objective 1.5)

(SAHSP p.5)

SAHSP stated the system performance measures for strengthening PHC included:

Smoking

- > Percentage of young cigarette smokers
- > Smoking quit rates per annum
- > Percentage of surveyed SA smokers aware of the health effects of active smoking.

Healthy Weight

- > Proportion of South Australians 18 and over with healthy weight
- > Percentage of adults achieving sufficient physical activity levels
- > Serves of fruit and vegetables consumed per day – adults and children.

Healthy South Australians

- > Healthy life expectancy of South Australians
- > Incidence of mortality and the prevalence and severity of illness (morbidity) in the South Australian population
- > Proportion of families offered Family Home Visiting Program who complete the program
- > Proportion rates in immunisation programs for vaccine preventable illness
- > Potentially preventable hospitalisations for targeted diseases and conditions.

Chronic Diseases

- > Proportion of people living with a chronic disease whose self-assessed health status is good or better
- > Number of general practices that have participated in the *GP Plus* Practice Nurse Initiative
- > Number of people enrolled in self-management and integrated health care plans
- > Proportion of people who complete chronic disease management programs.

Early Childhood

- > Proportion of low birthweight babies
- > Rate of infant mortality
- > Percentage of pregnant women who have their first antenatal assessment in the first trimester
- > Percentage of teenage (<20 years of age) pregnancies
- > Percentage of women who do not smoke during the second half of pregnancy
- > Proportion of low birthweight babies born to women living in low socioeconomic status (SES) areas who have their first antenatal assessment in the first trimester compared to those who do not.

(SAHSP p.6)

2. How did SA Health Perform?

In considering performance, the HPC made an assessment against the data and information provided by SA Health and particular stakeholders.

In this section the HPC's specific findings for each key objective are discussed.

Focus on health protection and promotion (Objective 1.1)

Key Findings

1. SA Health has strengthened its focus on health protection and promotion through its efforts to tackle health risk factors as early as possible and improving services provided outside the hospital setting. The HPC notes the ongoing monitoring of many of these initiatives and acknowledges SA Health has plans to evaluate their impact on population health outcomes.

Discussion

SA Health reported that health risk factors are the main topics for attention in its key promotional approaches; with a strong emphasis during 2008-2010 on *South Australia's Strategic Plan* (SASP) targets.⁴ In reporting on this objective SA Health focused mainly on the targets related to smoking and healthy weight.

SA Health, through the Public Health operational arm, funds and implements many disease prevention initiatives including: child immunisations; H1N1 flu vaccinations for at risk groups; treatment and follow-up of people with HIV/AIDS and other sexually transmitted infections; food safety inspections across the community; and monitoring of water safety.

SA Health indicated a number of strategies have been developed and are underway to promote and encourage reduction of health risk factors such as smoking, obesity, inadequate nutrition, and insufficient physical activity. These are listed below.

Smoking

SA Health reported that the *SA Tobacco Control Strategy 2005-2010* is progressing and they are currently implementing and monitoring annual programs aimed at reducing the prevalence of smoking among Aboriginal youth and disadvantaged/low socioeconomic status groups.¹³

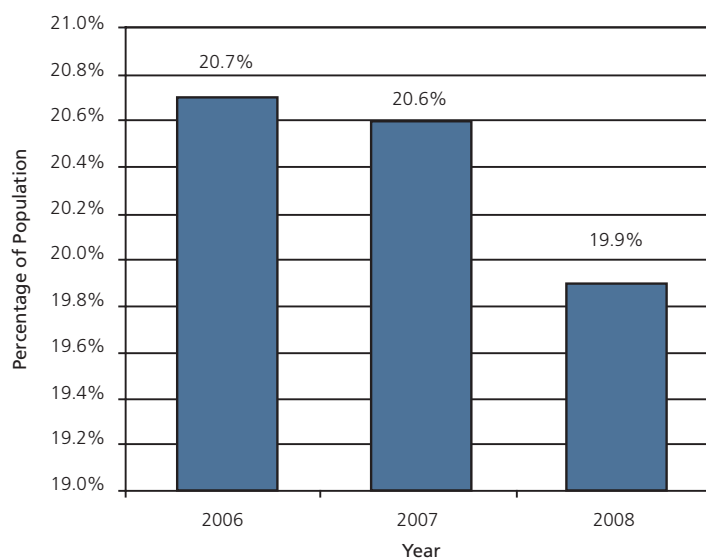
Since 31 May 2010, all South Australian public hospital and health services grounds have been smoke free. SA Health indicated this policy has been successfully implemented and it has offered its experience to advise other government departments on the introduction of similar policies.

Other developments include an increase to social marketing investments, SA Health reports increasing this to 700 Targeted Audience Rating points per month, the planned introduction of regulations to remove tobacco displays at point of sale in general retailers from January 2012 and the development of the *South Australian Tobacco Control Strategy 2011-2016*.

Population Smoking Rates

Data provided for the adult population (15+) smoking rate indicates that the level of smoking in the adult population consistently decreased over the two years to 2008. While this is encouraging, it is not clear what impact SA Health specific strategies have had on these rates given similar trends are occurring nationally (see Chart 2.1.1).

Chart 2.1.1 Population smoking rate (15+ years), South Australia, 2006 to 2008



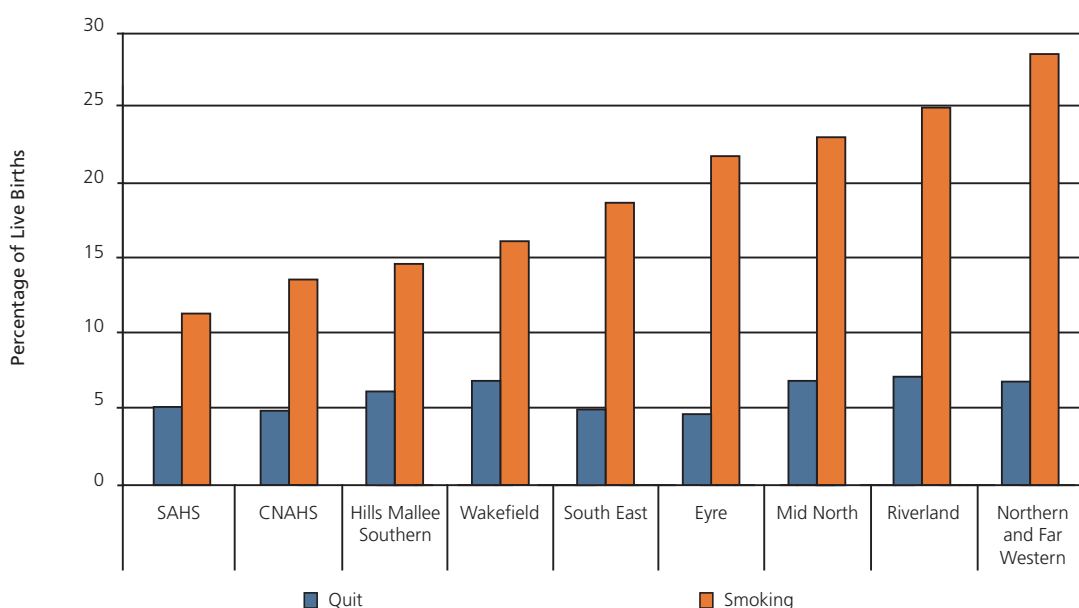
Source: SA Health

From the data the HPC received, it is noted that in 2008:

- > 48% of adult Aboriginal people smoked as compared with about 20% of non-Aboriginal people
- > 22% of males smoked, compared with about 18% of females
- > 23% of people aged 15 to 29 years of age smoked, compared with 20% in the general adult population
- > 25% of people living in country SA smoked as compared with about 18% of people living in metropolitan SA.

Data presented to the HPC indicates that smoking rates are consistently higher in rural and remote areas of South Australia. For example, data on pregnancy smoking rates indicates significant regional variations (see Chart 2.1.2).

Chart 2.1.2 Smoking and quit rate during pregnancy, South Australia, 2006-08



Abbrev: SAHS (Southern Adelaide Health Service), CNAHS (Central Northern Adelaide Health Service)

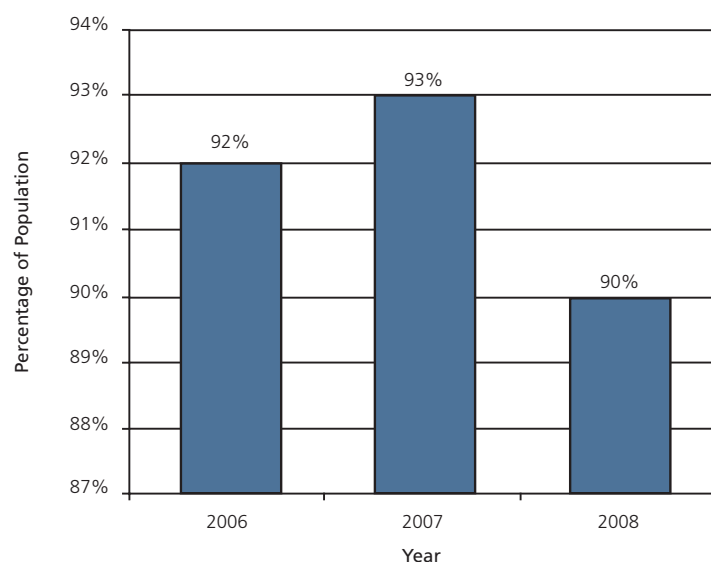
Source: SA Health, Pregnancy Outcomes Unit, Epidemiology Branch

These disparities provide an indication for differential and targeted interventions for specific population groups. The HPC received limited information of programs targeted at reducing smoking in these population groups.

Awareness of the Health Effects of Smoking

Population awareness of the health effects of smoking provides some insight into the effectiveness of public health campaigns and other health promotion activities. The data provided by SA Health does not provide a clear indication that public awareness is improving (see Chart 2.1.3).

Chart 2.1.3 Population awareness of smoking health effects, South Australia, 2006-2008

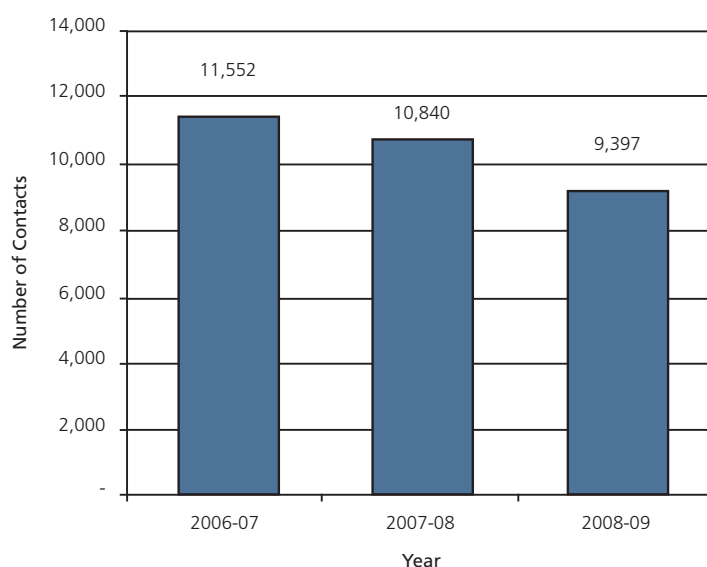


Source: SA Health

Number of Quitline Contacts

The number of contacts with the SA Quitline has decreased over the two-year period 2006-07 to 2008-09 by about 19% (noticeably the rate of smoking in the general adult population has only fallen about 4% during this period). This could reflect a decreasing awareness of the health effects of smoking, greater resistance to change from the smoking population, reduced perceived relevance of the SA Quitline and/or reduced capacity/access to the SA Quitline (see Chart 2.1.4).

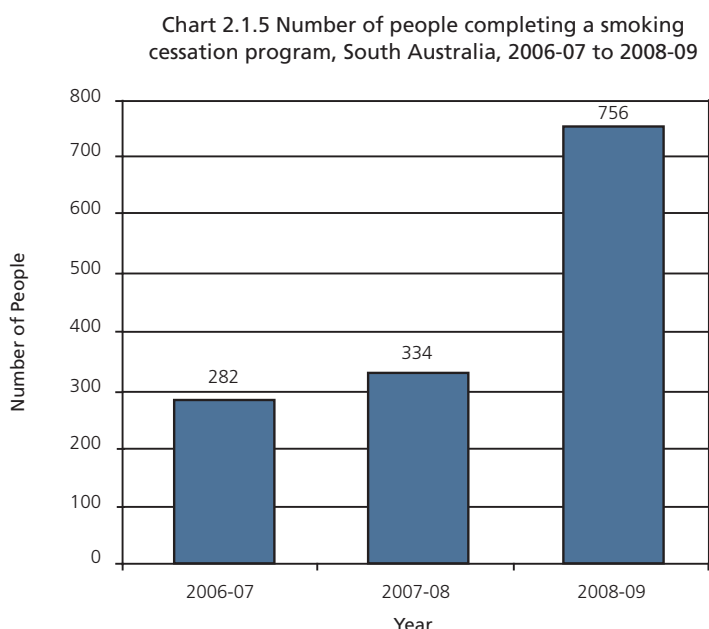
Chart 2.1.4 Number of contacts with SA Quitline, 2006-07 to 2008-09



Source: SA Health

Number of People Completing Smoking Cessation

The number of people completing a smoking cessation program has increased significantly since 2006-07 (nearly three times as many people), particularly in 2008-09. This may reflect efforts to reduce smoking rates under the *GP Plus* Health Care Strategies and is in line with the SASP targets (although this is more focused on youth smoking) (see Chart 2.1.5)^{4, 6}



Source: SA Health

The quit rates at the six-month follow-up are reported to have remained static at 16% between 2004 and 2007.

Obesity & Healthy Weight

SA Health reported that the *Eat Well Be Active Healthy Weight Strategy for South Australia 2006-2010* (EWBA) is progressing⁷. The strategy's focus on promoting healthy lifestyles and disease prevention is being implemented in a range of more than 20 initiatives/plans. These plans concentrate on community education and awareness programs and campaigns, school and community programs and services, policy and legislation changes, and capacity building through workforce development and training as well as research programs.

SA Health reported that programs to reinforce and improve the health of South Australians is being pursued through targeted programs such as Home Visiting and Children's Centres and through the *Do it for Life Program* that targets individuals 18+ who are considered at high risk of developing a chronic disease which can be prevented by lifestyle changes.

Early childhood birthweight has had considerable focus through promotion of the health risk factor principles in pre-conception education programs as well as programs to reduce smoking in pregnant women.

SA Health reported that significant work was undertaken to evaluate its healthy eating, physical activity and obesity interventions. This included monitoring the physical activity levels, dietary behaviour and weight as longer-term health outcomes.

For example, the evaluation of the EWBA Communities Program 2005-2010 measured outputs such as policy changes in different settings; changes in knowledge and behaviour and population level changes in weight and waist circumference over three years.⁷ Evaluation results showed that the improvements occurred among those who were most in need.

This evaluation directly informed the strategic goals, measurements and design of the Obesity Prevention and Lifestyle (OPAL) Program. SA Health indicated that OPAL would have a rigorous evaluation over the next seven years, matching the level of investment in the program.

SA Health indicated that its prevention programs are informed by the findings of population surveys (2007 Australian National Children's Nutrition and Physical Activity Survey, South Australian Monitoring and Surveillance System, Health Monitor and Health Omnibus) which provide targets for achievement and identify population groups with which to work around issues previously identified.

Stakeholders consulted by the HPC provided positive feedback about SA Health's protection and health risk promotion approaches. These stakeholders also indicated that substantial gaps in health literacy remain and need to be addressed. These gaps include education of clients, potential clients and the community about the options and opportunities available in relation to PHC generally.

SA Health plans to undertake statewide and regional level health literacy initiatives focusing on reducing inequalities and addressing gaps. Its new SA Health web site was designed to provide access to health services and health information with a focus on early intervention, primary health care and health promotion.

It is difficult to assess the effectiveness of these programs, as the variables influencing changes in these factors are diverse. However, the slight decrease in young people's smoking rates (see Chart 2.1.1) is encouraging, as are early results related to the EWBA Communities program.⁷ An ongoing system wide evaluation will help to understand the impact of these programs on health status. Such evidence would facilitate decision-making regarding ongoing investment and further expansion of successful programs.

Social and Economic Determinants

As indicated in the SAHSP, understanding and addressing social and economic determinants is considered an important part of strengthening PHC.³

In regards to the social and economic determinants of health, the major area of focus is around the *Health in all Policies (HiAP)* approach.^{14, 15} This aims to provide a framework for cooperation across government in planning, policy development and programs, based on the understanding that health issues do not exist in a vacuum. There are strong interrelationships between health and other factors such as education, employment, housing, and lifestyle options.

There are some clear instances where plans and strategies take into account, and specifically aim to address circumstances of population groups who might be otherwise disadvantaged. For example, SA Health advises it is progressing with the *South Australian Tobacco Control Strategy 2005-2010*.¹³ This strategy involves the implementation of programs aimed at reducing the prevalence of smoking among Aboriginal, youth and other disadvantaged and/low socioeconomic status people and groups.

It is too soon to assess the impact of the rollout of the *HiAP* approach; however, the HPC notes that there is evidence of a variety of working groups and commitment across government agencies to this approach.^{14, 15} What was not clear, is how well placed these relationships are to generate policies and programs that will address these interrelated issues. The HPC will review the extent and impact of the strategy over the next four years.

Often the lead-time between population based interventions to promote health and the intended outcomes is protracted and influenced by a number of factors (in addition to those of the intervention), making it difficult to assess and demonstrate their effectiveness. However, feasible research methodologies do exist, and if properly planned and resourced, their strategic application can help evaluate the interim impact and value of key population based strategies.

Assessing Health protection and promotion performance

On the basis of the information the HPC received from SA Health, it is clear that a wide range of plans and strategies have been developed and are underway, to promote and encourage reduction of health risk factors (for example, smoking, obesity, inadequate nutrition, and insufficient physical activity). These are consistent with the strategic intentions for strengthening PHC.

Provide effective avenues for prevention and early intervention (Objective 1.2)

Key Findings

2. SA Health has increased avenues for illness prevention and early intervention that improve early childhood health outcomes by targeting risk factors in pregnant women through its Universal Contact Visit and Family Home Visiting Programs. Whilst significant efforts have been noted, it is too early to determine the effectiveness of these programs in producing improved health outcomes.

Discussion

The SASP Plan requires ongoing action from SA Health to improve early childhood health outcomes in the population, particularly with Aboriginal people.⁴ SA Health has implemented strategies to improve the access and effectiveness of antenatal care, address health risk factors of pregnant women, improve the birthweight of babies and reduce infant mortality.

SA Health indicated that the *Primary Prevention Plan*, which is being designed to address the SASP targets, would outline strategies for policy and legislation, services and programs, and provision of information in appropriate formats.⁴

SA Health currently invests \$17 338 841 on primary prevention in the following areas:

- > Promotion of healthy eating, physical activity and healthy weight (\$9.3 million)
- > Smoking prevention and cessation (\$650 000)
- > Prevention strategy to address binge drinking (\$1.13 million)
- > Sexual health (\$470 000)
- > Safe sleeping strategies in line with coroners report on deaths in infants (\$152 000)
- > Health in all policies including hosting 2010 International Conference (\$270 000).^{14, 15}

This investment reflects state targets and key areas for prevention effort in the longer term.

The introduction of the Universal Home Visiting Program, the Do it For Life, the EWBA Communities programs, along with Drug and Alcohol Services South Australia's (DASSA) links with public hospitals to provide services to women prior to and during pregnancy, were presented as achievements in progressing this objective.⁷

In 2008-09, SA Health's Child and Family Health Service introduced and evaluated a new developmental, social and emotional assessment at 12 and 18 months of age. The evaluation of this assessment in terms of parental acceptance revealed that all parents found it was comprehensive, easy to use and provided useful feedback.

The HPC notes the following monitoring and evaluation activity:

- > The Family Home Visiting program (FHV) is tracking the paths that mothers and infants follow through services from the time of the infant's birth until infants are two years old. A total of 435 infants and mothers in metropolitan Adelaide and 130 families in rural areas who are receiving FHV are being tracked as part of this evaluation. This is being assessed against 235 comparable families in rural areas who have not received FHV because it was not available in their area at the time of the infant's birth. This will enable a comparison of outcomes across these groups and investigate which families have the best outcomes after receiving FHV. Assessments of mothers and infants are undertaken when infants are aged three, nine, 18 and 24 months.
- > The Impact of the FHV program on Aboriginal families was evaluated in 2007. The evaluation process involved interviewing the Aboriginal women in the FHV program in terms of access, whether the expectations of the program were fulfilled and any changes they thought necessary.
- > The evaluation found that families of Aboriginal children living in metropolitan Adelaide generally perceived the program to be a convenient, responsive, positive approach to child health and development, delivered in an empowering and respectful way.

Assessing Prevention and Early Intervention Performance

Data provided by SA Health indicates that across the whole South Australian population the percentage of people smoking during pregnancy has been marginally decreasing (see Table 2.1.1).

However, the proportion of mothers quitting during pregnancy has not increased, putting into question the marginal effectiveness of antenatal care and other interventions to help reduce smoking during pregnancy.

While a greater proportion of Aboriginal mothers quit smoking during pregnancy, it is noted that the proportion of Aboriginal women smoking during pregnancy is nearly four times that of pregnant, non-Aboriginal women.

Table 2.1.1 Smoking & Smoking Cessation Rates during Pregnancy, South Australia, 2006-2008.

Smoking rate and self reported smoking cessation rate during pregnancy, by year				
Ceased smoking during pregnancy			Smoking during pregnancy	
	n	%	n	%
2006	999	5.4	2889	15.7
2007	1049	5.4	2791	14.4
2008	1012	5.2	2754	14.1
Total	3060	5.3	8434	14.7

Smoking rate and self reported smoking cessation rate during pregnancy, by ATSI Status				
Ceased smoking during pregnancy			Smoking during pregnancy	
	n	%	n	%
Non-Aboriginal	2941	5.3	7556	13.6
Aboriginal	119	7.0	878	51.7
Total	3060	5.3	8434	14.7

Note: Ceased smoking during pregnancy rates were derived from those who quit before 1st antenatal visit and those who were smoking at first antenatal visit and were not smoking any cigarettes per day in the second half of pregnancy. The overall unknown smoking status was 2.5% for the years 2006 to 2008, and the overall SA Health Regions. The unknown smoking status was 2.4% among non-Aboriginal and 6.3% among Aboriginal women.

Source: SA Health, Pregnancy Outcomes Unit

Consulted stakeholders suggested more resources be directed to preventative programs aimed at adolescents as well as early intervention programs for Aboriginal people and other people from culturally and linguistically diverse communities.

SA Health's Cervical Cancer Screening Program is a positive example with its extensive CALD material, as well as having multicultural and Aboriginal staff involved.

The HPC considers there is room for greater attention to Aboriginal consumer needs in these programs, both in relation to the prevalence of chronic disease and the pressing need for prevention and early intervention and in relation to management of chronic disease in the community.

Strong links with hospitals and with non-government organisation (NGO) services are a significant factor in SA Health being able to achieve effective avenues for prevention and early intervention. The HPC acknowledge that a long-term investment is required before impacts can be demonstrated.

Facilitate effective coordination and continuity of care (Objective 1.3)

Key Findings

3. Although a variety of programs are operating across the health system to improve continuity of care, particularly for those suffering from a chronic disease, the HPC considers the performance measures currently available to assess performance in this area to be insufficient. A greater focus on measuring patient experiences across the continuum of care is needed.

Discussion

The *GP Plus* Strategy was reported by SA Health to be a key mechanism for improving coordination of services and continuity of care.⁶ To achieve the outcomes envisaged by SAHSP there needs to be system wide participation across the state as well as clear mechanisms and processes for enabling coordination and for ensuring continuity of care.³ Improving the continuity of care within a service and across services and providers is central to the overall thrust for system improvement.

Improving Coordination and Continuity of Care

SA Health reported there are a number of programs, in various stages of development, to facilitate effective coordination and continuity of care in the PHC system in relation to managing chronic disease, including the:

- > Establishment of the National Health Call Centre
- > Development of regional referral centres and the related provision of packages of community care and support, transitional rehabilitation and chronic diseases management
- > Introduction of in hospital flow coordinators and initiatives to improve the timely transition of patient care from emergency departments
- > Plan to enable direct admission to hospital beds by community based health professionals
- > Ongoing initiatives to improve discharge planning
- > Overall information system developments aimed at improving communication between various providers and their patients
- > Formal mechanisms to build clinical networks and work with General Practitioner (GP) Practice.

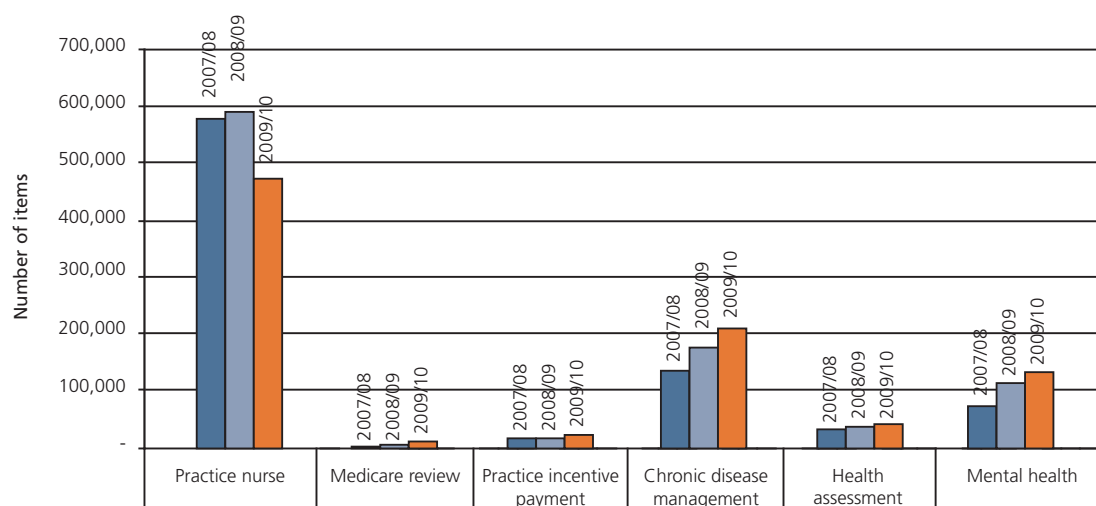
The GP Practice Nurse Initiative is seeking to support GPs in improving management of chronic conditions, from early detection to complex co-morbidities. SA Health indicated the encouraging uptake of this initiative in Metropolitan Adelaide led to its expansion in 2009-10 to include nine rural divisions of General Practice and two Metropolitan Divisions with Rural Chapters.

Since the commencement of this initiative in the former CNAHS Region, 47% (156) and in the former SAHS Region, 49% (50) of all practices in the region have participated in this initiative.

SA Health reported that feedback from the metropolitan Divisions of General Practice indicates that the existing level of take-up by general practices of practice nurses via the GP Practice Nurse Initiative is close to saturation point. SA Health envisaged that the Australian Government's Practice Nurse Initiative might well meet any additional demand by general practices for practice nurses after 2010-11.

While the impact of this initiative on the management and health outcomes of people with chronic conditions is unclear, there were signs of improved access to relevant general practice services through increased utilisation of Enhanced Primary Care (EPC) item numbers on the Australian Medical Benefits Scheme. Total utilisation of the EPC item numbers is summarised below (see Chart 2.1.6).

Chart 2.1.6 Enhanced Primary Care MBS Item Utilisation, South Australia, 2006-07 to 2009-10



Note: Reliance on the 2009-10 figures is cautioned as they represent a simple full year extrapolation of the first quarter of data (September 2009).

Source: Unit record data from Medicare Australia held by SA Health

SA Health indicated that a number of performance indicators are used to monitor the effectiveness of continuity of care, including:

- > Emergency department access
- > Time in emergency department for admitted patients
- > Length of hospital stay
- > Clients seen by a community mental health services within seven days of discharge
- > Mental health consumers with current patient electronic care plan
- > Unplanned hospital readmissions
- > Radiation oncology consultations occurring <30 days of initial referral
- > Elective surgery strategy waiting times
- > Patients with timely and informative discharge summaries
- > Consumer feedback and complaints.

Collectively, SA Health put improvements in these measures forward as an indication of a more connected and integrated health care system that facilitates continuity of care. SA Health routinely monitors many of these indicators.

Improving Access to Services

SA Health demonstrated the following access improvements to early childhood services and mental health – two of the government's key service priority areas.

Child and Family Health Service (CAFHS)

- > There was an increase in 2009-10 of the numbers of families who consented and were registered to receive a Universal Contact Visit (19 322), with an increase in the percentage of clients seen within two to four weeks.
- > The rollout of the FHV program continued with coverage now in rural areas. As at 31 July 2010, the statewide FHV program had 1484 active clients including 242 Aboriginal clients. Overall, 925 Aboriginal and Torres Strait Islander clients have commenced in the program since 2004, with 321 clients having successfully completed the program.
- > There has been an increase in the number of children who have an age appropriate health check in the northern suburbs supported by a nurse within the Kids-n-You program. Those children identified with developmental delay have been referred on to appropriate services.

Child and Adolescent Mental Health Services (CAMHS)

- > CAMHS have significantly reduced the number of children, young people and families waiting for an ongoing service over the past year ensuring more timely access for families. In July 2009, the number waiting for an ongoing service was 448 and at the end of June 2010, the number of families waiting for an ongoing service was 120.
- > The median wait time for an ongoing service has also reduced significantly from 84 days for the first four months of the year to 41 days in the last four months of the financial year.
- > This reduction has been achieved due to the completed roll out and subsequent full effect of the State Government's funding of Healthy Young Minds initiative from 2006-07 to 2009-10 that has provided extra workers in CAMHS teams and a service improvement strategy to address workload and work flow.

Children's Centres

- > SA Health is part of a cross government effort to establish 17 Children's Centres across the state by the end of 2010. A range of health and social services will be available on-site and via direct referral. SA Health reported preliminary profiles of Children's Centre users indicate that access to services is improving for those most in need. For example, families using Children's Centres are more disadvantaged than families who took part in the Longitudinal Study of Australian Children (LSAC – baseline data source). In fact, 14.4% of Children's Centre families had three or more 'disadvantages' – almost five times the proportion of LSAC.

The effective functioning of *GP Plus* is critical to providing consumer access to services whilst ensuring effective continuity of care, in particular between hospital care and NGO services.⁶

Consulted stakeholders noted some improvements in accessing allied health services and acknowledge that various parts of the system are seeking to improve access to services. They also reported the lack of a clear pathway for consumers regarding to the patient journey across the system.

Metropolitan and country stakeholders expressed concerns about the lack of access to GPs (an Australian Government responsibility that requires attention by that jurisdiction), and that this was resulting in consumers having to travel long distances to see whoever was available. Stakeholders indicated that this was affecting their continuity of care.

Consulted stakeholders also expressed concerns about the limited support carers and families receive from SA Health for the component of recovery that happens at home. NGO representatives also expressed concerns about the limited funding they receive from SA Health to support carers and families for the work they do.

SA Health's Safety and Quality Committee established an advisory group in 2010 to oversee the development of a new statewide initiative – The South Australian Consumer Experience Surveillance System. This system will identify emerging issues around consumers' experiences of key dimensions of care and trigger action on priority problems and populations.

Assessing continuity of care performance

The HPC considers that the available data does not provide a clear indication of improvement in continuity of care. The existing indicators are not sufficient to adequately assess continuity of care for the overall population. These indicators do not adequately cover the patient journey, or provide suitable measures to monitor the key interface points in the system, particularly the interface between hospital, primary, and community care providers.

For example, the HPC noted that SA Health reported that on average 40% of hospital patients discharged are discharged or referred to other services or facilities. The HPC was not able to determine if these services received timely and informative discharge summaries for this patient population.

An alternative set of indicators could be explored. For example, for people with chronic diseases, the following type of indicators could be considered:

Planned Care

- > Admitted patients with chronic disease that have an integrated current care plan.
- > Chronic disease Medicare Benefit Schedule (MBS) item utilisation per total hospital admissions with a chronic disease.

Interface between Hospital and Primary Care

- > Admitted patients without an integrated current care plan who are referred to their GP upon discharge.
- > Admitted patients with chronic disease who have contact with a GP, or received services from a *GP Plus* health centre within seven days of discharge.
- > Admitted patients with chronic disease who had contact with a GP, or received services from a *GP Plus* health centre within seven days prior to admission.⁶

Utilisation of Care Pathway

- > Admitted patients with chronic disease who were referred to a Regional Referral Centre prior to admission.
- > Referrals to a Regional Referral Centre with chronic disease that receive a Hospital Avoidance Package.
- > Admitted patients with chronic disease who received a Hospital Avoidance Package prior to admission.
- > Admitted patients with chronic disease who received a Hospital Avoidance Package within seven days of discharge.

Access to Ongoing Care and Support

- > Admitted patients with chronic disease who receive ongoing community care from Metropolitan Domiciliary Care or other community care agency.
- > Admitted patients with chronic disease who receive ongoing (or episodic) community nursing care.

It would also add value and give a greater sense of how well the system is operating for the patient, if qualitative measures related to patient journey and experience of health care across settings were included. These could assist in indicating areas in the system that are working well and identify overlaps or gaps that should be addressed.

A number of well-established tools exist that could be considered to complement existing tools and enable national and cross-national comparison. This could include the periodic international population based policy surveys undertaken by The Commonwealth Fund in the US, the patient based surveys of the Picker Institute in Europe or the Consumer Assessment of Healthcare Providers and Systems program in the US.^{16, 17, 18}

The continuous monitoring of consumers' experiences should build up a detailed picture, examine performance along the patient journey, monitor changes over time, and provide a mechanism for internal and external benchmarking within and across organisations to improve the quality and performance of the public health system.

Minimise the burden of disease on the health system (Objective 1.4)

Key Findings

4. The investment into *GP Plus* strategies over the last three years represents a significant commitment to strengthen primary health care in South Australia. Sound evaluation of these strategies will be required.

5. There are signs and early trends that some of the *GP Plus* strategies are having an impact on service utilisation for selected chronic conditions, with preliminary evidence that they are reducing pressure on the public hospital system.

Discussion

There is a range of programs and services in place that aim to minimise the effects of disease on the individual and consequently on the health system. Many of these are referred to in the information the HPC gathered in relation to the other four objectives in this chapter.

SA Health provided further information in relation to the priority areas for *GP Plus* services and Clinical Network Plans, where causes of mortality and morbidity burdens are targeted and monitored.⁶

SA Health's *GP Plus* services are designed to develop the capacity of the primary health care system in order to reduce the growth in demand on hospitals.⁶

GP Plus funding effectively commenced in 2007-08 with \$14.7 million and has been increasing annually. To-date over \$115 million has been allocated to the various contributing strategies.⁶

A significant investment of \$68 million was allocated to *GP Plus* in the 2009-10 financial year, and distributed as follows:

- > 4% was directed to programs with an emergency department (ED) focus (for example, allied health and drug and alcohol workers in emergency departments)
- > 10% primary care focus (for example, integrated community care for older people, nurse practitioners)
- > 26% primary prevention/health promotion
- > 30% for packages of care (including hospital avoidance and length of stay reduction)
- > 30% clinical streams led by hospital specialists (for example, some of the respiratory and rehabilitation programs).⁶

The aims of *GP Plus* are to contribute to the development of comprehensive chronic disease management and improved systems of care at the primary health care level and its interface with the acute health sector.⁶

Managing Chronic Disease

SA Health anticipates that through better management of people with chronic disease, pressure will be taken off the hospital sector, notably through a visible impact on hospital admissions, length of stay and ED and outpatient attendances.

SA Health reported that current hospital activity indicates that *GP Plus* programs are contributing to a reduction in hospital separations across a number of service areas for some selected extended service related groups (ESRG)/Diagnostic Related groups.⁶

The total public hospital separations (metropolitan and country hospitals) were up 2.27% in 2009-10, which is just over the statewide target of holding growth to 2%. This can be compared to an average annual increase of 3.5% for the previous three years.

SA Health currently monitors monthly activity to assess the impact of *GP Plus* reforms on hospital usage across a range of service areas.

In 2010, further enhancements to the monitoring process and methodology to assess their impact were undertaken. SA Health will conduct detailed analysis of the impact of ED presentations and admission rates by ESRG, and closely monitor the impact *GP Plus* centres and *GP Plus* super clinics (Australian Government initiative) have on hospital activity, in particular ED presentations.^{6, 19}

From the \$68 million invested in *GP Plus*, the SA Health regions reported that in the financial year 2009-10, they prevented 13 227 ED presentations, prevented 14 969 admissions, saved 34 526 bed days and prevented 8 480 outpatient appointments, which equates to a potential saving to the health system in 2009-10 of approximately \$70 million.⁶

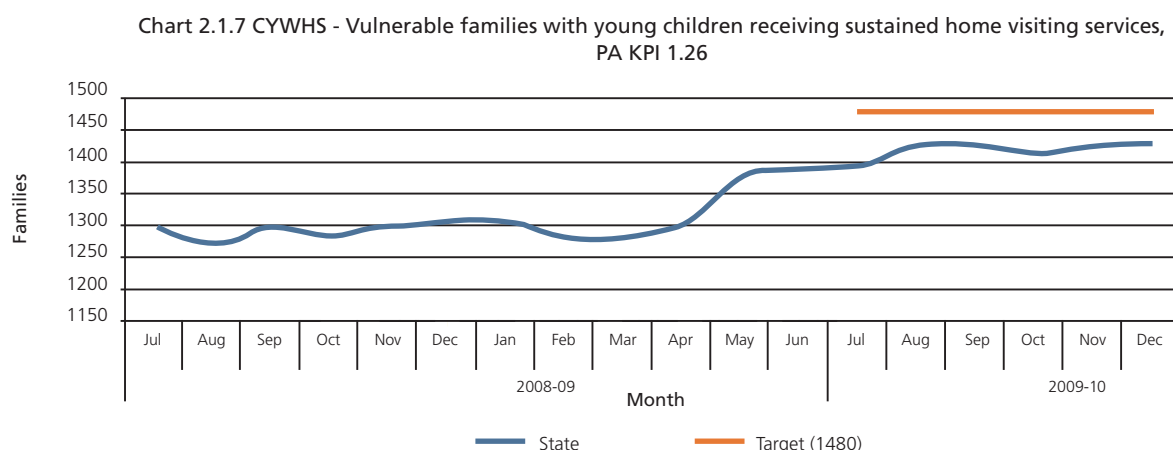
SA Health stated that activity avoided for each *GP Plus* program is predicted by applying local evidence or evidence found in the literature.⁶ SA Health estimated that 46% of persons enrolled in the Chronic Respiratory program at the former CNAHS avoided a hospital admission.

Potentially preventable admissions relate to specific conditions that have been identified as being sensitive to primary care.

In the period that the after hours GP service has been operating out of the Aldinga *GP Plus* centre, activity for the Noarlunga Hospital ED indicates that:

- > There has been a 1.4% increase in total ED presentations from 2008-09 to 2009-10.
- > There has been a 3.6% reduction in combined triage 4 and 5 from 2008-09 to 2009-10.⁶

SA Health indicated that by extending the Universal Home Visiting program and linking it with the FHV program, progress had been made. Expansion of the *Do it for Life* program across the state was anticipated however, SA Health advised that the level of investment has been adjusted to more appropriately match the current number of clients in the program (see Chart 2.1.7).



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

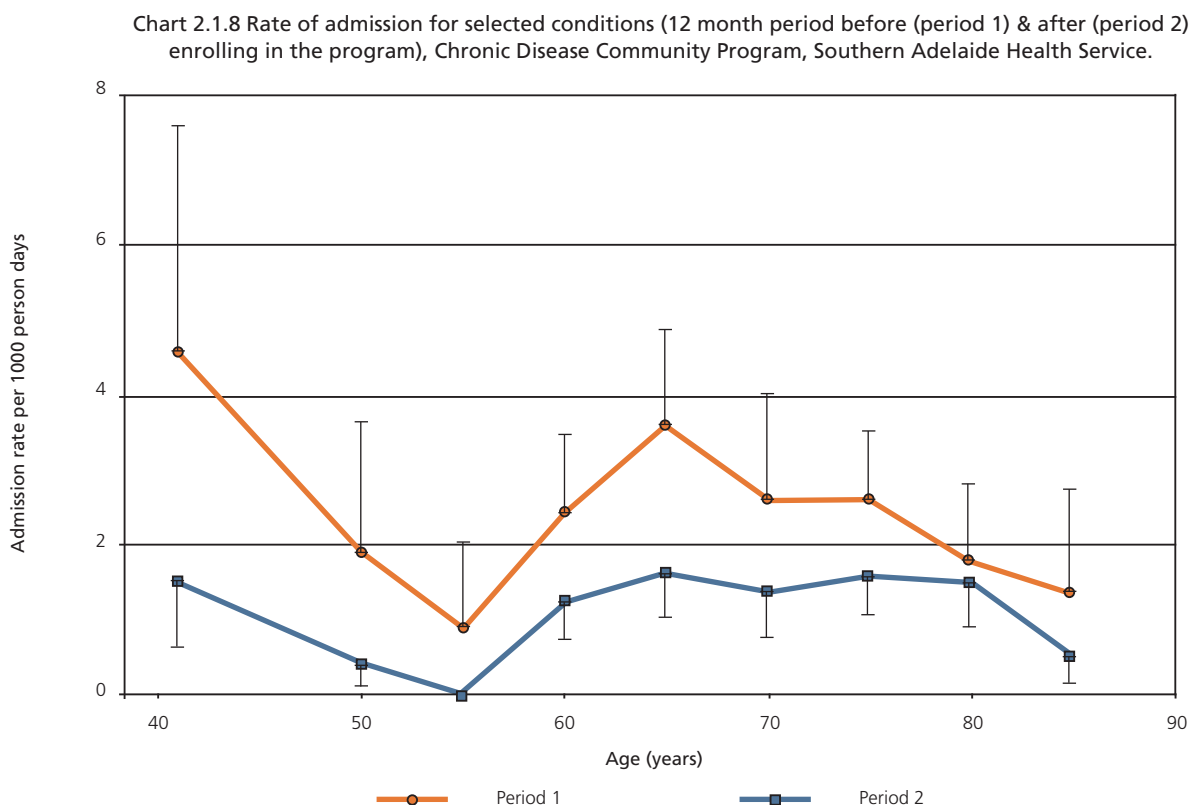
SA Health also reported that there have been positive developments in chronic disease programs across the former CNAHS, Children Youth and Women's Health Service (CYWHS) and Country Health SA, particularly in relation to self-management. The following were mentioned:

- > A multidisciplinary approach to discharge resulting in reduction in re-representations/re-admissions (CNAHS)
- > The diabetes chronic disease community program (CYWHS)
- > The trial of a web-based Chronic Disease Self Management Program (Country Health SA).

Chronic Disease Community Programs target the population who have chronic complex health issues. The programs provide tailored care packages to assist people with better management of their health and wellbeing and ensure that individual chronic disease management plans are developed.

SA Health reported that the number of people enrolled in self-management and an integrated health care plan has increased since January 2007 from 516 to 1065 people. The number of people participating (completing) chronic disease management programs increased from 426 (94%) in 2007-08 to 1560 (92%) in 2008-09. The HPC notes the slight drop in completion rates.

The Chronic Disease Community Program provides a package of service to people with chronic obstructive pulmonary disease, diabetes, heart failure and unstable angina, with a focus on self-management. The results from SA Health's initial analysis of the data from this program found that the rate of hospital admissions for selected conditions in the 12 months after the package of services (period 2), was nearly 50% lower than the rate in the 12 months prior to enrolling in the program (period 1) (see Chart 2.1.8).



Error bars represent the 95% of confidence interval levels

Source: SA Health, Southern Adelaide Health Service, Chronic Disease Community Program.

Carers play a significant role in reducing the burden on the health system. Consulted stakeholders expressed concerns about perceived gaps in the provision of:

- > Information on the use of self-management plans
- > Ongoing support for carers including respite care.

Given the nature and focus of *GP Plus*, it would be reasonable to expect that the impact of this strategy will be reflected in age and sex standardised population rates for these conditions over time.⁶ The signs of a downward trend in the data for some chronic conditions (for example, asthma, diabetes) provided a degree of confidence of reduced burden (see Chart 2.2.23 in Hospital Care section).

It is noted that there are no specific targets established for avoidable hospital admissions for particular population groups (for example, Aboriginal people, older people and people living with mental illness).

Provide appropriate services closer to where people live (Objective 1.5)

Key Findings

6. While the development of hospital networks, Intermediate Care Centres for mental health clients and *GP Plus* centres and related services and programs are progressively strengthening services in metropolitan areas, planned service developments in rural and remote communities are in their formative stages and are not ready for evaluation at this point.

Discussion

GP Plus is SA Health's principal strategy for delivering a more integrated and accessible health care system.⁶ Considerable investment has been placed on building the infrastructure to ensure the *GP Plus* health care centres assist local service providers to improve coordination and delivery of care.

A number of changes have been, or are being, introduced within the primary health care sector and the health system as a whole, to bring services closer to where people live. These include:

- > Health Improvement Plans (HIPs). It is intended that HIPs will provide an evidence-based approach to the planning, management and evaluation of service delivery to meet the priority population health need in each *GP Plus* network area. HIPs will also guide the location of future *GP Plus* health care centres and services that could be provided in the out of hospital care sector. The *GP Plus* Strategy is intended to provide more responsive services closer to where people live.⁶
- > Development of new models of care and settings for receiving health care. This introduces *GP Plus* health care centres as the focal point within the community where a range of primary health care service providers will work together and enable improved coordination and delivery of care, while ensuring the specific needs of the local community are met.⁶
- > Technological advances in the delivery of health care services. This involves collaborating with Health Direct (National telephone information and advisory service) to provide 24 hours a day, seven days a week phone service to access health information and advice from home.

In relation to the initiatives outlined above, SA Health reported the following specific achievements:

- > Opening of *GP Plus* health centres at Aldinga and Woodville, with construction starting at Marion and Elizabeth
- > Country Health is progressing plans for the building of country centres at Ceduna and Port Pirie
- > *GP Plus* super clinics are being built at Playford North, Modbury and Noarlunga¹⁹
- > *GP Plus* health care centre in Morphett Vale brings together the Child Adolescent Mental Health Onkaparinga Region, Southern Primary Health Morphett Vale and the CAFHS.⁶

Rural Initiatives

The *Strategy for Planning Country Health Services in SA* builds on SAHCP.^{12, 20} The strategy underpins the strengthening of clinical capacity at the Country General Hospitals (that is, Mount Gambier, Berri, Whyalla and Port Lincoln) to provide more clinical inpatient services and greater support for the primary health care functions of the community and other country hospitals. This is intended to result in fewer people having to travel to metropolitan hospitals for treatment.

Country Health SA was allocated more than \$10 million of the *GP Plus* Services Fund in 2009-10 and has developed a range of service initiatives that work with local hospitals and existing community and primary health care services to reduce the need for acute services (either locally or in Adelaide).⁶

For example, the Better Care in the Community initiative seeks to ensure country residents are able to receive the endocrinology, respiratory and cardiology care they need at a local level. SA Health reported there was a 25% reduction in separations for respiratory related conditions at Port Pirie Hospital, achieved through the dedicated focus on coordinated care and direct respiratory nursing services.

In addition, dialysis services have already expanded (with an increase of 38.5% of country patients being treated in country hospitals from financial year 2006-07 to financial year 2009-10) and planning for expansion of chemotherapy services was completed with funding provided in the 2010-11 budget for implementation. Implementation of the Clinical Plans for Rehabilitation, Palliative Care, Older People and Stroke Services is progressively expanding service availability in country areas. In the 2009-10 year, there have been approximately 550 occasions of use in those services, which were supported by increased clinical leadership and key clinical appointments within Country Health SA.

The overall proportion of country residents treated in country hospitals fell from 2006-07 to 2008-09; however, this is now increasing, which is consistent with the overall directions of the *Strategy for Planning Country Health Services in SA*.²⁰

SA Health reported the following service improvements in country and rural communities during 2008-2010:

- > The expansion of renal dialysis capacity in Murray Bridge, Victor Harbor, Whyalla, Port Pirie and Port Augusta. Volumes of dialysis performed at Murray Bridge and Port Augusta Hospitals increased by 62% and 14% respectively over the five-year period ending 2009-10. Victor Harbor opened its dialysis service in 2009-10. The Whyalla service opened in July 2009 and the Port Pirie service opened in late August 2010.
- > The appointment of clinical directors in the areas of: Cardiology; Emergency Services; Mental Health; Oncology; Paediatrics; Renal; and Surgery, with GP consultants in: Anaesthetics; Maternity; Mental Health; and Safety & Quality.
- > The development of agreements for the sustainability of specific services including emergency services at Gawler and Riverland, and surgical services in the Riverland.
- > Investment in the *GP Plus* Strategy – key achievements include:
 - The continuing focus for 13 sites across country SA on redirection of services from in hospital to out of hospital; thereby better supporting people with chronic disease in a coordinated way in the community. This includes the appointment of 'Better Care in the Community Facilitators', whose role is to provide intensive care coordination and support country residents with complex health needs, to reduce their reliance on metropolitan hospital services. In September 2010, 443 clients were being supported by the Better Care Facilitators.
 - The establishment of cardiac and pulmonary rehabilitation programs in a number of country locations. This includes additional cardiac rehabilitation services at Gawler, Port Augusta, Berri, Victor Harbor, Mount Gambier and Wallaroo; and additional pulmonary rehabilitation services have been provided at Port Pirie, Victor Harbor, Millicent, Whyalla, Wallaroo and Port Augusta.
 - The establishment of the Whyalla Respiratory Service, which augments the existing respiratory program at Whyalla Hospital through the development of Pulmonary Function Testing Services, to better manage the demand for coordinated COPD and lung cancer in the community.
 - The appointment of Chronic Condition Lead Podiatrist to identify opportunities for country clients to access podiatry services closer to home, and reduce demand on metropolitan health units outpatient clinics.
 - The appointment of the Patient Liaison Network Coordinator with a key focus on the country patient journey; supporting close to home service delivery and transfer of care from metropolitan hospitals when clinically appropriate.
 - An additional 28 FTE positions throughout country SA providing improved coordination of services and direct services for people with chronic disease.
 - In 2009-10, 1412 clients received services through the Rapid Intensive Brokerage Support program, resulting in 829 clients avoiding a hospital admission. A further 583 clients were supported with additional community based services thus facilitating an early supported discharge from hospital.⁶
- > Mental health reforms have resulted in an additional 51 new patients being managed in country areas, rather than needing transfer to metropolitan facilities for care and treatment. Ongoing care in the community is now available locally for these patients.
- > Investment in the Aboriginal Patient Pathway Officer (APPO) roles across the state to improve the patient journey for Aboriginal people and their families. There are 10 APPO positions located in country health services at Ceduna, Coober Pedy, Mt Gambier, Murray Bridge, Port Augusta (two positions), Port Lincoln, Berri, Whyalla and Maitland. The role of the APPO is to act as a cultural broker assisting Aboriginal and Torres Strait Islander patients to access culturally appropriate transition care within the mainstream and the Aboriginal Community Controlled sectors.
- > The expansion of Aboriginal specific birthing services to increase case loads for Pt Augusta, Leigh Creek (and surrounds), Coober Pedy, and Whyalla. New sites are being established in Ceduna and Murray Bridge. This will result in an increase in service case load from 30 clients to 135 clients across these locations.

Consulted stakeholders noted some improvements in relation to services being closer to where people live in the country.

Examples include rural doctors, who after receiving mental health training are now providing services to their local communities; and maternity services in the Adelaide Hills region are now providing a 24-hour maternity service because of organisational changes within Country Health.

A number of stakeholders indicated that as a consequence of 'hospital in the home' programs they had noted some improvement in the development and availability of services closer to home.

In terms of obtaining access to services closer to where people live, the majority of stakeholders indicated that the cost of transport is the most pressing issue for families and carers living in rural and remote communities. Of particular concern to many stakeholders was the limited improvement they had observed in the number of services available outside the metropolitan areas and the cost burden this is placing on families/carers.

Assessing provision of services closer to where people live

The HPC notes the planned service developments in rural and remote communities and the progressive strengthening of services in metropolitan areas.

The HPC will review achievement of this objective over the coming four years, in collaboration with key stakeholders including the Health Advisory Councils to further assess the impact of service developments in rural and remote areas.

SA Health Strategic Direction: Enhance Hospital Care

SA Health recognises that safe, effective, efficient and appropriate hospital care is fundamental for South Australians experiencing ill health. South Australia's hospitals provide a broad range of services, including inpatient, outpatient and emergency services, aged care and mental health, as well as community services, and 'Hospital in the Home' programs. Our hospitals are major contributors to improvement of the health system through teaching and research... SAHSP p.7

1. What did SA Health commit to do?

a. Strategic Position

In addition to the *SA Health Strategic Plan 2008-2010* (SAHSP) document, there are three other key elements of the SA Health approach – *South Australia's Health Care Plan 2007-2016* (SAHCP), *GP Plus Health Care Strategy 2007* (GP Plus) and the *Strategy for Planning Country Health Services in SA*.^{3, 6, 12, 20}

SAHSP presents a strong commitment to enhancing hospital care, recognising the increasing demand on hospital services generated by an ageing population and increasing prevalence of chronic disease. This situation is intensified by an international shortage in medical and nursing staff and ageing hospital facilities (see SAHSP p.7).³

South Australia's Health Care Plan 2007-2016 (SAHCP) and the *Strategy for Planning Country Health Services in SA* set out the blue print for the provision of an enhanced hospital system where the services provided at each hospital are clearly defined and well aligned to the needs of the community.^{12, 20} This includes appropriate responses to ageing hospital facilities to ensure safe and effective services which meet the changing needs of future generations.

The *GP Plus* Strategy further details the development of *GP Plus* centres (up to eight metropolitan and two country centres).⁶ These centres will provide improved coordination and delivery of health care within the community and deliver strengthened primary health care and support services whilst reducing demand on the hospital system.

b. Key Objectives and Performance Measures

The key objectives presented in SAHSP (p.7) signify the major areas of system reform and improvement of outcomes in enhancing hospital care:

- > Provide a coordinated hospital system across metropolitan and country regions (Objective 2.1)
- > Improve health outcomes, and safety and quality, for people in hospital care (Objective 2.2)
- > Improve efficiency and effectiveness of hospital care (Objective 2.3)
- > Reduce dependency on hospitals (Objective 2.4)
- > Provide an attractive learning environment for health professionals (Objective 2.5).

(SAHSP p.7)

SAHSP reported the system performance measures for enhancing hospital care included:

- > Timely admission for elective surgery by category (percentage)
- > Percentage of public hospital emergency department admissions seen on time by category
- > Level of consumer satisfaction with hospital services
- > Number of adverse events/sentinel events
- > Proportion of patients entering hospital as Day of Surgery Admissions (DOSA)
- > Length of stay as measured by Relative Stay Index (RSI)
- > Emergency readmissions to hospital within 28 days.

(SAHSP p.7)

2. How did SA Health perform?

In considering performance, the HPC made an assessment against the data and information provided by SA Health and particular stakeholders.

In this section, the HPC discusses specific findings for each key objective.

Provide a coordinated hospital system across metropolitan and country regions (Objective 2.1)

Key Findings

7. Initial steps have been taken toward the planned clinical service reconfiguration across the hospital system, with a number of the remaining changes dependent on future capital developments. The Statewide Clinical Networks offer significant potential for clinical service improvements and enhanced collaboration; however, some are still in their formative stages.

The HPC recognises that service reconfiguration takes time and that the planned service movements and enabling capital developments span nearly a decade. For instance, the establishment of the new Royal Adelaide Hospital (RAH) is not anticipated before 2016. Therefore, the Statewide Clinical Networks seem to offer the most opportunity for immediate improvements.

8. Although ongoing efforts to improve continuity of care across and within health services are noted, their overall effectiveness is not demonstrated at this stage. The timely transfer of client/patient information requires greater rigour as consulted stakeholders indicated that information was not provided when required, which affected the ability to provide optimal care. A strategic review of information exchange at points of clinical handover would be valuable.

The HPC believes that in order for the range of activities reported by SA Health for improving coordination and continuity of care to be effective and sustainable, they need to be part of a strategic and systematic approach. The HPC will be keen to see this approach developed and progressed over the next four years. Whether it is between metropolitan and country hospitals, doctors and nurses, nursing shift to nursing shift or hospitals to GP practice or community, systems for improved communication and transfer of clinical and other patient related information are required. While the development of electronic health record capability in South Australia promises to facilitate significant improvements in this area, it is unlikely that the anticipated changes will be fully realised within the next decade.

Discussion

SA Health indicated that rather than each hospital operating independently and seeking to provide the full range of services, the new plan is for opportunities for service consolidation and specialisation to be explored. This would enable major hospitals and general hospitals to be more complementary and enhance the interface with the primary and community care sectors.

SA Health indicated that key drivers to bring about these changes would include the implementation of designated role delineation of hospitals and the outcomes from the service planning work undertaken by the Statewide Clinical Networks. SA Health provided the following examples of expected service improvements:

- > The development of nurse practitioner roles in a range of clinical streams
- > Rapid access to cardiac catheter laboratories in conjunction with SA Ambulance service
- > The development of a range of cancer control activities including multi-disciplinary teams across a range of tumour streams, creation of cancer coordination roles and development of the cancer quality and safety framework
- > The expansion of community based palliative care services and packages of home based, supporting palliative care patients to remain at home during the end of life
- > The development of stroke pathways to increase timeliness of access to therapeutic regimes that minimise potential for post-stroke disability.

Within country communities, the *Strategy for Planning Country Health Services in SA* sets out the planning principles for the development of 10-year local health service plans for future services in rural and regional South Australia.²⁰ Country Health SA has been working with local Health Advisory Councils and health services to develop these comprehensive local health service plans. It is intended that these plans will identify opportunities for a greater range of services to be provided in country locations and reduce the number of people who need to travel to metropolitan Adelaide for care in the future.

Over time, the HPC would expect to see the clinical profile of hospitals in metropolitan and country regions altered to line up with the service plans; a lower proportion of country residents being treated in metropolitan hospitals in specific clinical areas; and improvements in the continuity between hospital and out of hospital primary and community care services.

Clinical Services Profile

SA Health indicated the following changes to the clinical mix of services at the metropolitan hospitals have occurred because of the implementation of the SAHCP:¹²

- > The renal transplantation services have transferred from The Queen Elizabeth Hospital to the Royal Adelaide Hospital.
- > A review of services at the Flinders Medical Centre, the Repatriation General Hospital and the Noarlunga Hospital resulted in:
 - Oncology, vascular, and complex orthopaedic services being transferred to the Flinders Medical Centre from the Repatriation General Hospital
 - Elective orthopaedic services being consolidated at the Repatriation General Hospital from the Flinders Medical Centre
 - The establishment of a 30-bed geriatric assessment and management unit at the Repatriation General Hospital.
- > A net increase of 30 beds is being delivered as part of the Flinders Medical Centre redevelopment.
- > Cardiac and Cancer services are expanding at the Lyell McEwin Hospital.
- > Obstetric and Paediatric Services have been refocused from the Modbury Hospital to the Lyell McEwin Hospital and the Women's and Children's Hospital. Overnight paediatric surgical services have transferred from the Modbury Hospital to the Women's and Children's Hospital.
- > Transfer of palliative care and care of the older person services from the Lyell McEwin Hospital to the Modbury Hospital.
- > An additional 30 mental health beds have been opened at the Lyell McEwin Hospital.
- > Preparation for the establishment of onsite rehabilitation services at The Queen Elizabeth Hospital has commenced.
- > Additional elective surgery services have commenced at the Modbury Hospital.
- > Progress on the establishment of *GP Plus* health care centres at Elizabeth and Marion continues. Further centres are being developed at Playford and Modbury in partnership with the Australian Government.⁶
- > The development of Intermediate Care facilities is progressing on the Glenside campus and in the western, northern and southern suburbs.

In addition, SA Health established its new statewide pathology service (SA Pathology) and a statewide retrieval system (MedSTAR).

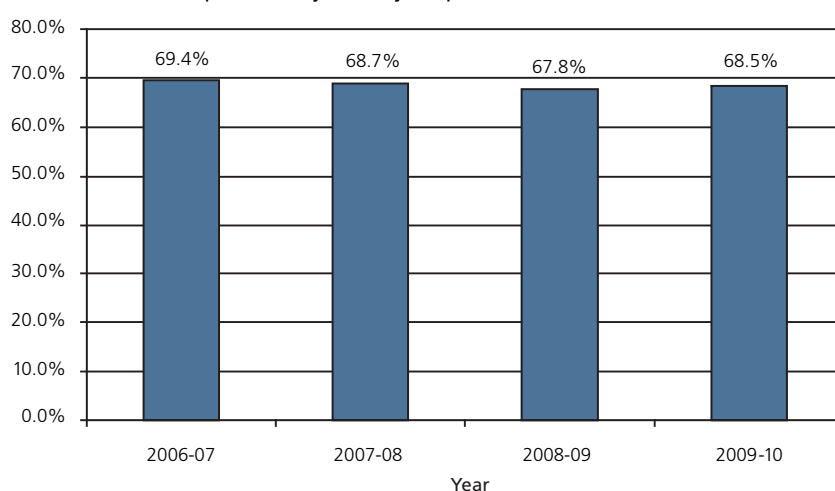
The New Royal Adelaide Hospital Master Plan has been launched and Public Private Partnership bids lodged. The Queen Elizabeth Hospital has been increasing its focus on services for an older local population as part of the overall planned realignment process.²¹

Country Residents

SA Health indicated that the metropolitan/country interface is now being more efficiently and effectively managed to the benefit of country patients. Initiatives included linking major metropolitan and country general hospitals by the appointment of joint 'Heads of Service' in different specialty areas, the associated 'repatriation' of services to these hospitals, and attention to creating better and stronger operational linkages across the metropolitan/country interface.

It is noted the overall proportion of country residents treated in country hospitals had been falling from 2006-07 to 2008-09, however it is now increasing, which is consistent with the overall directions of the *Strategy for Planning Country Health Services in SA* (see Chart 2.2.1).²⁰

Chart 2.2.1 Proportion of total country resident admissions provided by country hospitals 2006-07 to 2009-10



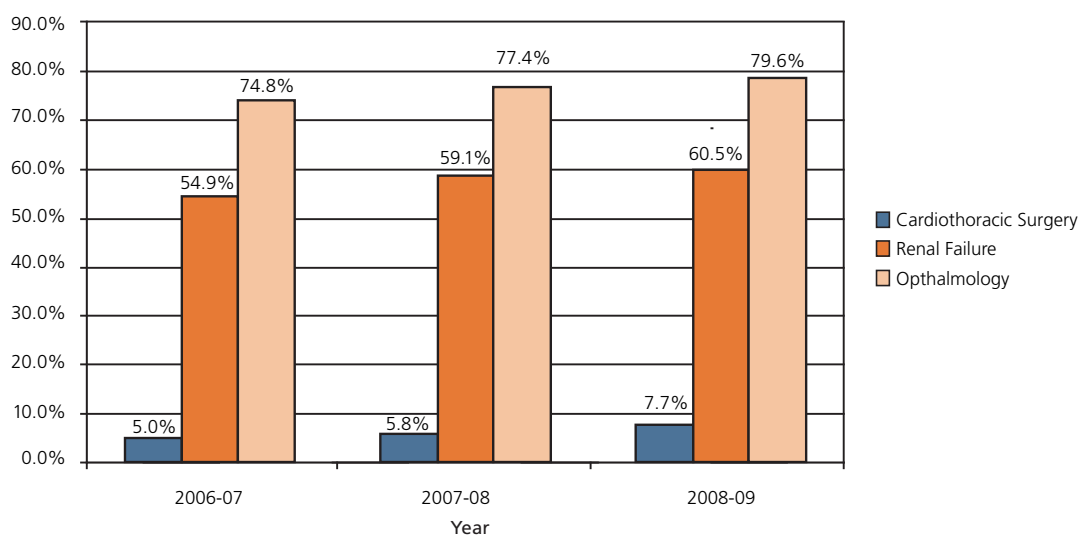
Note: Excludes chemotherapy & endoscopic procedures

Source: SA Health, Integrated South Australian Activity Collection

Within this overall picture, there are specific clinical areas where this proportion has been rising because of planned service development or innovative changes in treatment. They include cardiothoracic surgery (minor procedures coded as cardiothoracic and dealt with by general surgeons/physicians and general practitioners), ophthalmology and renal failure (see Chart 2.2.2).

The percentage of residents admitted to a country public hospital for renal dialysis in 2009-10 has risen to 69.9% from 63.8% in 2006-07.

Chart 2.2.2 Proportion of selected country resident admissions by service related group provided by country hospitals 2006-07 to 2008-09



Note: Excludes chemotherapy & endoscopic procedures

Source: SA Health, Integrated South Australian Activity Collection

SA Health indicated that the use of telemedicine for country patients is increasing, particularly in relation to new patients and inpatient review. This is likely to provide opportunities for greater access to specialist advice and clinical management of mental health patients living in country regions.

Continuity of Care

A coordinated hospital system that relates effectively with the range of community care and support providers is fundamental to effective continuity of care. The Statewide Clinical Networks along with other initiatives to enhance the interface between acute and community based care are expected to deliver improvements in continuity of care.

A range of initiatives and strategies for improving continuity of care focus on clinical pathways and care planning.

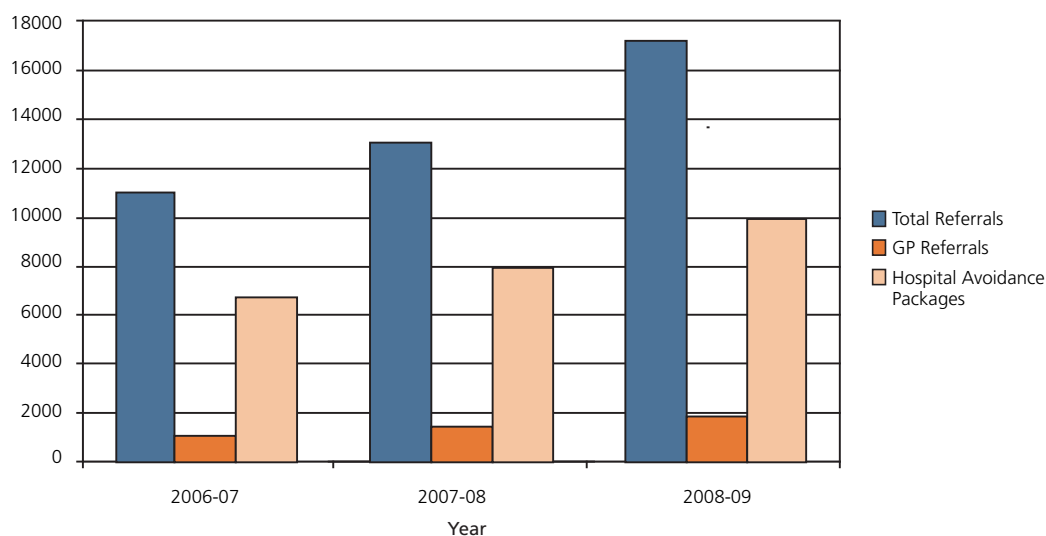
These often focus on the internal hospital system, such as the Sorted Patient Pathway Trial (Flinders Medical Centre, October 2009). This program was set up to improve the patient pathway from emergency department (ED) to an inpatient bed in relation to time and access to the right specialist team at the right time, and the introduction of Patient Flow Coordinators in EDs and other areas of activity.

A Patient Liaison Network that links Rural Liaison Nurses and Transfer Coordinators in metropolitan hospitals with Patient Liaison contacts in Country Health SA to provide greater continuity of care now serves country people.

Strategies also focus on the needs of people to have clear pathways in and out of hospital, for example, the establishment of Regional Referral Centres to assist in patient transition out of hospitals. Metropolitan Aboriginal Liaison Officers, funded through the COAG arrangements, form a network of support for Aboriginal people travelling to access health services.

The HPC noted the total number of referrals, GP referrals and referrals receiving hospital avoidance packages at the Regional Referral Centres has increased over the period 2006-07 to 2008-09 (see Chart 2.2.3). The HPC is concerned that from late 2009, when the Regional Referral Centres were created, there appeared to be a downturn in packages. The HPC is interested in monitoring the impact on continuity of care and other desired service outcomes over a longer period.

Chart 2.2.3 Regional referral centre activity 2006-07 to 2008-09



Source: SA Health

In relation to coordination, consulted stakeholders emphasised continuity of care as an issue, highlighting the need to simplify the patient journey within the hospital system and the pathways that lead to admission and discharge. There was support for the use of electronic file transfer and a strong view that it should operate across the whole system as a critical element in assuring continuity of care and improving coordination of services.

Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of the care of a patient. SA Health provided a number of examples of coordination activities in the health system, including the introduction of electronic clinical handover tools such as the Nursing Discharge Letter System within the clinical information system application.

SA Health indicated that on average 40% of hospital patients are discharged or referred to other services or facilities. These patients require both medical and nursing summaries, as there is discipline-specific information that needs to be communicated to ensure the effective and safe transition of care from one health care team to another. Electronic transfer of this information provides the means of ensuring that the information is at the right place at the right time.

Investing in new information management systems is further evidence of SA Health's efforts to improve coordination within the hospital system. SA Health indicated the *Careconnect.sa* Project would establish a personal, web-based entry point (or 'web portal') to access integrated patient health information. It intends to:

- > Provide consolidated and standardised patient information electronically across the public health system so that it is available at the point of care
- > Improve the coordination of health care services due to the increased accuracy and timeliness of patient information
- > Store information in a secure and protected manner within the SA public health care sector
- > Connect public sector hospitals, health professionals and the community statewide by 2017.

In addition, SA Health is working with the Australian Government in the development of a Personally Controlled Electronic Health Record. This development will establish a secure network of connected systems that will enable electronic summaries of medical history information to be accessible in a single view to individual patients and their authorised public and/or private health service providers.

Other initiatives reported to the HPC recognise the contribution of good communication and cohesive teams to continuity of care. Multi-disciplinary team meetings and case conferencing, involving discussion of a patient's case by the relevant health care professionals, teams, community agencies and families were reported as being pivotal in resolving issues and for ongoing care planning.

Another example brought to the HPC's attention relates to developing and reinforcing shared values, priorities and approaches in teams. Following a successful evaluation of five pilot sites, including Pt Augusta, TeamSTEPPS™, a program for enhancing teamwork, values, communication and safety, is being planned for statewide participation. However, during the review it became apparent that only a very small proportion of staff working across the system had been trained in TeamSTEPPS™ to-date.

In relation to emergency evacuation and care, the MedSTAR statewide retrieval service became operational in February 2009. MedSTAR provides rapid and high level emergency medical care to acutely ill and injured South Australians. Specialist teams are dispatched from one central location and work in partnership with the SA Ambulance Service and the Royal Flying Doctor Service. MedSTAR also provides a critical-care transportation service that allows access to Intensive Care beds at better equipped and staffed hospitals, such as the Royal Adelaide Hospital and the Flinders Medical Centre, for hospital patients who require a higher-level of care.

SA Health indicated it is implementing a range of strategies to better coordinate services and to enable people to access services in a more timely manner; and in some instances, closer to home (for example, the metropolitan *GP Plus* centres and regional dialysis and chemotherapy services).⁶ While the strategies recently put in place appear to address the continuity issue – an increase in use of electronic transfer of information is a good example – it is difficult to assess the extent to which these strategies are effective and whether they are part of a systemic approach.

SA Health receives regional reports regarding hospital compliance with quality standards relating to continuity of care, including detailed information about high priority recommendations, non-compliance and those standards in which the organisation achieved a commendation. However, it is unclear how this information is utilised in tandem with the aforementioned indicators to assess performance and inform decision-making in this area.

For example, ACHS EQuIP4 Standard 1.1 Continuity of Care – selected indicators:

- > Number of medical records containing evidence of multidisciplinary assessment
- > Number of variances identified in pathways in relation to care planning
- > Number of consumers/patients who cannot be discharged on the expected discharge date
- > Number of consumers/patients with chronic conditions who hold a personal medical record
- > Number of medical records where care plans are not documented.²²

Improve health outcomes, safety and quality, for people in hospital care (Objective 2.2)

Key Findings

9. While substantial work is underway to improve the safety culture and to monitor adverse events within the public hospital system, further work to both understand and improve patient experiences and clinical effectiveness of in hospital and out of hospital care is indicated.

Although the HPC received substantial data and information on the hospital system, the majority of the existing measures relate to inputs, activity and to a lesser extent outputs. There is currently little measurement of outcomes and other performance metrics that might demonstrate the success or otherwise of the new reform agenda. In terms of service quality, the HPC would encourage that the planned development of a suite of clinical indicators to assess technical effectiveness and survey tools to regularly monitor consumer experiences of health care, including their reflections on the safety and reported outcomes of care, be progressed as a matter of priority.

In June 2009 SA Health introduced systems that provide a framework of clear governance including individual and health service responsibilities in the management of consumer feedback and complaints. The framework establishes mechanisms for using complaints and consumer feedback to improve services and the HPC looks forward to reviewing ways in which systemic change has resulted from analysis of feedback and complaints.

10. Structural incentives to improve hospital service quality, based on measured patient outcomes or processes of clinical care, were not clearly demonstrated.

Both locally and internationally, health systems are exploring ways to provide incentives to providers for greater 'value for money' in the care they provide and to shift their effort onto improving the effectiveness and outcomes of care. These arrangements aim to reward not only the provision of efficient hospital care but also quality care. While a number of important aspects of hospital service safety are routinely monitored, there may be scope to further pursue efficiency objectives through incentives to avoid unsafe practices and the associated additional care burden. For example, funding mechanisms are currently being explored overseas whereby hospitals are being asked to be accountable for the costs of avoidable readmissions and the care of serious adverse events occurring to patients while in hospital.

Discussion

The HPC was presented with a range of information to demonstrate that there is a clear focus on safety and quality in hospitals in relation to specific practices and protocols including infection control, prevention of falls and safe use of pharmaceuticals. The HPC was also advised of standards and indicators that are used to govern and monitor these activities. It appears that a number of the initiatives mentioned are currently under implementation, or have been operational for a relatively short time.

SA Health routinely monitors a set of hospital safety indicators including sentinel events and hospital acquired infection rates. SA Health reports that monitoring of safety indicators such as the monthly falls rate helps inform the further development of current departmental strategies, such as the 'Green Box' Falls and Fall Injury Prevention Training Program.

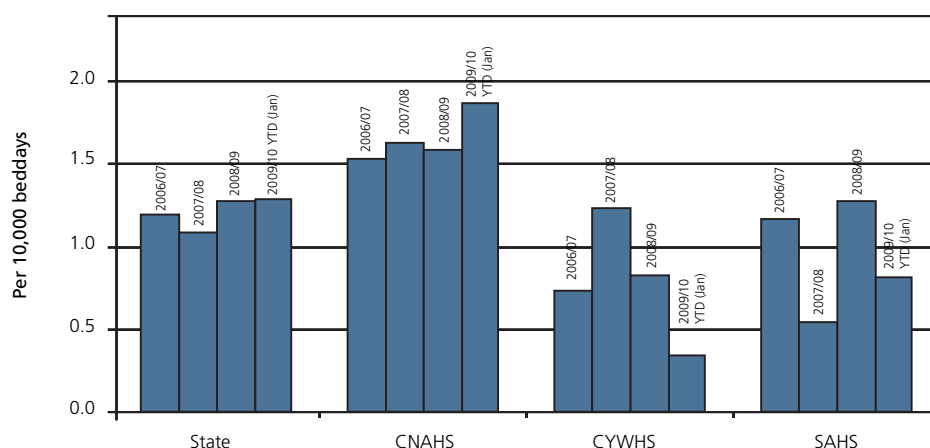
HPC understands that there will never be a single aggregate measure of health care safety through which to assess performance in this area. However, it is important that SA Health is able to determine from the range of individual measures whether hospitals are becoming progressively safer.

Longitudinal data reported through the SA Health adverse events monitoring system provides encouraging signs that the reporting culture across SA hospitals is improving. However, this data does not enable insight into whether service safety is improving or deteriorating in the areas reported.

The data on adverse events must be carefully interpreted given the inherent volatility in the data resulting from low incidence rates in some areas such as sentinel events.

For example, it is not clear from the data provided on in hospital staphylococcus infection if the situation in SA has improved over the three years 2006-07 to 2009-10 (year-to-date) (see Chart 2.2.4).

Chart 2.2.4 SA Public Hospital Staphylococcus Aureus rate, 2006-07 to 2009-10 YTD January



Abbrev: CNAHS (Central Northern Adelaide Health Service), CYWHS (Children, Youth and Women's Health Service), SAHS (Southern Adelaide Health Services)

Source: SA Health, Infection Control Service

SA Health reported that safety related performance targets and assessment tools were included in 2009-10 regional health service performance agreements, including indicators relating to falls prevention systems and strategies, and the safe and appropriate use of blood and blood products. In addition, some larger country hospitals have recently begun contributing data to the statewide health care associated infection surveillance system.

SA Health reported a variety of safety initiatives including hospital participation in promotional programs, such as the award winning campaign, *Wash, Wipe, Cover Don't Infect Another!*, designed to promote good hand and respiratory hygiene. This is partnered by the introduction of the National Hand Hygiene Initiative, designed to increase compliance of health care workers with the most basic infection control measure.

SA Health reported having numerous indicators that are associated with safety including those relating to Safety and Assessment Classification (SAC) categories and infection control incidents. In addition, SA Health reported the use of standards and indicators that have external status including:

- > Australian Pharmaceutical Advisory Council's Guiding Principles²³
- > Statewide health care associated infection surveillance system
- > Australian Commission For Safety and Quality in Health Care National Guidelines for preventing Harm From Falls in Older People in Australian Hospitals and Residential Care Facilities (2005)²⁴
- > National Health and Medical Research Council, and the Australia New Zealand Society of Blood Transfusion Clinical Practice Guidelines.^{25, 26, 27}

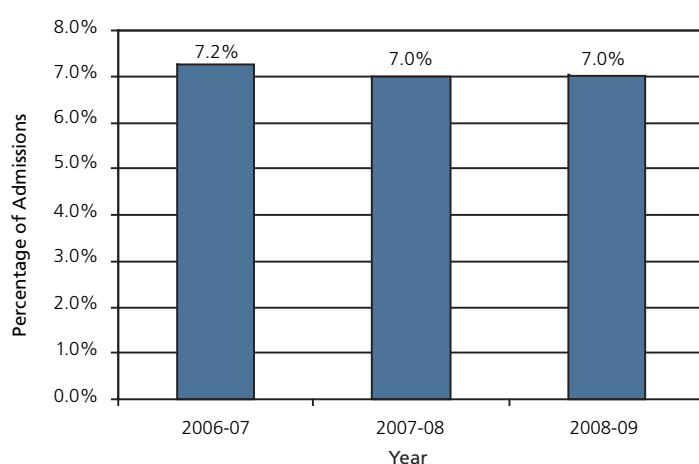
SA Health has established the South Australian Falls Advisory Group as the peak body to provide advice on the development, monitoring and planning of strategies including a training program to assist with implementing best practice in hospitals and residential aged care, development of indicators and training, education and research to build workforce capacity. In addition, South Australian universities have assisted in the development of postgraduate education in this area for clinicians.

SA Health is implementing an incident management toolkit to improve consistency and continues to analyse adverse events to learn and take action to improve systems by reducing the risk of adverse events. SA Health supports root cause analysis training to identify weaknesses or gaps, and identify improvement opportunities. Information regarding safe practice is shared across SA Health via a safety alert broadcast system.

Under the SASP the overall health of South Australians is monitored through such measures as healthy life expectancy and infant mortality rates.⁴ Prevalence and incidence of particular diseases and conditions are reported periodically through SA Health publications such as the 2008 edition of *South Australia: Our Health and Health Services*, with wellbeing trended over time to monitor change.²⁸ SA Health has a well-established program of population health surveys and population based registries (including the SA Cancer Registry) which assist in monitoring health status, disease prevalence and population risk factors.

While unplanned (emergency) readmission can be viewed as a proxy measure for hospital care effectiveness, more robust measures (for example, case fatality rates for acute myocardial infarction and stroke) are warranted and are currently under development within SA Health (see Chart 2.2.5).

Chart 2.2.5 Rate of emergency readmission within 28 days, South Australia, 2006/07 - 2008/09



Source: SA Health, Integrated South Australian Activity Collection

The SA Health Clinical Data Committee has been established to identify relevant clinical outcome measures and commence routine reporting on these. The committee has agreed that Standardised Mortality Ratio derived from inpatient morbidity data and deaths at agreed intervals from discharge (for example, one month, three months and one year) will be the first clinical indicators to be produced and evaluated.

Interpretation of changes in the rate of unplanned readmission cannot be confidently attributed to improved hospital performance as these rates might be influenced by the capacity and effectiveness of the primary and community care sector. Further, methodological issues relating to identifying unplanned readmissions were indicated by SA Health, which reduces the validity of the indicator in its present form.

The HPC believes more information is also required on the effectiveness of hospital care for specific population groups. It is of concern to the HPC that a disproportionately large number of Aboriginal and Torres Strait Islander people self-discharge from hospital against medical advice. However, the impact on their health, given this situation, is unclear.

Consulted stakeholders expressed a view that acute care is of high quality but overall, the quality and safety focus appears to be more on workforce shortages than on patient outcomes. Participants referred to SA Health's recent Patient Cultural Survey where approximately one third did not know how to make a complaint and about a quarter believed that staff made mistakes under pressure. Concerns were also raised about the need for more effective discharge planning, particularly in ensuring safety of the elderly.^{29, 30}

SA Health indicated that discharge support programs have been initiated as part of its integrated response to the needs of elderly patients as outlined in its *Health Service Framework for Older People 2009-2016*, in consultation with the Older People Services Clinical Network.³¹ The enhancement of the Transition Care Program that provides pathways to support timely discharge of older people back into the community, was one of many examples SA Health provided.

South Australia is not alone in having difficulty assessing overall system performance in relation to quality and safety, although specific measures such as hospital acquired infections and sentinel events provide insights in particular aspects of safety. The development of indicators of clinical effectiveness and patient experiences of hospital care could enhance SA Health's capacity to monitor and encourage improvements in health care quality in the future.

Improve efficiency and effectiveness of hospital care (Objective 2.3)

Key Findings

11. The focus on improved efficiency has resulted in SA Health having the lowest *Cost per Casemix-Adjusted Separation* in Australia. In part, this is attributable to reduced lengths of stay and increased day of surgery rates. This significant achievement does however require evaluation in the context of relatively high public hospital bed utilisation and out of hospital care provided by carers.

SA Health has sought to improve the efficiency of hospital provision. The imperative to do so has been heightened by the prevailing financial situation of the system and the ongoing demand pressures on hospitals. The HPC considers that the achievements in efficiency demonstrated by SA Health (for example, earlier discharge from hospital) may need to be assessed on an ongoing basis, to ensure additional pressures are not being unduly placed on other parts of the system, both in terms of cost and quality of overall service provision.

While South Australia's hospital system appears to have favourable capacity compared with other states and territories, demand is increasing at such a rate (ageing population, burden of chronic disease) that hospitals find themselves operating at capacity for most of the year. This situation is placing staff working in the system under sustained pressure, making their task in maintaining the safety and quality of care even more difficult and providing management with additional challenges in seeking to retain well qualified health professionals.

12. Continued efforts to improve effectiveness were difficult to assess, particularly in relation to the quality of care and patients' outcomes for priority population groups.

It would appear that while greater attention is being given to issues of safety and quality of hospital services, there is little data and information available to attest to improvements in the effectiveness of hospital care. The HPC is aware of current efforts to develop a suite of clinical indicators that should, once available, improve SA Health's capacity to monitor and assess the effectiveness and quality of hospital based care and overall system performance. Related issues are explored in more detail under the discussion of the objective related to improving health outcomes, safety and quality, for people in hospital care.

Discussion

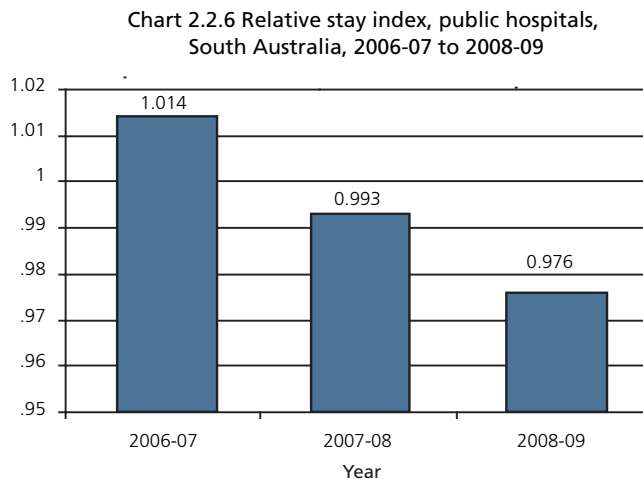
SA Health has indicated that efficiency gains have been made over recent years, because of the conscious and targeted attention given to key hospital and related service cost drivers. It is noted that the key monthly performance review processes of SA Health have featured a number of related performance indicators.

The Total Cost per Casemix-Adjusted Separation and the Relative Stay Index (RSI) are indicators used nationally to monitor the efficiency of hospital activity, as governments hold the view that shorter time in hospital results in reduced cost and greater efficiency. As indicated in the Productivity Commission's Report on Government Services 2010 (Vol 2, p 10.60), although a lower Total Cost per Casemix-Adjusted Separation can reflect more efficient service delivery in public hospitals, it needs to be viewed in the context of the set of performance indicators as a whole, as cost is not necessarily related to quality and efficiency.³² The report also warns that a low RSI is only desirable if it is not associated with poorer health outcomes or significant extra costs outside the hospital systems, such as in-home care (pg 10.61).

Length of Hospital Stay (readmission rates)

The RSI is a measure of hospital efficiency that takes into account the casemix of SA hospitals as compared with other hospitals in Australia.

Over the period 2006-07 to 2008-09, the RSI in SA reduced, and has been less than 1.00 for the past two years, which indicates that the length of stay in SA public hospitals now compares favourably with other hospitals in Australia. Data that is more recent suggests that further reductions in the RSI have been achieved in 2009-10 (see Chart 2.2.6).



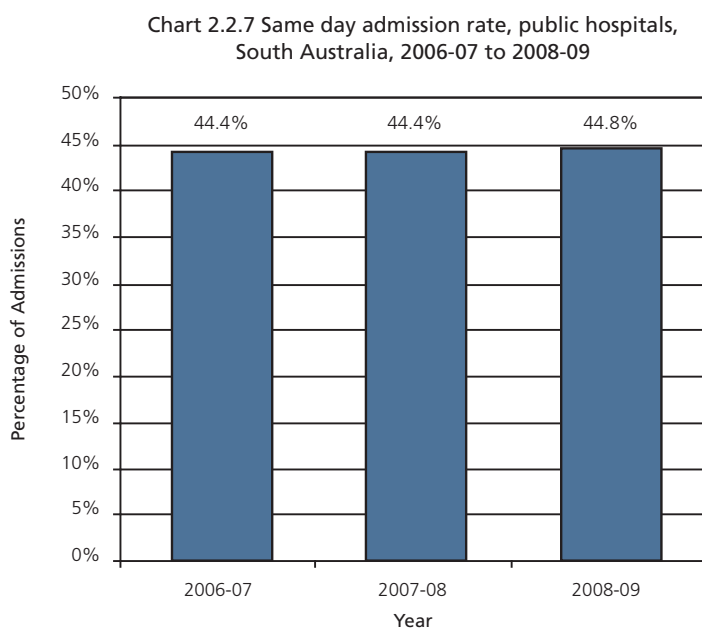
Source: SA Health, Integrated South Australian Activity Collection

A common concern raised in relation to the reduction in the length of stay in hospital is that it may result in patients being returned to live in the community too early, without the necessary support, resulting in a return to hospital for care. However, a review of the data provided by SA Health on the readmission rates to the same hospital (current data systems do not allow ready monitoring of readmission to a different hospital) does not provide a basis for concern in this area (see Chart 2.2.5). The rate of emergency readmission within 28 days of discharge from a public hospital in South Australia actually decreased during the same period the RSI decreased for South Australian hospitals.

Therefore as a proxy measure for hospital care effectiveness, the marginal improvement in this indicator is encouraging. It should however be noted that the interpretation of changes in the rate of unplanned readmission, cannot be confidently attributed to improved hospital performance as these rates can also be influenced by the capacity and effectiveness of the primary and community care sector.

Same Day Admission Rate

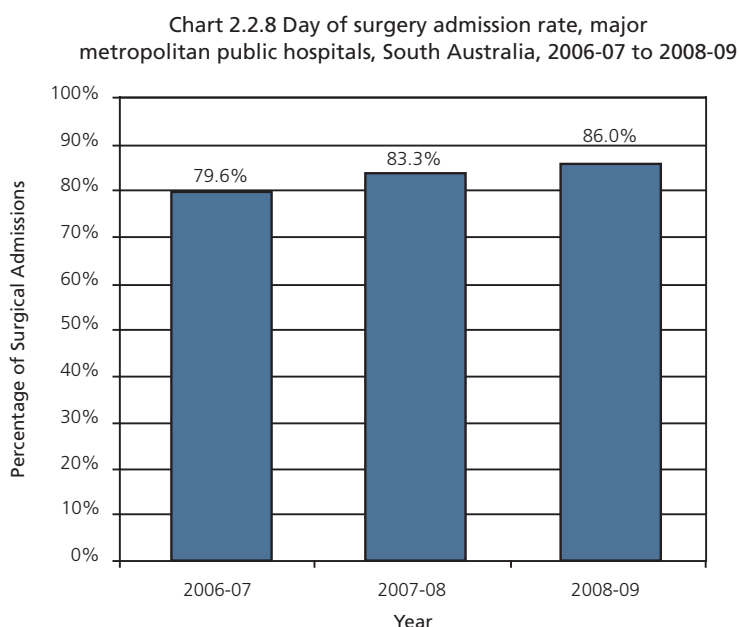
The proportion of people admitted to and discharged from hospital on the same day (rather than stay overnight) has remained relatively stable over the period 2006-07 to 2008-09 (see Chart 2.2.7).



Source: SA Health, Integrated South Australian Activity Collection

Day of Surgery Admission Rate

The proportion of people admitted for surgery on the day of their surgery (rather than a day or so before) has improved over the period 2006-07 to 2008-09 (see Chart 2.2.8).



Source: SA Health, Integrated South Australian Activity Collection

It is also noted that over the past three years SA Health has undertaken a number of related service consolidation

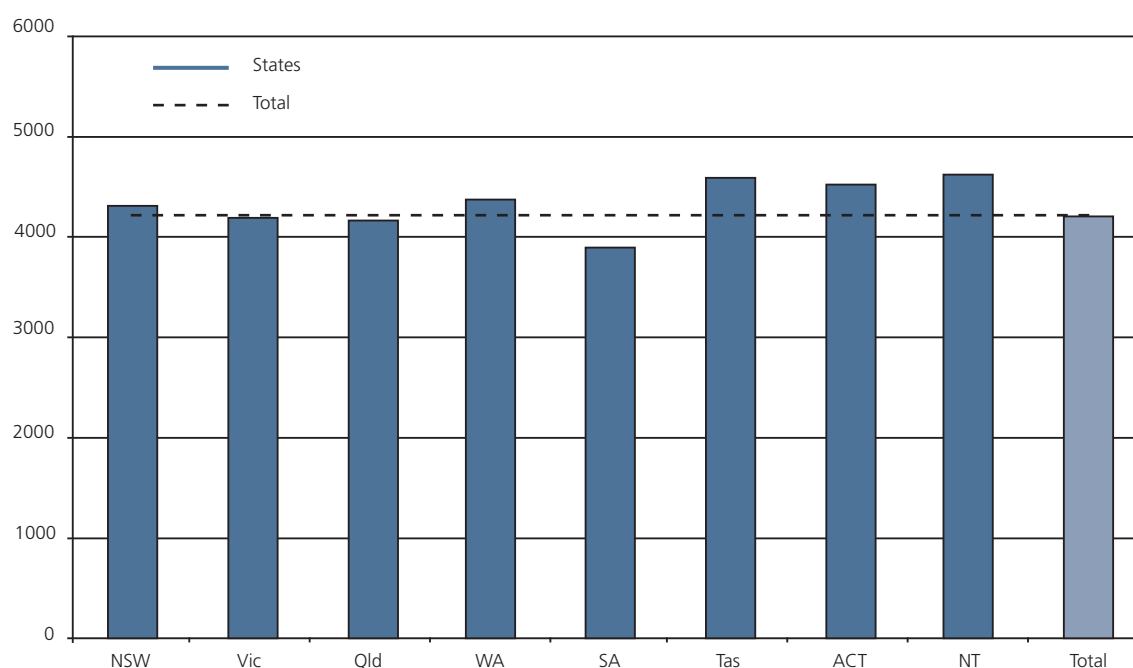
initiatives that aim to accrue economies for hospital and overall service provision in the system including:

- > Consolidating the Finance, Human Resources and Information Services functions of the system, in line with the whole of government strategy related to such services
- > Establishing the SA Pathology Service, this brought the various public pathology services under one corporate governance arrangement.

It is difficult to attribute the improvements in efficiency to any one individual initiative or even a specific group of initiatives. Rather, it would appear that a strong focus on cost containment, combined with a broad range of efforts to improve processes and systems, both within and outside hospitals, is responsible for the observed improvements. It is noted that South Australia has achieved the lowest cost per hospital admission in Australia (see Chart 2.2.9).

However, it is difficult to envisage that overall system capacity or financial sustainability will be improved sufficiently as a direct consequence of such gains in efficiency in the absence of other complementary policy measures.

Chart 2.2.9 Average cost per Casemix-adjusted separation, 2007-08 (\$)



Notes:

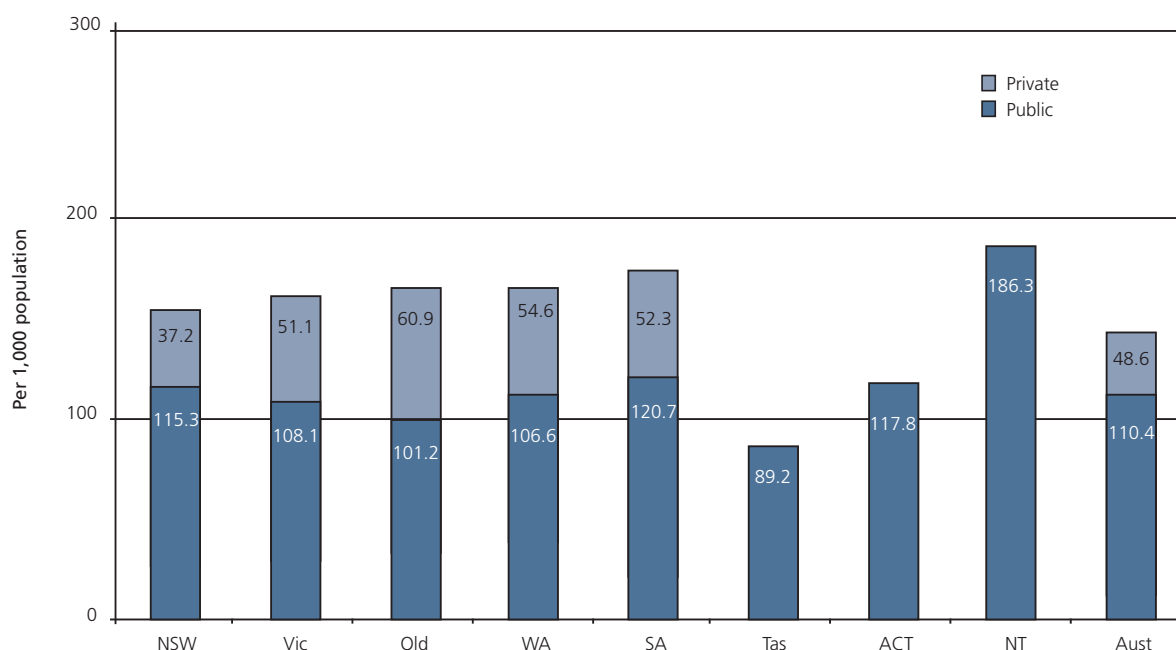
1. Limited to public hospitals that provide mainly acute care.
2. Data represents the average cost per case mix-adjusted separation excluding depreciation.
3. Small acute care hospitals are included in the average costs, but are not separately identified in figure 10.5.
4. See volume 2, table NHA.69.1 for data.

Sources: COAG Reform Council, 2010 using AIHW (unpublished) National Hospital Morbidity Database; AIHW (unpublished) National Public Hospital Establishments Database.

It is noted that amidst significant demand pressures, there are indications that the provision of public and private hospital services in South Australia fares quite favourably when compared with other states, even after taking account of the demographic profile of the community (see Chart 2.2.10).

The HPC would encourage SA Health to consider the implications of this situation and confirm whether it can be largely accounted for by the unique configuration of sub-acute, non-acute and country hospital services in the state.

Chart 2.2.10 Overnight separations, by hospital sector, by State and Territory, 2007-08



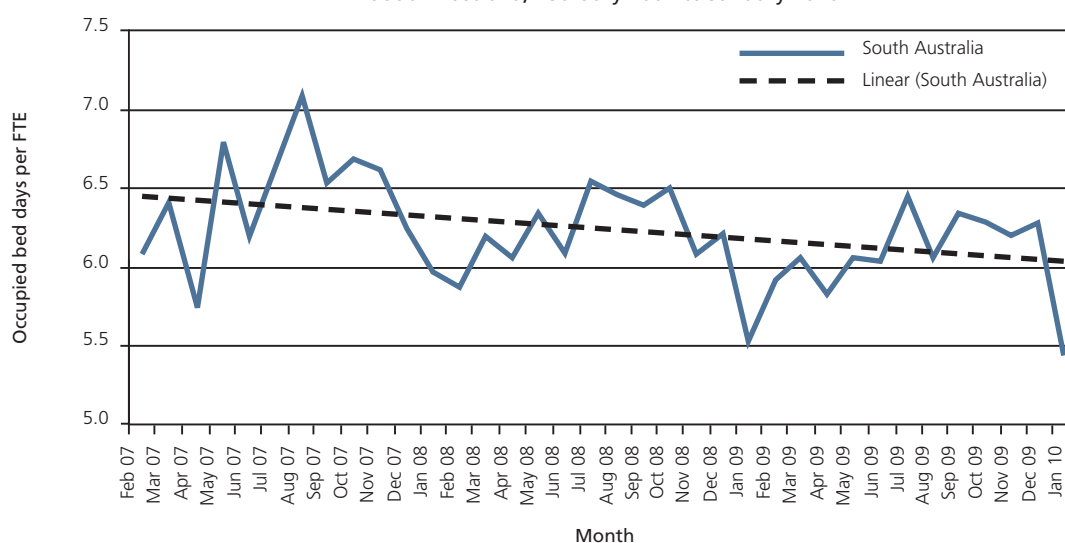
Notes:

1. Data are not published for private hospitals in Tasmania, the ACT and the Northern Territory to protect the confidentiality of individual hospitals, but are included in the national total.
2. Data are presented according to the State or Territory that delivered the service, which may include services delivered to residents of other jurisdictions.
3. Rates are aged standardised to the Australian population as at 30 June 2001.
4. See volume 2, table NHA 45.1 for data.

Sources: COAG Reform Council, 2010 using AIHW (unpublished) National Hospital Morbidity Database; ABS (unpublished) Estimated Residential Population 30 June 2007.

Further, the HPC did detect a signal that efficiency gains in hospital service provision may not be as favourable as presented through length of stay metrics. Based on data provided to the HPC by SA Health, an initial picture of workforce productivity was made possible (see Chart 2.2.11).

Chart 2.2.11 Monthly average days of public hospital care per employee, South Australia, February 2007 to January 2010



Note: Occupied bed day data excludes bed days related to chemotherapy and endoscopic procedures.

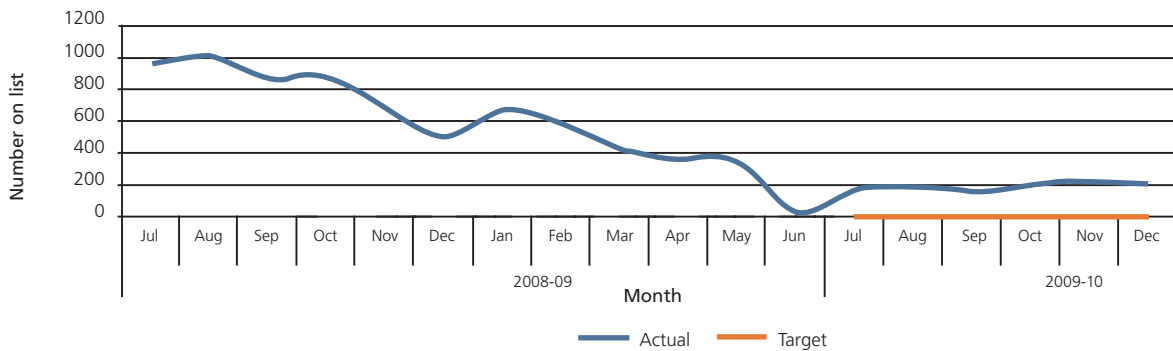
Source: SA Health

It is noted that while there is quite marked fluctuation during each year, the number of hospital days per employee (full-time equivalent) has trended downwards over the past few years (from February 2007 to January 2010). This suggests that while the length of stay in SA hospitals may have been decreasing, the level of resource utilisation per day of stay may have increased. While the downward trend in productivity was observed across all health regions, the magnitude and impact of changes in bed days per full-time equivalent employee was most noticeable across the hospitals in the former CNAHS.

The HPC considers that further consideration of the underlying factors for this situation are warranted to determine to what extent the observed trend reflects increased care intensity resulting from shorter lengths of stay, improved quality of care, changes to service arrangements or data related issues.

SA Health has indicated that improvements have been achieved in access to hospital services, particularly elective surgery and ED services. The HPC notes the number of people waiting longer than clinically appropriate for elective surgery fell dramatically during 2008-09 (see Chart 2.2.12).

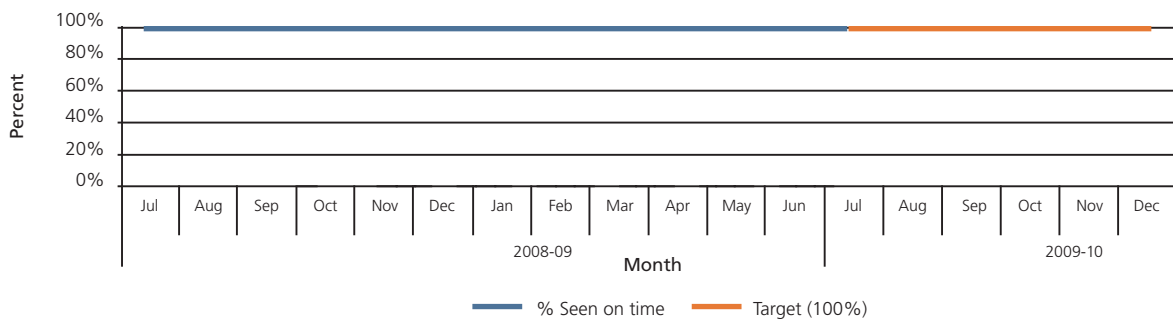
Chart 2.2.12 Metro – Total number overdue on waiting list (Cat.1,2,3), PA KPI 1.18



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

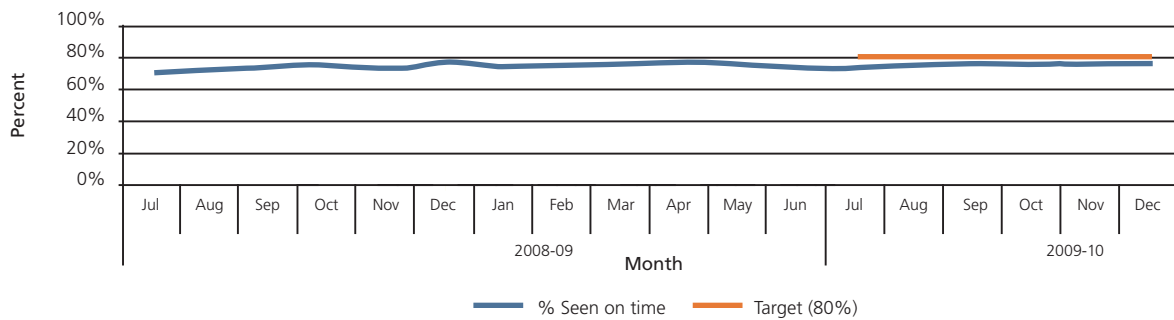
Waiting times for public hospital ED care have remained relatively stable and SA Health currently meets the Australasian College for Emergency Medicine (ACEM) targets for triage categories 1 (most urgent and generally the sickest) and 5 (least urgent and generally the least sick).³³ It is noted that although SA public hospital EDs show improved compliance with the ACEM targets set for triage categories 2, 3 and 4 they still fall short of most targets (see Charts 2.2.13, 2.2.14, 2.2.15, 2.2.16 and 2.2.17).

Chart 2.2.13 Metro – % Patients seen immediately – Triage1, PA KPI 1.04/SAHSP SD 2



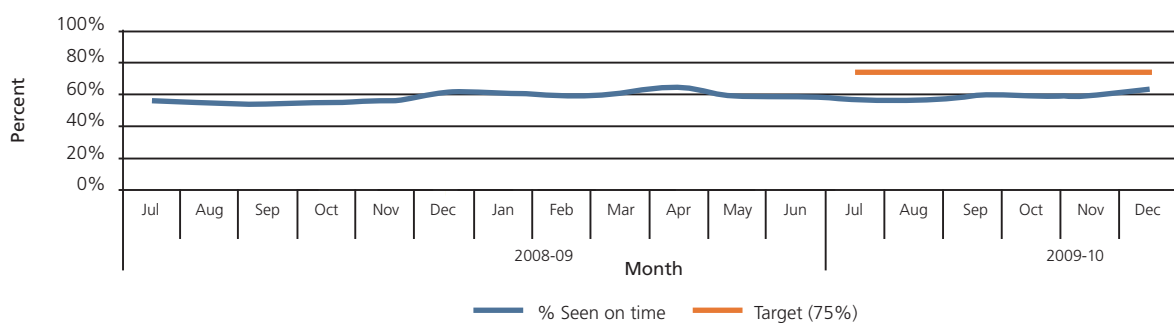
Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Chart 2.2.14 Metro – % Patients seen within 10 minutes – Triage 2, PA KPI 1.05/SAHSP SD 2



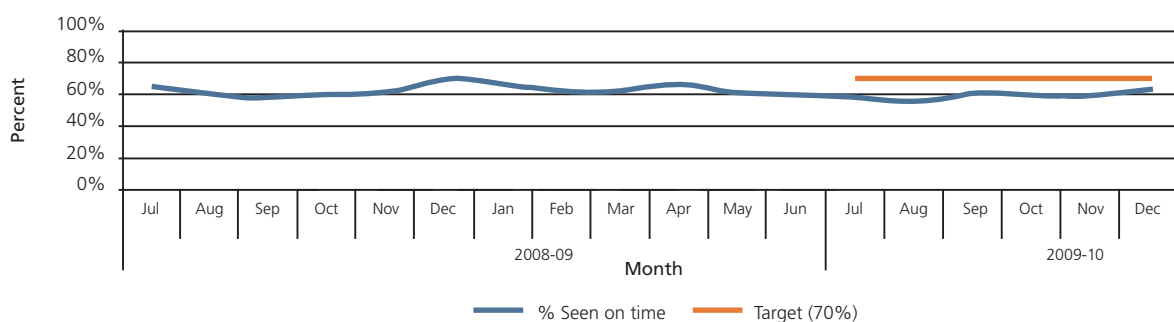
Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Chart 2.2.15 Metro – % Patients seen within 30 minutes – Triage 3, PA KPI 1.06/SAHSP SD 2



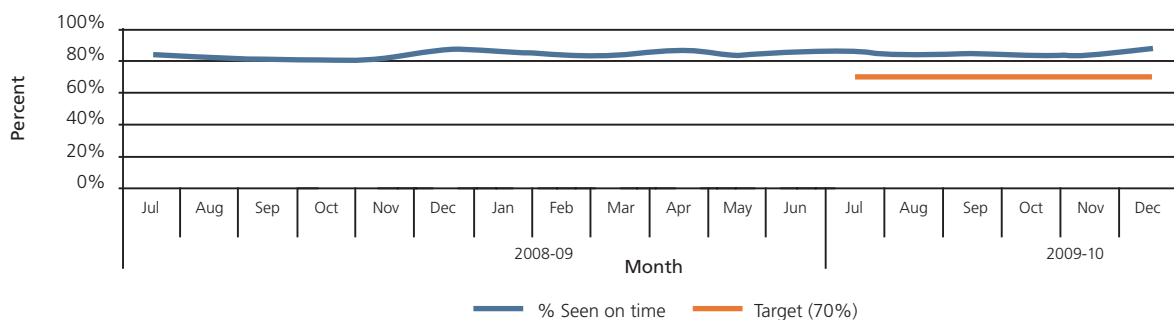
Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Chart 2.2.16 Metro – % Patients seen within 60 minutes – Triage 4, PA KPI 1.07/SAHSP SD 2



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

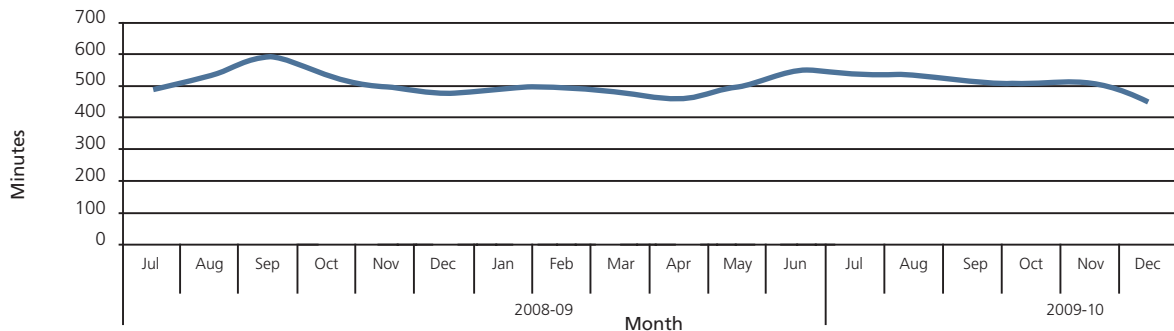
Chart 2.2.17 Metro – % Patients seen within 120 minutes – Triage 5, PA KPI 1.08/SAHSP SD 2



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Further, managing admissions from the ED into a hospital bed remains an area of significant challenge and SA Health has indicated there will be further work undertaken to reduce actual and potential 'bed block' issues arising from this process (see Chart 2.2.18).

Chart 2.2.18 Metro – Average ED visit time of admitted patients

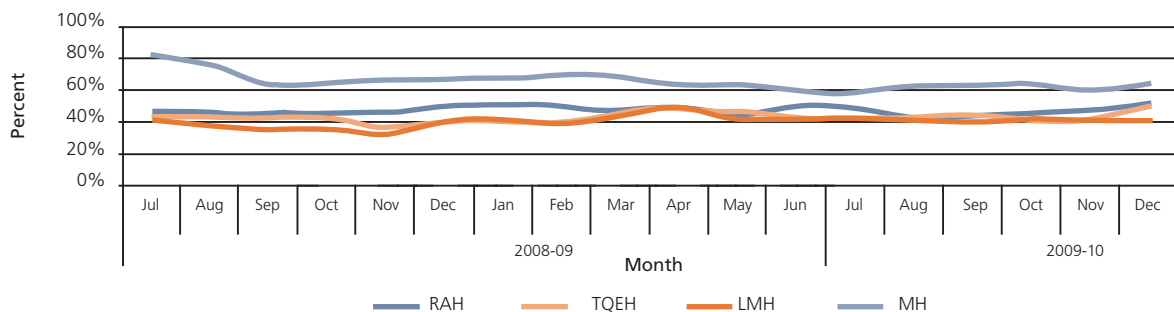


Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

The aim is to consider the overall flow of patients through the system, from the initial point of contact in the community or in an ED through to hospital admission, treatment and then discharge back into the community.

Nationally significant focus and attention is being placed on the total time a patient spends in the ED. At this time, the aim is to maximise the proportion of patients whose total visit time is less than four hours, regardless of whether they are eventually admitted to the hospital or return into the community. The current target in SA Health is 60%, which is presenting an ongoing challenge for a number of the major metropolitan public hospitals (see Charts 2.2.19 and 2.2.20).

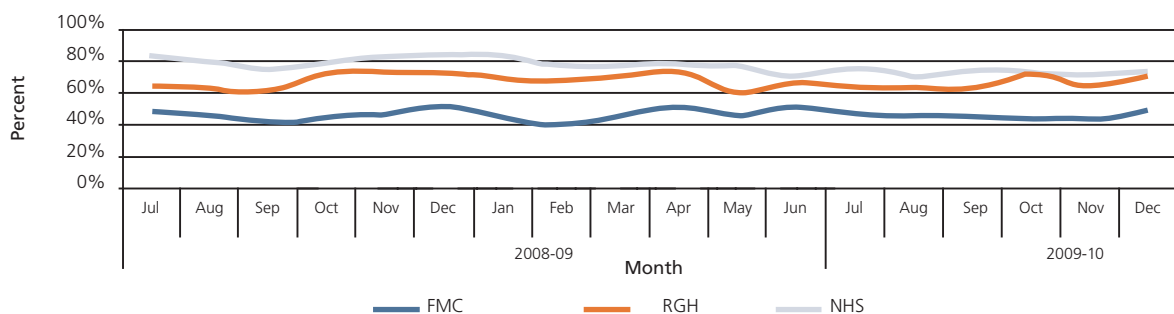
Chart 2.2.19 CNAHS – % visit time within 4 hours by hospital, PA KPI 1.02



Abbrev: RAH (Royal Adelaide Hospital), QEH (The Queen Elizabeth hospital), LMH (Lyell McEwin Hospital), MH (Modbury Hospital)

Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Chart 2.2.20 SAHS – % visit time within 4 hours by hospital, PA KPI 1.02



Abbrev: FMC (Flinders Medical Centre), RGH (Repatriation General Hospital), NHS (Noarlunga Health Service)

Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

While data is available on waiting times for elective surgery and ED care, data relating to waiting times for specialist consultations (including public hospital outpatients), which are often required before a patient is referred for admission to hospital and placed on an elective surgery waiting list, would have assisted in evaluating this indicator.

As noted earlier in this report, SA Health indicated that there is better resource utilisation through the use of a more efficient system (rather than single institution) based approach to management of patients promoted through the establishment of Statewide Clinical Networks, most notably in orthopaedics. The extension of this approach to other specialty areas via a newly created Surgical Task Force will be monitored for impact.

In addition, effective management of the interface between hospital and community care and support is recognised as an essential prerequisite to achieving timely and efficient movement of patients from the hospital into other more appropriate forms of community based care. SA Health has invested heavily in improving this interface through programs under *GP Plus* such as Transition Care, Hospital in the Home and Home Rehabilitation Services, and other initiatives such as Metro Homelink (and the associated provision of Hospital Avoidance Packages).⁶

SA Health indicated the development of standard minimum data collection definitions and associated data collection systems has progressively improved existing monitoring processes. SA Health reports that the application of strict evaluation criteria to the 2009-10 *GP Plus* programs resulted in the cessation of a number of programs that failed to reduce hospital activity, while others were modified to improve effectiveness.⁶

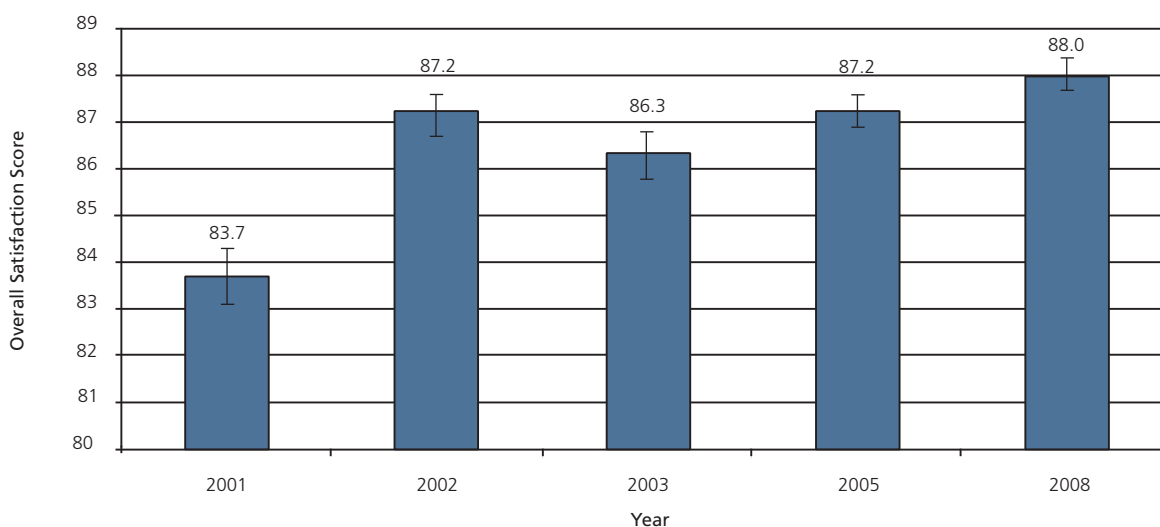
Referrals to the multitude of outpatient clinics operated by the major metropolitan hospitals are thought to significantly influence both access to and the efficient utilisation of hospital services. SA Health has commenced a major review of this area in order to develop a comprehensive understanding of the current service arrangements and then devise ways to improve them with a view to enhancing the overall efficiency and effectiveness of the system.

SA Health reports that improved management of discharge arrangements with NGOs through the development of Regional Referral Units has enhanced efficiency and value for money achieved using packages of care. These units operate seven days a week and accept referrals from ED's and general practice so care can be provided, thereby avoiding an admission to hospital. The introduction of the single Adelaide Health Service is expected to provide further efficiency gains through the merger of some of these units. The new metropolitan wide referral unit will commence operating in late 2010 and manage referrals for both adults and children.

SA Health is preparing for the anticipated national reform to hospital and primary care funding as it is anticipated that the funding for many primary care services, including outpatient services, will transfer directly to the Australian Government.

Exit surveys used by public hospitals indicate overall consumer satisfaction with hospital care remains at a high level. A number of stakeholders consulted by the HPC raised concerns about access to hospital care, and in particular, their inability to access culturally appropriate services (see Chart 2.2.21).

Chart 2.2.21 Patient satisfaction with inpatient care, South Australia, 2001-2008



Note: SA Health considers that scores of 90 and above indicate a high level of satisfaction has been achieved ('gold standard'). Whereas scores around 80 indicate a reasonable satisfaction level has been achieved with room for improvement and scores around 70 indicate a level of satisfaction that warrants urgent attention. I-Shaped Error bars represent the 95% confidence interval.

Source: SA Health, Patient Evaluation of Health Services data

Reduce dependency on hospitals (Objective 2.4)

Key Findings

13. The evidence suggests a containment of demand escalation and more appropriate treatment outcomes, significantly in access to primary health care and out of hospital services. However, it is important that in the face of escalating demand for hospital services, investment continue in primary health care and out of hospital services notwithstanding the long lead times for demonstrable success.

Efforts are being made to reduce hospital demand through the raft of *GP Plus* and re-designed care processes both in and out of hospitals.⁶ However, hospitals remain overcrowded for much of the year, meaning the best that might be expected from measures aimed at reducing dependency on hospitals, is that they keep demand increases at lower levels than would otherwise have been the case. There are indications that the implementation of various strategies has been more protracted than planned and that actual demand pressures are exceeding projected levels.

Discussion

SA Health's aim to benefit individuals as well as the entire health system by diverting potential hospital users to alternative options is noted.

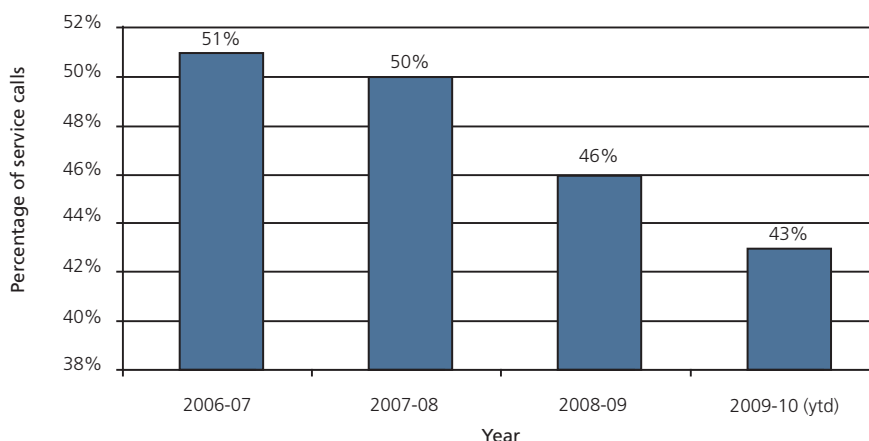
GP Plus services are being developed to expand community based responses to health care needs and these are seen as critical to the reduction of dependency on hospitals.⁶

SA Health reported that the needs of frail older people have a particular focus for reduction of dependency on hospitals. A number of key initiatives supported by the *GP Plus* Strategy funding have been implemented to improve timely access for older frail people. These include:

- > The SA Ambulance Service Extended Care Paramedic Program. This initiative involves specifically trained and skilled paramedics providing enhanced clinical assessment and, where appropriate, management of patients in the community to avoid unnecessary transportation to EDs of hospitals (see Chart 2.2.22).

There are clear signs that the proportion of SA Ambulance responses resulting in transport to EDs is decreasing and that the SA rate compares favourably with other states. It is noted that any changes in the relative mix of categories of responses in this period might have also contributed to this observed outcome.⁶

Chart 2.2.22 Proportion of ambulance services calls resulting in transport to a public hospital emergency department, South Australia, 2006-07 to 2009-10 (YTD January)



Source: SA Health, SA Ambulance Service

- > The Integrated Care for Older People Program (a partnership between the Adelaide Health Service, Royal District Nursing Service, Adelaide Western GP Network and local general practitioners), targets older patients with complex health care needs and older people at risk of episodic deterioration, which might result in unplanned hospital care. SA Health reports that this program has resulted in a reduction in the need for general practitioner, community, or hospital based interventions.

Information provided on strategies in place to achieve reduced dependency on hospitals includes:

- > Implementing health service design and planning reforms across the continuum of care.
- > Establishing *GP Plus* health networks to improve primary health care services.⁶
- > Expanding clinical services in the community and increasing primary health care options to improve community wellbeing.
- > Establishing statewide clinical networks that provide leadership and strategic planning for clinical services, as well as monitoring implementation and advising SA Health on relevant key issues.
- > Developing indicators, including Indigenous status, to improve the way the primary health care services sector is measured. Currently community mental health and drug and alcohol services data is maintained. Community health, district nursing and dental services data are due to be added in 2009-10. Further additions will be made in 2010-11.
- > Establishing robust data collection mechanisms that improve the availability of primary health care services data through a central data repository.

SA Health reported that it is monitoring a range of indicators including assessing the effectiveness of expanding clinical services in the community, and increasing primary health care options to improve community wellbeing; collaboration between hospitals and its *GP Plus* services; monitoring separations, ED presentations, outpatient occasions of service, purchased services against agreements and hospital waiting times.⁶

It was noted that the Department of Health Portfolio Performance Review Committee (PPRC) carries out regular monitoring of regional and statewide services data and information. The PPRC comprises the Chief Executive of SA Health, Regional Health Service chief executive officers and other senior executives of SA Health and meets on a monthly basis.

The data reviewed by the PPRC reflects the traditional focus on hospital activity. Limited 'Out of Hospital Services' data is also presented, notably:

- > Number of hospital avoidance packages
- > Average length of stay by Hospital Avoidance program
- > Breastscreen, Ambulance Service, Dental Service and SA Pathology statistics
- > Number of families receiving sustained home visiting services
- > Number of Aboriginal families receiving sustained home visiting services
- > Health Call Centre activity
- > Mental health consumers with electronic care plan
- > Mental health clients seen by community mental health services seven days prior to hospital admission
- > Mental health clients seen by community mental health services within seven days of discharge from hospital
- > Waiting time for community mental health clients
- > *GP Plus* health checks for Aboriginal clients.⁶

A fundamental problem for the health system remains the increasing demand for hospital services. The community expects these services to be provided and this constrains the ability to invest in alternatives that might ultimately reduce demand. SA Health reported that total public hospital separations (metropolitan and country hospital) increased by 2.27% in 2009-10, which is just over the statewide target of holding growth to 2%. This can be compared to an average annual increase of 3.5% for the previous three years.

These problems are not unique to South Australia. The final report of the National Health and Hospitals Commission commented on the need for substantial investment in, and expansion of sub-acute services, the 'missing link' in care. In the absence of such services, there is a tendency for people to continue to be treated in the acute hospital system.

The aims of *GP Plus* are to contribute to the development of comprehensive chronic disease management and improved systems of care at the primary health care level and its interface with the acute health sector.⁶ It is anticipated that through better management of people with chronic disease, pressure will be taken off the hospital sector, notably through a visible impact on hospital admissions, length of stay, and ED and outpatient attendances.

GP Plus funding effectively commenced in 2007-08 with \$14.7 million and has been increasing each year. The funding is directed in a number of key areas to achieve the above objectives as follows:

- > Approximately 50% of funding is provided for:
 - Early discharge support packages
 - Admission avoidance packages
 - Care management of complex patients who have a history of frequent admissions and ED attendances.
- > Approximately 35% of funding is provided to clinical specialists within the health system to divert care to the community based programs. This includes the provision of additional services in EDs to improve management and divert care to the community (for example, drug and alcohol workers, and allied health staff in EDs).⁶

SA Health has undertaken some preliminary analysis of the effectiveness of the *GP Plus* Strategy and has indicated that a review of inpatient and ED activity since 2005-06 provided an overview of trends in growth prior to, and following, commencement of the expansion of *GP Plus* services.⁶ In line with the SAHCP this activity is presented as separations and presentations so that all ED activity, acute and sub-acute, is represented (see Table 2.2.1).¹²

Table 2.2.1 Emergency Department Presentations and Inpatient Separations in Metropolitan Public Hospitals

Financial Year	ED Presentations	Annual % growth ED	Separations	Annual % growth separations
2005-06	335,539		259,652	
2006-07	355,295	5.89%	271,719	4.69%
2007-08	364,553	2.61%	280,659	3.29%
2008-09	357,418	-1.96%	286,629	2.13%
2009-10 projection*	373,700	4.56%	291,785	1.86%

Note: ED growth 2007-08 to 2009-10 is 2.5%

Note: chemo/scopes excluded from all separations

The data indicates inpatient activity is showing a clear reduction trend in the level of growth recorded, as expenditure in *GP Plus* services has increased, while activity in EDs is more variable.⁶

While the total quantum of services provided under *GP Plus* is not available at this time, a list and description of the various programs funded under the strategy each year was made available to the HPC.⁶ The HPC notes there are approximately 60 initiatives funded through the overall strategy including a number of pre-existing programs. They include Hospital Avoidance Packages and the Chronic Disease Community Program (which had previously demonstrated that the rate of hospital admissions for selected conditions in the 12 months after enrolment in the program were reduced by nearly 50% compared with the previous 12 months). Information provided to the HPC during the review did not enable a full appreciation of how each of the 60 or so initiatives contributed to the overall aims of the strategy. Further evaluation of specific strategies could inform future investment decisions.

SA Health reported to the HPC that the inclusion of an after-hours GP consulting service at the Aldinga *GP Plus* health care centre had resulted in a significant impact on triage categories 4 and 5 presentations at Noarlunga Hospital's ED.⁶ The data indicated that in 2009-10 triage category 4 presentations were 13% (4693) less than in 2006-07, and triage category 5 presentations were 88% (1803) less for the same comparative period.

SA Health indicated that management of ED activity within metropolitan hospitals remains a challenge. There is an expectation that the *GP Plus* health care centres at Elizabeth and Marion, and the GP super clinic at Modbury will affect the EDs of the general hospitals within their vicinity, once they become operational.⁶

In addition, SA Health is introducing a new program in 2010-11 aimed at reducing the use of EDs for residents of aged care facilities. This is expected to impact on approximately 16 000 calls received by SA Ambulance from aged care facilities that result in a visit to hospital (this equates to an average of 40 transfers from aged care facilities to metropolitan EDs daily). The program will target specific aged care facilities depending on their use of '000', which will be monitored monthly throughout the implementation.

The HPC sought data to assess the overall impact of *GP Plus* on the hospital system by requesting:

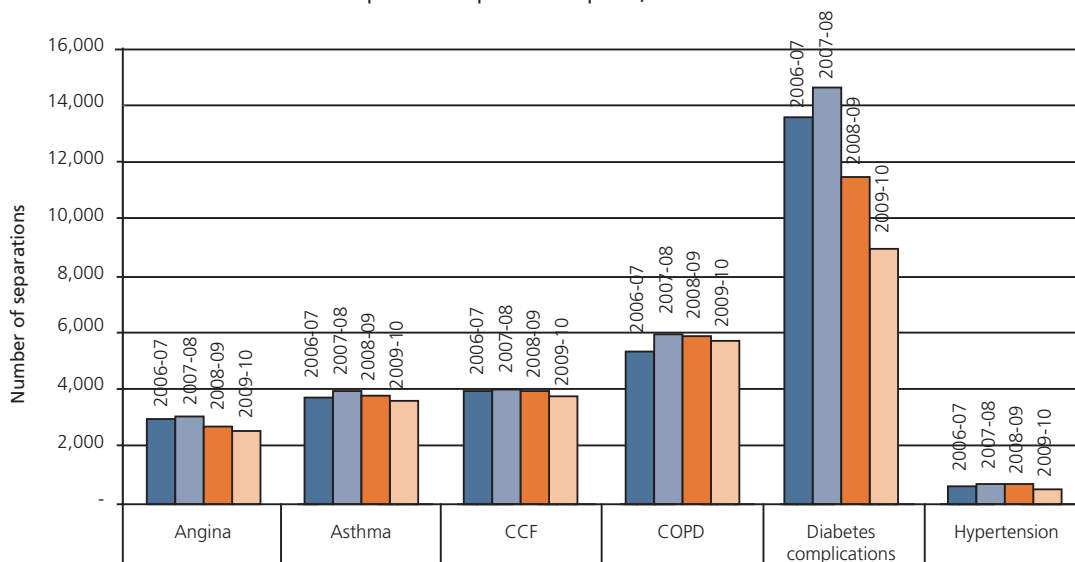
- > Avoided hospital activity (estimates), actual activity and projected activity (admissions, ED and outpatient) for the past three years and cost estimates of any savings
- > The number of potentially preventable admissions for selected chronic conditions for the past three years.⁶

Although such data and analysis is at a preliminary stage, the HPC understands the findings are encouraging, and supports further work to more clearly identify the benefits of strategic interventions aimed at reducing hospital activity.

Potentially preventable admissions relate to specific conditions that have been identified as being sensitive to primary health care. Given the nature and focus of *GP Plus* it could be reasonably expected that the impact of this strategy will be reflected in age and sex standardised population rates for these conditions over time (see Chart 2.2.23).⁶

The data provided by SA Health is raw public and private hospital utilisation data and therefore does not reflect changes in the underlying demographics of the population. However, given underlying population growth and ageing, the signs of a downward trend in the data provided can be viewed with some degree of confidence.

Chart 2.2.23 Potentially preventable hospitalisations for selected chronic conditions, public and private hospitals, 2006-07 to 2009-10

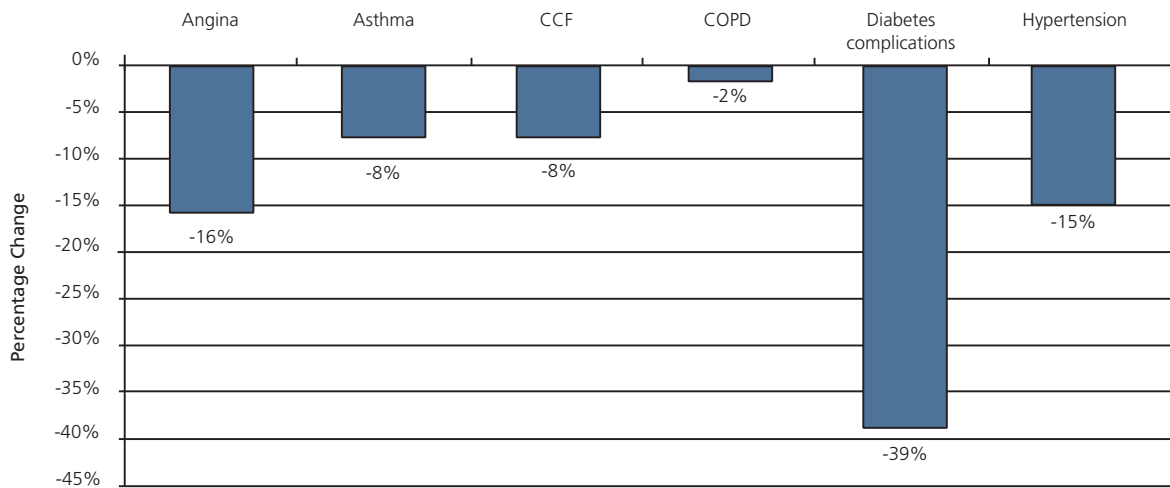


Notes: Admission data is a raw count of separations from the Integrated South Australian Activity Collection (ISAAC). The data is not age or sex standardised and the 2009-10 figure is based on simple full year extrapolation of January 2009-10 year to date figure.

Source: SA Health, Integrated South Australian Activity Collection

It is noted that over the two years from 2007-08 the level of admissions fell across the selected chronic conditions: angina (16%), asthma (8%), congestive cardiac failure (8%), chronic obstructive pulmonary disease (2%), complications of diabetes (39%), and hypertension (15%). (See Chart 2.2.24).

Chart 2.2.24 Change in potentially preventable hospitalisations for selected chronic conditions, public and private hospitals 2007-08 to 2009-10



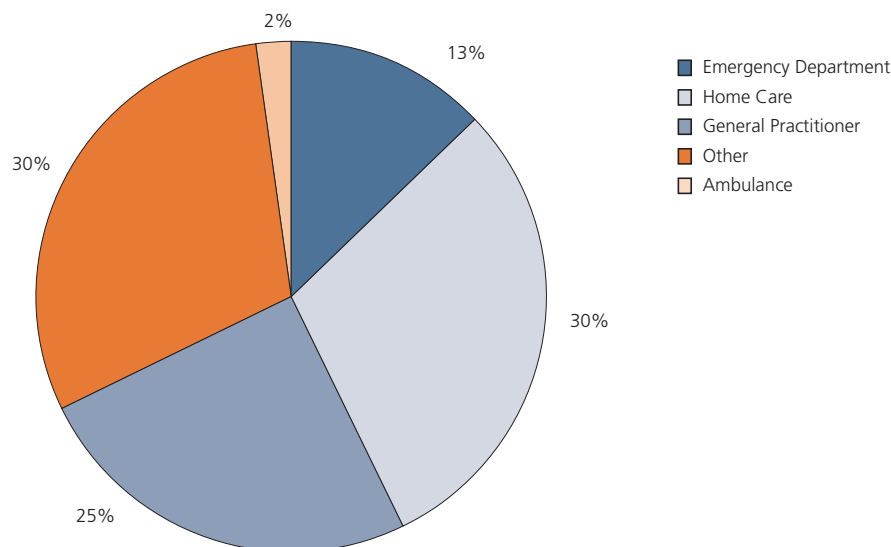
Source: SA Health, Integrated South Australian Activity Collection

Further, consideration of the validity of this data (particularly the 2009-10 data extrapolation) is warranted before a firm conclusion can be made, however there are some positive signs that the level of hospital utilisation for conditions targeted by *GP Plus* has been steadily decreasing.⁶

The National Health Call Centre (NHCC) provides help and advice on health issues. The HPC understands that there is no noticeable increase or decrease in ED attendances that can be directly attributed to the call centre in South Australia. However, it was noted that the major objective of the NHCC, in relation to ED attendances, is for more appropriate attendances through the telephone triaging process and there is some evidence of that being the case.

Quarterly surveys of callers to the service consistently show that, of the people that had the original intent to present at ED's, approximately half received advice for alternate care. Callers to the NHCC receive advice about services and only 11-13% received advice to attend an ED (see Chart 2.2.25).

Chart 2.2.25 Advice to callers by major service category, National Health Call Centre, South Australia



Source: National Call Centre, South Australia (unpublished estimates)

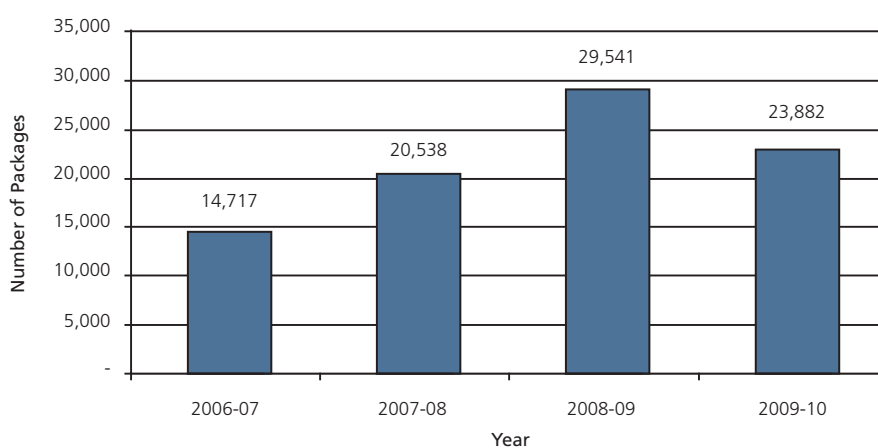
Considerable effort will be required to develop indicators which measure success across the system rather than in its individual components.

The intent for hospitals to focus more effectively on the core business of acute care is clearly evidenced. SA Health has clearly focused on moving funding from hospital activity to activities likely to have a positive impact on reducing hospital activity, for example, hospital avoidance programs and the *GP Plus* initiative.⁶

The program known as Metro Home Link appears to have been a significant success in allowing people to return home earlier with a package of support services including clinical monitoring, nursing and physiotherapy, overnight care workers, respite, domestic and personal care assistance and support to attend medical appointments.

The number of packages of community care provided to reduce hospital admission and length of stay in hospital increased two-fold from about 15 000 packages in 2006-07 to nearly 30 000 packages in 2008-09 (see Chart 2.2.26).

Chart 2.2.26 Number of hospital avoidance packages 2006-07 to 2009-10

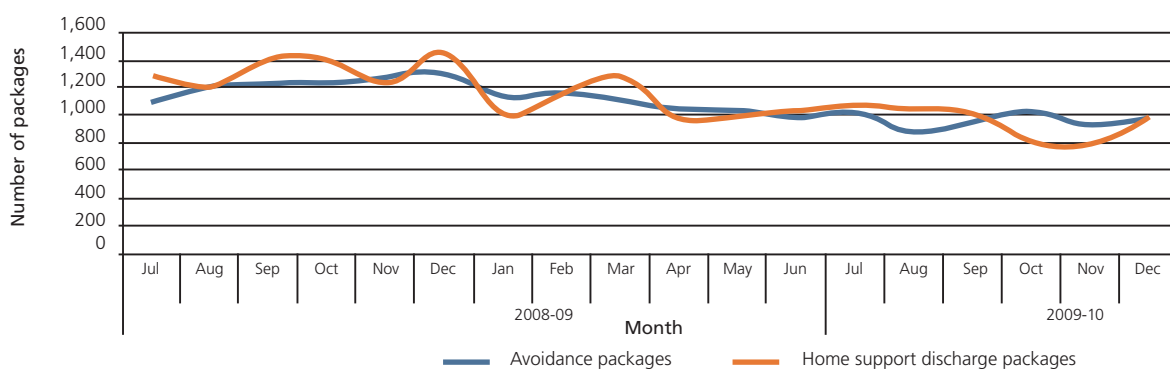


Note: 2009-10 annual figure based on a simple extrapolation of 2009-10 January year to date data.

Source: SA Health

However, as noted earlier, indications of a recent downturn in the number of packages is a matter of some concern and requires careful analysis (see Chart 2.2.27).

Chart 2.2.27 Metro - Number of hospital avoidance packages (core & plus)



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

In the development of Statewide Clinical Networks, the concept of working across the full spectrum of hospital and community based services is noted. As indicated earlier, a good example is the Orthopaedic Network focus on falls prevention rather than just joint replacements.

The HPC notes that much of the information collected and used by SA Health appears to be traditional monitoring of activity and inputs rather than outputs and outcomes. The HPC was not presented with baseline or trend reports on most of the indicators mentioned, making it difficult to determine whether service improvement had occurred. Considerable effort will be required to develop indicators that do allow SA Health to understand and demonstrate its progress in improving hospital efficiency and effectiveness, and will also measure success across the system rather than in its individual components.

Provide an attractive learning environment for health professionals (Objective 2.5)

Key Findings

14. There is evidence that alignment of workforce development with health care reforms has commenced with the introduction of new roles (for example, nurse practitioner, allied health assistant and physician assistant) now underway.

SA Health provided an extensive list of education and training that is funded and coordinated by the Department of Health, which provides training and development opportunities in a wide range of topics covering professional development, day-to-day management and teamwork, clinical practice improvement and patient care.

The HPC noted that SA Health has commenced evaluation of the effectiveness of its nurse practitioner, allied health assistant and physician assistant programs.

SA Health also indicated that in order to meet the challenges of the future and deliver sustainable, quality health care, it has created the Health LEADS leadership program to ensure current and future leaders share, enact and embody a common set of leadership qualities, competencies and behaviours. This program is customised to meet the specific needs of clinical and non-clinical employees.

15. While significant improvements in professional development opportunities for hospital medical staff are noted, indications of providing similar opportunities to nursing and allied health staff are less apparent.

SA Health provides medical staff with training at the Intern, pre-vocational and specialist level. Pre-vocational training includes basic/early training for several college programs, general training and pre-set surgical training. Specialist training is provided in more than 35 specialist areas.

16. The development of a new medical research facility should further strengthen overall research in South Australia.

It needs to be recognised that clinical research is an integral component of the total research effort. Much, if not all, of this research is undertaken in hospitals and other health facilities rather than in major research facilities. Moves to streamline hospital services in response to ongoing demand pressures need to be assessed in terms of the constraints placed on teaching and research.

Discussion

SA Health stated in its strategic plan that the *'health workforce is its most valuable asset and commits to attracting and retaining the best-qualified and skilled staff'*. It also recognises the importance of *'aligning workforce reform agenda to identify new approaches that further develop a competent, flexible, sustainable and responsive workforce'*. This is in a context where the shortage of health professionals is worldwide.

SA Health regions fund and provide a range of education and training opportunities for students and health professionals. This includes mandatory training, for example, occupational health and safety, leadership and management, orientation and induction, as well as support for transition to new roles. This also includes training for new graduate nurses, midwives, doctors and mental health workers, and takes the form of specialised programs and preceptorships. Emergency care training is largely conducted by regions and hospitals with accredited training programs being provided at major hospitals.

The model of care service reforms, along with SA Health's commitment to COAG initiatives, is driving workforce reforms. To support this reform, the Organisational Change and Workforce Reform Committee (OCWRC) was established and is responsible for *'...systemic workforce reform, leadership and advice in the context of SA Health's Patient Centred Model of Care'*. (The department Annual Report 2008-09).^{34, 35}

Seven Workforce Reform Groups act as profession-based subcommittees to the OCWRC (that is, Aboriginal, Mental Health, Medical and Dental, Corporate, Health Support, Nursing and Midwifery, Allied Health, Scientific and Complementary). Each group has developed an action plan outlining key strategic responsibilities. It is not clear how these plans influence the availability of education and training opportunities.

The HPC was advised that all health regions deliver mandated Aboriginal cultural awareness training for staff. Cultural awareness training is also provided for a number of specific groups including international medical graduates commencing practice in Country Health SA, especially those working in areas with significant Aboriginal populations. The Clinical Director Emergency Medicine, who commenced work for Country Health SA in 2009, also provides leadership in ensuring workforce competence.

In addition, the Port Augusta Centre for Excellence in Aboriginal and Torres Strait Islander Health is currently in the development phase with plans to inform development planning for the Aboriginal workforce and for the broader workforce. It is intended that opportunities for joint training programs between Aboriginal Community Controlled Health Services (ACCHS) and mainstream health services within Country Health SA will also be explored in partnership with the Centre for Excellence and other stakeholders.

SA Health has indicated that enterprise bargaining agreements for hospital staff provide for substantial improvement in professional development allowances. SA Health indicated this has resulted in a number of improvements including:

- > Allied and Scientific Health professionals having an opportunity to participate in the Online Continuing Professional Development Program
- > SA Health's work with the Australian Nursing and Midwifery Federation on the Capability Development Framework for nursing and midwifery. The framework will identify the capabilities required by the nursing and midwifery workforce to enable gaps in capability to be addressed by education and training
- > An increasing number of nursing and allied health professionals participating in the Health LEADs program.

There is a wide spectrum of training programs. The HPC review process did not include analysis of all workforce professional development activity within SA Health. The HPC will assess improvements in more detail in future reports. Areas of interest will include:

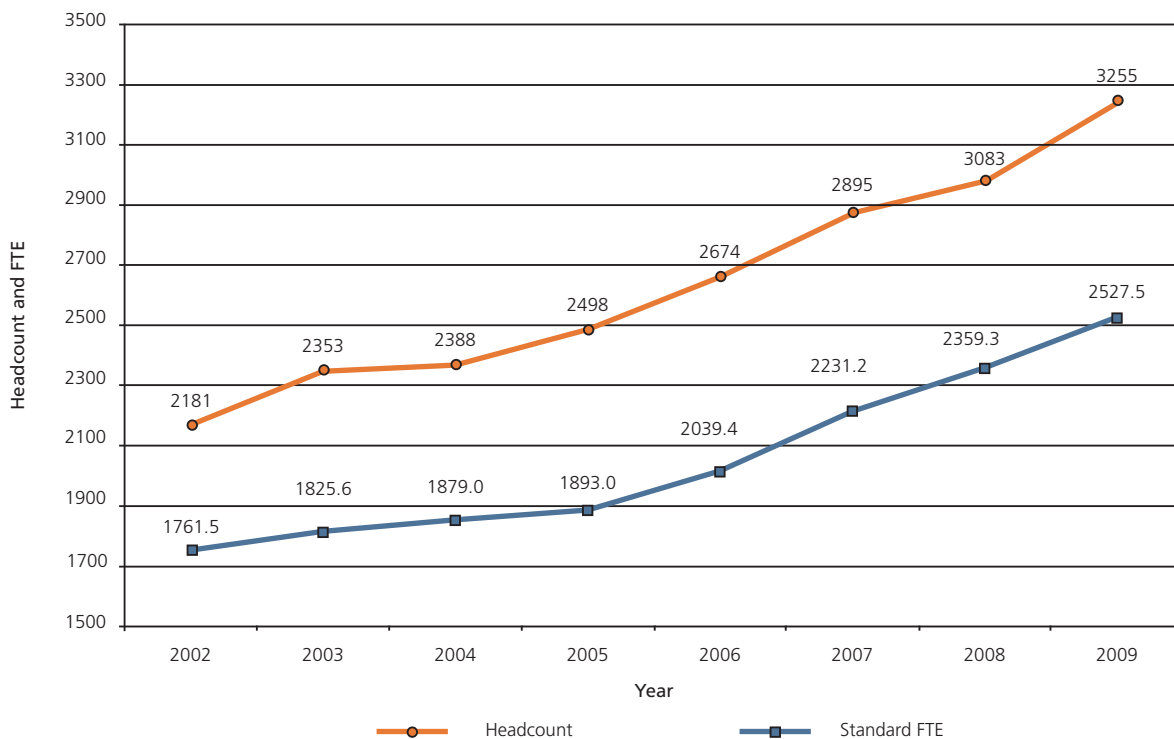
- > Specialist training, in particular paediatrics (medicine, surgery, anaesthesia or psychiatry)
- > Specific measures introduced in all health disciplines to increase teaching capacity in metropolitan public and country hospitals
- > Steps taken to quarantine the time for teaching in public hospitals (both for teachers and students)
- > Work undertaken with SA universities to increase the number of nurses and allied health workers training in SA.

SA Health indicated that questions about the learning environment were included in a CNAHS staff survey in 2006 and 2008 and again in the patient safety survey (2008), and that the SA Institute of Medical Education and Training has an accreditation framework that assesses learning/teaching, and physical and human resources for trainee medical officers.³⁶ Recommendations arising from the 2008 patient safety survey highlight a need to focus workforce development improvements on improving safety and quality, leadership and teamwork skills.^{29, 30}

Some stakeholders indicated that there was well developed training in some areas. However, other stakeholders held the view that SA Health's culture did not actively encourage innovation and that education tended to be predominately mandatory training.

In relation to workforce attraction and recruitment the HPC notes the achievement in relation to recruitment of medical staff and further notes that this has occurred in a tight market. SA Health reported that, as at June 2009 there were 3255 doctors (2528 full-time equivalents [FTE]) engaged in the South Australian public sector. This represents an increase of 5.6% or 172 doctors (168 FTE) since 2008 and an increase of 1074 doctors (766 FTE) since 2002 (see Chart 2.2.28).

Chart 2.2.28 Number of doctors (and FTE) in the SA public health system, June 2002 to June 2009



Notes:

1. Historical information adjusted to include Modbury Hospital. Transferred to SA Health July 2007.
2. Estimated Modbury based on MMSS FTE information converted to CHRIS estimates. Headcount calculated on headcount/FTE ratio for June 2008 applied to historical FTE information.
3. FTE based on standard FTE definition, for all pay summaries containing last pay period(s) of June.
4. Includes all Salaried Medical Officers and Visiting Medical Specialists. Excludes Clinical Academics.
5. Headcount does not denote individuals but actual employees in a role at a specific site, regardless of their full-time or part-time status.

Sourced: Department of Health, HR Data Warehouse. Excludes the Department of Health and SA Ambulance Service.

SA Health Strategic Direction: Reform Mental Health Care

Mental illness is one of the most prevalent problems in Australia today and significantly affects the social and emotional wellbeing of the community. SA Health is committed to reforms to the mental health system and will work with consumers, carers and service deliverers to improve early access to a more integrated set of specialist and support services. Our focus will be on prevention and recovery in the community. We will work with other agencies to improve life outcomes for people with mental illness. A key focus will be to increase community awareness of mental health and remove stigma around, and discrimination toward, people with a mental illness... SAHSP p.10

1. What did SA Health commit to do?

a. Strategic Position

The South Australian Social Inclusion Board Report *'Stepping Up': A Social Inclusion Action Plan for Mental Health Reform 2007-2012*, proposed a detailed five-year action plan to reform the mental health system in South Australia.³⁷ The aim of this plan is to deliver increased wellbeing for South Australians.

The *SA Health Strategic Plan 2008-2010 (SAHSP)* presents a strong commitment to reforming mental health care in South Australia recognising that there are fundamental structural and system changes required in order to provide better targeted services, increase the focus on prevention and to foster and encourage community awareness and social inclusion for people who suffer from mental illness.³

SA Health is not simply committed to improving services; it is also focusing on making fundamental changes in the approach and understanding of mental health in the social and community context. While SA Health cannot be held directly accountable for how society generally behaves towards people with mental illness, the new approach means SA Health is prepared to assume responsibility for influencing the way South Australians view people with mental health illness, as well as ensuring that programs and services incorporate the values and practices of social inclusion.

These principles were set out in the reform and developments outlined in *Stepping Up* and the *Review of Community Health Services in South Australia, 2008*, that form the basis of the recently published *South Australia's Mental Health and Wellbeing Policy 2010-2015* (SA MHWP) in which SA Health stated:

Our vision is for South Australia to be a strong, inclusive community that provides all South Australians with the knowledge, resources and opportunities necessary to maintain good mental health and wellbeing and for a mental health care system that supports people with a mental illness towards recovery by providing access to the best possible mental health care (South Australia's Mental Health and Wellbeing Policy 2010-2015, p.3).

In addition, SA Health stated that it *'has made considerable progress in implementing the mental health reform agenda'*. SA Health also has an overarching plan based on the *Stepping Up* report and is engaged in a capital infrastructure development program that will support the rollout of this new approach.^{37, 38, 39}

b. Key Objectives and Performance Measures

The key objectives presented in SAHSP point to the following major areas of system reform and improvement of outcomes in mental health:

- > Provide integrated services to mental health clients in community, residential and hospital settings (Objective 3.1)
- > Improve access to appropriate care at an early stage (Objective 3.2)
- > Improve mental health services through better systems of care (Objective 3.3)
- > Improve inter-agency coordination of service delivery to people with a mental illness who have high needs (Objective 3.4)
- > Increase community understanding of mental health (Objective 3.5).

(SAHSP p.10)

SAHSP indicates the system performance measures for reforming mental health care include:

- > Proportion of South Australian population aged 18 years or over, who have high or very high levels of psychological distress (Kessler Scale)
- > Percentage of people who report high or very high psychological distress receiving mental health services
- > Number of unplanned mental health readmissions within 28 days
- > Rates of community follow-up for people within the first seven days of discharge from hospital
- > Percentage reduction in ED presentation by people with mental health conditions
- > Percentage of South Australians aware of signs and symptoms of depression and anxiety
- > Number of South Australians seeking health professional help who are at risk or are already experiencing mental health problems
- > Level of research funding to inform actions on psychological distress in population sub-groups
- > Percentage of South Australians diagnosed with a serious mental illness showing improved physical health outcomes
- > Percentage of eligible mental health clients with improved outcomes (measured by Health of the Nation Outcome Scale's scores)
- > Number of active mental health clients with a mental health care plan.

(SAHSP p.10)

2. How did SA Health Perform?

In considering performance, the HPC made an assessment against data/information provided by SA Health and particular stakeholders.

SA MHWP has recently been published and the HPC thinks this should form a strong basis for future developments to achieve objectives in this area.³⁹

In the following section, the HPC discusses the specific findings for each key objective. In doing so, the HPC is mindful that SA Health is three years into a five-year plan to implement the major principles of Stepping Up and recognises that in some cases it is too early to assess progress.³⁷

Provide integrated services to mental health clients in community, residential and hospital settings (Objective 3.1)

Key Findings

17. New models of care were developed in line with *Stepping Up* recommendations. Plans to establish community mental health centres as hubs for mental health integration are progressing with the aim of improving access to appropriate care.

SA Health is well placed to make changes that reflect the *Stepping Up* recommendations.³⁷ The HPC believes the development of the new models of care demonstrate SA Health's commitment to improving access for mental health clients in a range of different settings.

There appears to be a strong emphasis on capital infrastructure developments to support the integration of services. How successful these are in encouraging integration across the various health sectors depends on the rollout of the new models of care.

Based on the information provided to the HPC it is apparent that plans and strategies for SA Health's mental health objectives are in place and the system wide implementation of these plans is at an early stage. There is not yet a sense of a system wide approach.

18. It is unclear how SA Health plans to measure and evaluate the system wide access improvements and delivery of recovery outcomes achieved because of implementing integration strategies.

It is not clear how existing KPIs assess the quality of service integration or how monitoring results is used to improve services. SA Health has foreshadowed the development of a system of performance measurement and evaluation and this will be incorporated into the overall performance assessment activities of the HPC over the next four years.

The HPC considers the following system characteristics to be important:

- > The emergence of a people centred system that is recovery focused and provides innovative ways of ensuring consumers, along with their carers and families are included in the care planning process and are provided with timely and appropriate information and support.
- > People in country regions with an identified mental illness have access to a local community based specialist mental health response.
- > Improvements in health status for those population groups considered most at risk, for example, people with high and complex needs, and Aboriginal people.

Discussion

To assess the extent to which SA Health has included the *Stepping Up* recommendations in the implementation of this objective, the HPC requested information that outlines what SA Health is doing to provide integrated services for all mental health clients.³⁷

A range of plans and actions was drawn to the HPC's attention by SA Health to demonstrate reforms to the mental health system. SA Health reported the passing of the *Mental Health Act 2009*, and the release of the SA MHWP, ensure a framework is in place to address the *Stepping Up* Report recommendations.^{37, 39, 40}

SA Health defined 'integrated services' as '*a network of specialised mental health service components within the general health system, coordinated across inpatient and community settings, to ensure continuity of care for consumers*'. The network can be coordinated through area/regional management and uses a case management system across service components.

SA Health indicated a key reform priority has been the development of a stepped system of care, which will provide for services to be organised as a range of steps from least intensive to the most intensive.

The stepped system of care comprises:

- > Secure care
- > Acute care
- > Intermediate care
- > Community (recovery)
- > Supported accommodation.

The implementation of the stepped system of care is expected to establish clearly defined care pathways, linking the community mental health system with primary health care and other community services ensuring consumers and their families receive clear information about available care options (SA MHWP p.9).³⁹

SA Health provided the HPC with many examples of system improvement strategies currently in place to ensure service integration across community, residential and hospital settings. The HPC noted the new models of care and associated new facilities are key elements for achieving this and other mental health objectives. The new models address access as a critical factor in determining the adequacy of system response from a consumer or carer perspective. The focus has been on defining the limits of regional variations to ensure a consistent level of service provision.

SA Health indicated that community mental health services had been provided across 20 sites in a fragmented way and in poor facilities. Mental health reforms recommend the establishment of community mental health centres to become hubs for mental health care service integration. To support the implementation of the new models of care, there are plans to develop:

- > Six Community Mental Health Centres (to be progressively implemented between 2010 and 2013 and located near *GP Plus* centres)
- > Four Intermediate Care Centres (to be completed between 2010 and 2014) to provide an additional 60 metropolitan beds by 2014
- > Thirty Intermediate Care places across country SA (18 of which are to be completed in 2010-11 and the remaining 12 by June 2013)
- > Fifty-three supported accommodation dwellings in metropolitan Adelaide (to be available in June 2011).⁶

In addition, SA Health has been proactive in negotiations to tailor national investments to enhance and extend the reforms outlined in the *Stepping Up* report.³⁷ One example is the Australian Government Economic Stimulus spending on social housing where SA Health has negotiated to provide a targeted support program. The result will be an extension of the Housing and Support Program (HASP), which will ensure that people with mental illness will be able to access over 250 units of the Australian Government funded social housing.

Other initiatives include new services and contractual arrangements around the review of non-government organisation (NGO) community-based psychological services (introduced in April 2009) including the establishment of new mental health standards of care for NGO delivered services.

In addition, the transition of long-term aged care residents from Glenside to the aged care residential sector has commenced, with 34 completed and 127 to be completed by 2011. It is expected that the aged care sector will develop Behavioural Management Units and Transitional Care Units by 2013.

The HPC noted that none of the new 24-hour supported accommodation places (announced by the SA Government in response to the *Stepping Up* report) would be located outside the metropolitan area. However, 68 HASP units of social housing from the 262 provided from the Australian Government Economic Stimulus Plan will be located in country areas.³⁷

Aside from the implementation of the new models of care, the HPC noted a number of information system improvements including plans to:

- > Use the Client Activity Reporting System Database (used by NGOs) to monitor consumer outcomes
- > Use the National Outcomes and Casemix Collection data to establish a basis for the evaluation of service types and service integration and to some extent, to measure consumer outcomes
- > Develop an Enterprise wide Master Patient Index with the expectation of improving the mental health system's capacity to monitor consumer outcomes in an integrated way across community, residential and hospital settings.

In addition to the information collected from SA Health, the HPC sought feedback from informed stakeholders on the system's performance in relation to providing integrated services to mental health clients in community, residential and hospital settings.

The majority of stakeholders consulted indicated their support for the extent of SA Health's reform process and the system's commitment to improving integration across the sectors. These stakeholders expressed views that SA Health's focus to this point has been on developing the capital infrastructure and that the expected impact these reforms will have in terms of providing improvements to service integration across the sectors, is yet to be realised.

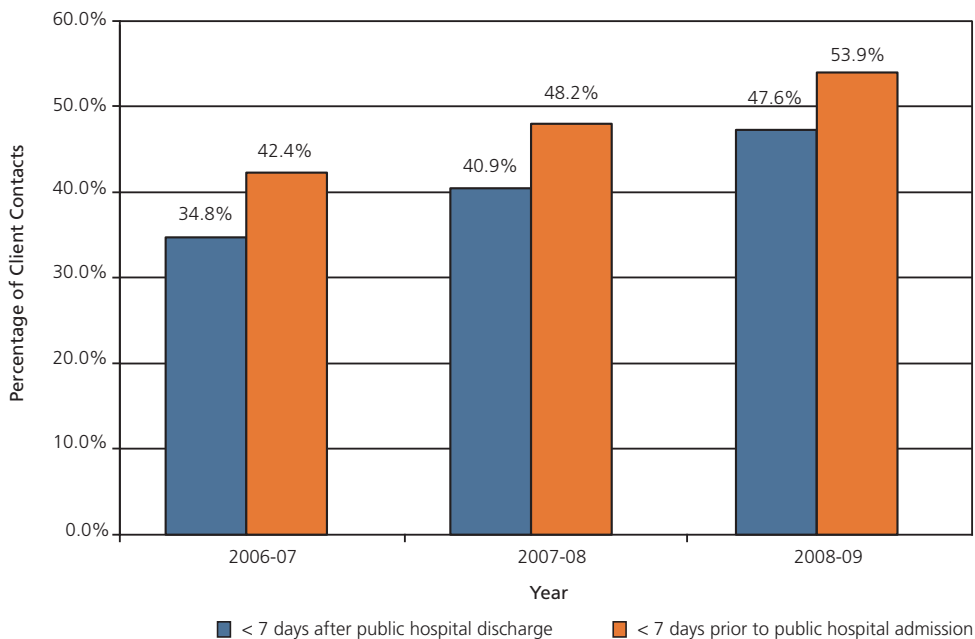
Some stakeholders raised concerns about patients in crisis not being able to access assistance and support when they most need it. These stakeholders also indicated that more integration is required to ensure improved access to appropriate care, for example, the services assisting those affected by dementia in the acute sector.

Assessing System Integration Improvements

To assess existing levels of service integration, the HPC analysed data relating to a number of SA Health's key performance indicators, with the view that it is reasonable to expect the above mentioned system integration initiatives to impact trends in mental health service usage.

The HPC analysed trends in community mental health service usage to assess whether access to community mental health services has improved. The data suggests that in metropolitan Adelaide the proportion of mental health clients that get in touch with community mental health services shortly before and after a hospital stay is increasing. This provides some indication that the integration of services and continuity of care might be improving (see Chart 2.3.1).

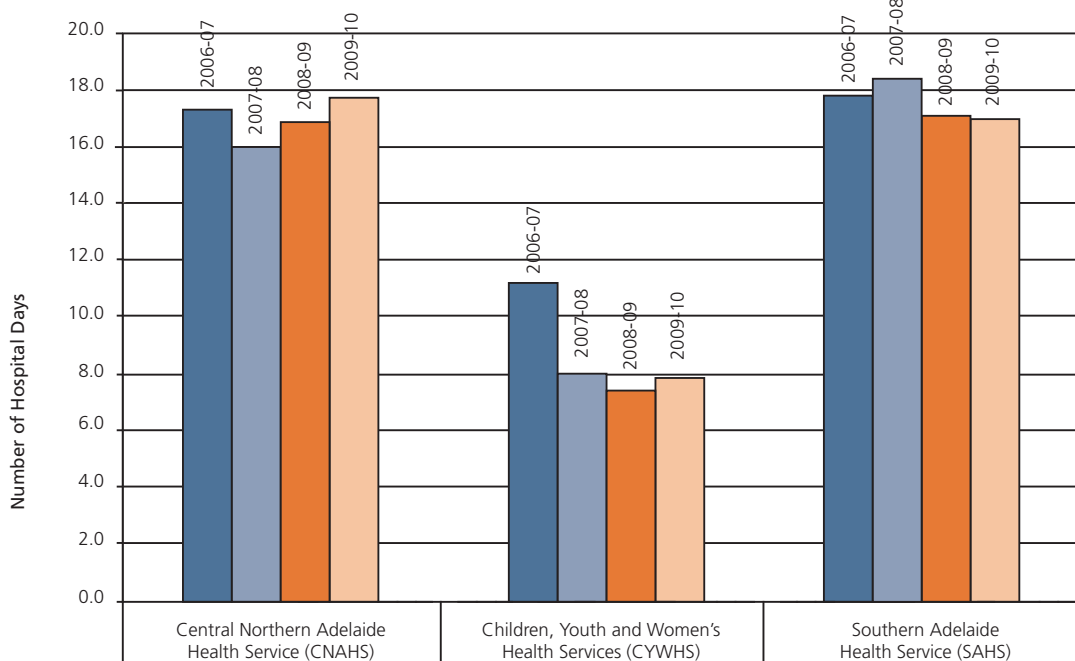
Chart 2.3.1 Metropolitan community mental health service contacts, South Australia, 2006-07 to 2008-09



Source: SA Health, Community Based information System, Child Adolescent Mental Health System

The HPC also believe a strong community based service sector should allow opportunities for earlier discharge from hospital and enable a reduction in levels of re-admission to hospital. The available data in this area indicates variable changes to length of stay across the metropolitan area (see Chart 2.3.2).

Chart 2.3.2 Mental health average length of stay, public hospitals, South Australia, 2006-07 to 2009-10 January YTD



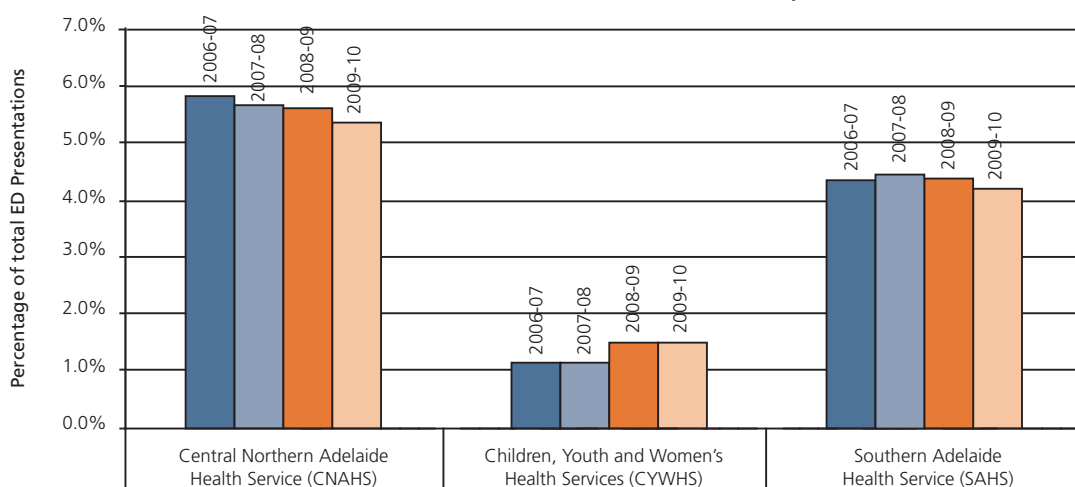
Notes: 2009-10 figure represents year to date data to January 2010.

Source: SA Health, Integrated South Australian Activity Collection

Although data limitations and changes in data definitions may contribute to this situation (for example 2007-08 re-admission data), there are no strong indications that re-admissions to hospital have decreased over the period.

The HPC also analysed SA Health's ED data with the view that it is reasonable to expect the above mentioned system integration initiatives to impact on the proportion of mental health clients presenting at EDs (see Chart 2.3.3). If SA Health's new models of care are delivering service improvements, then EDs would be the last port of call for patients requiring mental health services, and trends would indicate a reduction in numbers.

Chart 2.3.3 Mental health emergency department presentations, public hospital, South Australia, 2006-07 to 2009-10 January YTD



Notes: 2009-10 figure represents year to date data to January 2010.

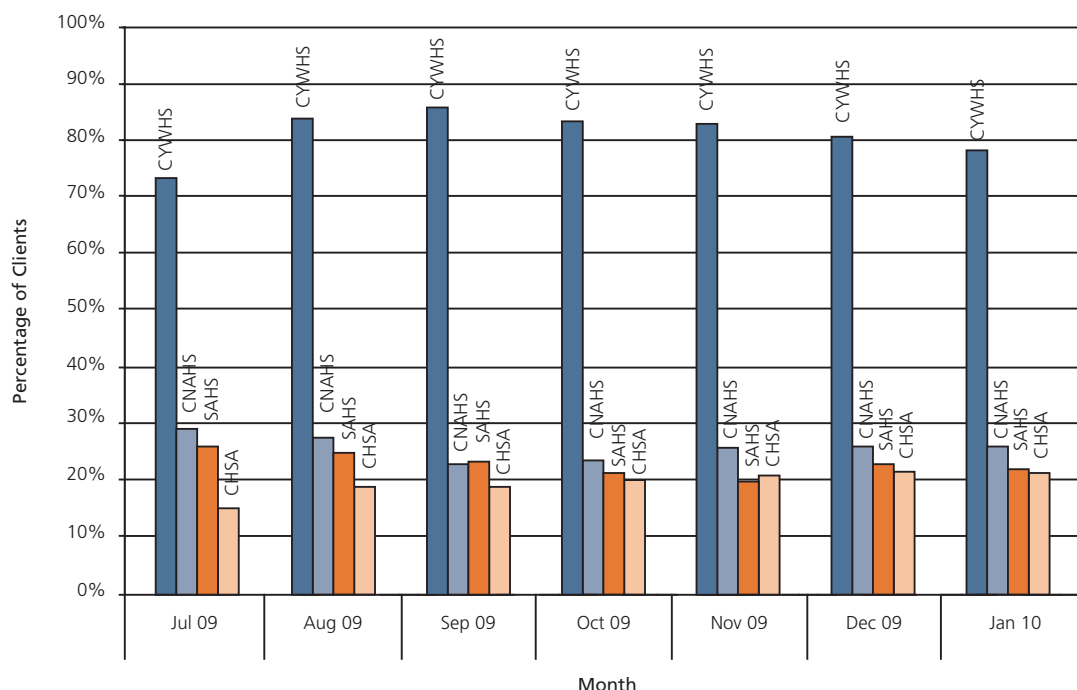
Source: SA Health, Integrated South Australian Activity Collection

The above ED data indicates that while the proportion of mental health client presentations have been falling in the former CNAHS, and to a lesser extent in the former SAHS. There are signs that the level in CYWHS is increasing.

This is consistent with stakeholder feedback as well as the data relating to waiting times to access community mental health services (see Chart 2.3.6), which shows the waiting time for child and adolescent services has increased.

To further test the level of integration achieved thus far, the HPC analysed data on the usage of electronic care plans (see Chart 2.3.4). Since it is widely asserted that the existence of an electronic care plan facilitates care planning, coordination and integration of services for a mental health client, the HPC sought data regarding the number of clients with electronic care plans.

Chart 2.3.4 Mental health clients with current electronic care plan, South Australia 2009-10 January YTD



Abbrev: CYWHS (Children, Youth and Women's Health Service), CNAHS (Central Northern Adelaide Health Service), SAHS (Southern Adelaide Health Service), CHSA (Country Health SA)
Source: SA Health, Community Based Information System, Child Adolescent Mental Health System

The data indicated a fairly stable proportion of clients with electronic care plans, approximately 20%, except for CYWHS. Electronic care plan usage remains at around 20% for adult clients and does not provide the HPC with an indication of system integration.

In response to the HPC's analysis, SA Health indicated that the introduction of electronic care plans allows for greater flexibility across the system and improves care as people can seek treatment in different locations. Electronic care plan training is required for all clinicians and it takes time for those trained to become familiar with the new system.

Improve access to appropriate care at an early stage (Objective 3.2)

Key Findings

19. The information provided by SA Health underpins the priority given to early identification and provision of services particularly in relation to young people and people in aged care. There is evidence to indicate a priority focus on improving capacity for country services to manage the broad spectrum of mental health presentations locally. These are in line with the *Stepping Up* recommendations and the focus of SAHSP.

The examples provided to the HPC demonstrate that there are some key plans developed and some relevant activities already in place.

SA Health provided a number of examples as an indication it is implementing strategies to improve capacity for country services to manage the broad spectrum of mental health presentations locally.

SA Health stated that *'under the Country Mental Health Service Model three large geographical regions will be established to provide a range of sustainable services at a local, regional and metropolitan level'*.

The HPC recognises the development and implementation of the Mental Health Strategic Plan, the system's response to the *Stepping Up* recommendations, is still in early stages.³⁷ To ensure the effectiveness of these strategies, SA Health will need to take account of the many points of view expressed through community engagement about how best to develop, implement and assess these strategies over the next four years.

Discussion

During the review, the HPC was particularly interested in how SA Health's strategies to improve access to appropriate care at an early stage enhance services available to children and adolescents, Aboriginal people, older people and people living in remote/rural communities.

SA Health defined 'appropriate care' as *'mental health care that is designed to meet the specific needs of the individual, based on established standards that are preferably provided in an environment that meets the circumstances of the client'*.

In addition, SA Health stated that the term 'early stage' applies to *'clients who display the signs and symptoms of a mental health problem or mental disorders before progressive onset of the condition'*.

In response to the HPC's review, SA Health outlined a number of system improvement initiatives.

System Improvements

The majority of initiatives mentioned focus on providing access to expert diagnosis and treatment at early stages of illness. These included:

Child and Adolescent Services

- > A proposed new Model of Care for Child and Adolescent Mental Health focusing on the introduction of a statewide early psychosis intervention service at a hub location, for the provision of clinical expertise and support to mental health practitioners across the state. This includes providing additional School Support Workers to liaise with schools and facilitate referrals, and the establishment of minimum level service expectations throughout the state. The new model of care also gives priority status to children from disadvantaged community groups.
- > Funding the Healthy Young Minds initiative that employs 26 clinicians to provide early intervention services for children and young people, to reduce the social, health and economic impact of mental illness. These clinicians provide community outreach services and work with the Department of Education and Children's Services, providing visiting services in schools.

Older People

- > A significant expansion of the Older Person's Mental Health Services over the next two years to increase the system's capacity to work with GPs in identifying people with a mental illness. Identified priorities include:
 - Increasing support to nursing home providers to ensure early intervention for nursing home residents who have a mental illness or severe behavioural and psychological symptoms of dementia
 - Working with SA Health regions to improve response time to ED presentations.

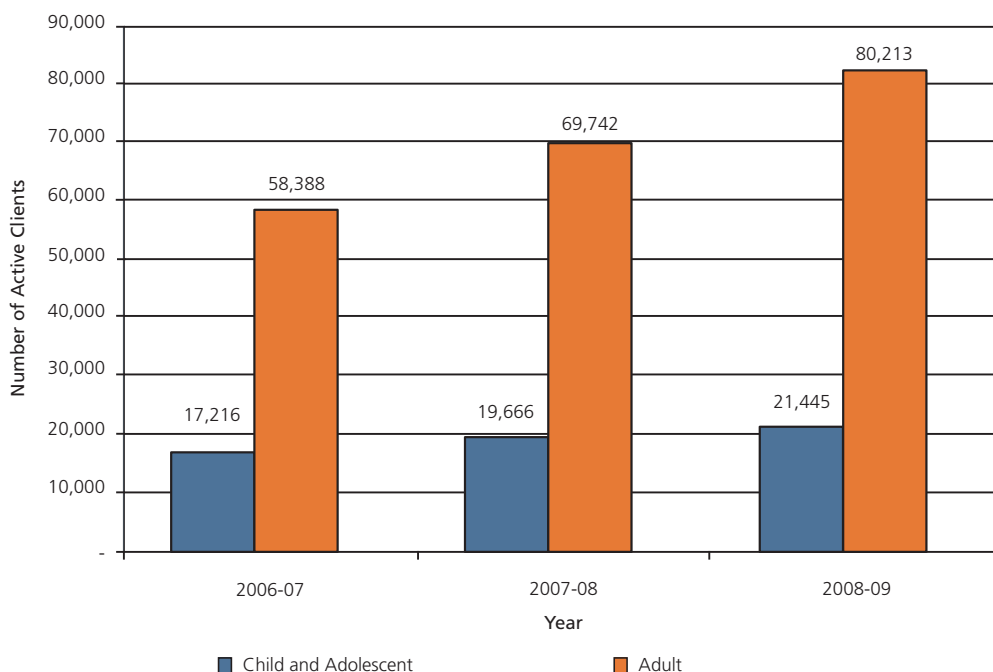
Rural and Remote Communities and Aboriginal People

- > The introduction of a new model of service delivery by Country Health SA to ensure rural and remote communities have access to appropriate care at an early stage. The establishment of an Early Psychosis Network will assist Local Mental Health Service Networks in the provision of early psychosis services using video conferencing and the consultation/liaison model. Service enhancements include expanding the scope of Nurse Practitioners to assist in early psychosis recovery, recruitment of a consultant psychiatrist with early psychosis expertise, and the development of a service agreement between CHSA and the former CNAHS to provide services to the Anangu Pitjantjatjara Yankunytjatjara (APY) Lands.
- > SA Health also reported developing a number of service variations to ensure people outside the metropolitan area are not disadvantaged. These include:
 - Analysing the data in the Consolidated Client Management Engine to identify and address emerging service needs for country clients
 - Using Mental Health Focus Groups across country mental health sites to provide feedback and explore solutions
 - Increasing the psychiatric medical workforce in country South Australia
 - Using the Rural and Remote Mental Health Emergency Triage and Liaison Service phone teleconference services to provide clinical support to country staff/GPs/consumers/carers and agencies
 - Ensuring referral pathways and liaison services are made available at the *GP Plus* centres at Ceduna and Pt Pirie to ensure the PHC network is able to identify emerging cases⁶
 - Providing emergency medical health and drug and alcohol training to staff and other agencies in Pt Augusta and Mt Gambier.
- > SA Health indicated it is prioritising the development of strategies to increase the system's capacity to respond to the needs of Aboriginal clients. SA Health reported that consultation with Aboriginal community representatives identified the low numbers of Aboriginal people employed within the service and the lack of cultural awareness as significant barriers to service access.

Assessing Access Improvements

To assess whether access to community mental health services has improved, the HPC analysed trends in community mental health service usage. The increasing number of active community mental health care clients over recent years appears to suggest that the capacity of the out of hospital mental health system is being strengthened, particularly in relation to adult services (see Chart 2.3.5).

Chart 2.3.5 Number of active community mental health clients, South Australia, 2006-07 to 2008-09



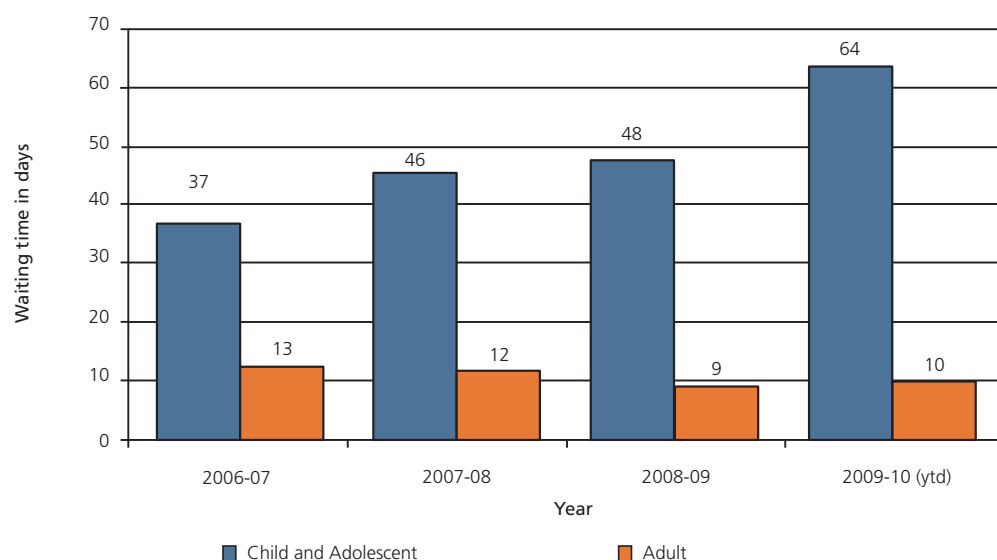
Source: SA Health, Community Based Information System, Child Adolescent Mental Health System

However, this cannot be asserted without reference to data that provides an indication of the changes in the level of need that may have arisen during this period and in particular the level of unmet need.

Performance indicator data, currently collected in relation to high or very high psychological distress, appears to suggest that although there has been an increase in the percentage of people needing mental health care and receiving mental health services, the percentage of people who were not receiving services, when the HPC conducted its analysis, remains at almost 90%.

Similarly, and although by no means a direct measure, the waiting time for mental health community services also provides some indication of the level of demand and capacity of service provision within the system (see Chart 2.3.6).

Chart 2.3.6 Median waiting time for community mental health services, South Australia, 2006-07 to 2009-10 January YTD



Source: SA Health, Community Based information System, Child Adolescent Mental Health System

Although the data indicates the waiting time for adult services has fallen over the past three years, the HPC notes the waiting time for child and adolescent services has increased. The HPC therefore questions the capacity and adequacy of services currently available for younger people in South Australia.

The capacity and adequacy of services for child and adolescent clients was further investigated using stakeholder feedback. The consultation process revealed that although access to psychologists through GPs has improved, access to psychiatrists for children and adolescents remains an ongoing issue for community groups.

In response to the HPC's and other stakeholder groups' concerns, SA Health has indicated that it is working on a number of initiatives to improve Child and Adolescent Mental Health Services (CAMHS). These include:

- > Over the past year, CAMHS has focused efforts to reduce the number of children, young people and families waiting for an ongoing service, to ensure more timely access. At the end of June 2010, the number of families waiting for an ongoing service was 120 compared to 448 in July 2009.
- > The completed rollout and subsequent full effect of the State Government's funding of Healthy Young Minds initiative from 2006-07 to 2009-10 has provided extra workers in CAMHS teams resulting in service improvements that have addressed workload and work flow. The fall in the median wait time for an ongoing service (reduced from 84 days for the first four months of the year to 41 days in the last four months of the financial year) has been attributed to this initiative. SA Health noted that improvements have primarily been achieved in the metropolitan CAMHS locations, stating that the pressures on country locations are significantly greater due to requirements for staff travel and lack of alternative agencies to support children and families.
- > The employment of a CAMHS staff member to provide APY Lands based clinical response to children and young people and families. An additional position, not yet recruited at the time of writing this report (November 2010), is expected to improve access to mental health services in the APY Lands and support other agencies that are providing services to children and young people.

Stakeholders also expressed concerns about the difficulty experienced in accessing services by some Culturally and Linguistically Diverse (CALD) communities, Aboriginal people, and in particular those living with a disability. Stakeholders questioned whether the needs of all population groups were taken into account with the introduction of telemedicine.

Improve mental health services through better systems of care (Objective 3.3)

Key Findings

20. Many activities were developed to improve systems of care and in some cases, these were implemented. However, it is difficult at this early stage to assess the impact of these initiatives. The focus thus far has been on capital infrastructure development and the HPC received no evidence to indicate access to services for consumers and carers has improved.

There is a strong emphasis on continuity of care and being able to step into the appropriate level of care at the appropriate time. However, the HPC is not clear that there are systemic means of capturing this and point to the importance of monitoring patient experiences in a model of continuity of care.

SA Health indicated that in 2008-09 KPIs were developed to enable monthly monitoring of service improvements. The HPC is particularly interested in outcome measures. Analysis of data relating to the Health of the Nation Outcome Scale's Scores (HoNOS) indicates limited improvement although a commitment to addressing this is acknowledged (SASP Target T2.7).^{4, 41}

Some stakeholders consulted by the HPC, particularly the veteran community, were critical of the provision of appropriate and timely treatment for those seeking emergency, out-of-hours assistance for mental health issues.

The HPC noted rural Aboriginal community groups are being consulted and issues are being identified, however they are not clear how it is intended that a better system of care will result to improve their health care and experiences in the health system.

Although there are plans to focus on measuring improved outcomes of care for those clients identified as being most in need, the incompatibility of data collection systems is placing severe limitations on SA Health's ability to undertake quality data analysis.

SA Health indicated it is currently seeking a vendor to implement a new Electronic Patient Administration System. This new system will provide for a single patient record for mental health clients across inpatient and community units. SA Health expects this to be an integrated system with a focus on addressing the inadequacies of the current multiple inpatient and community systems.

Discussion

SA Health reported it is simplifying mental health treatment pathways for individuals whose treatment needs involve multiple providers.

In addition to the plans and initiatives relating to integrated services and access to appropriate care at an early stage, SA Health indicated it has a range of initiatives to improve systems of care.

SA Health has recently developed an integrated electronic care plan to better manage individual patient care across various service regimes. The plan is developed between consumer, carer and mental health clinician and is updated on a regular basis. Prior to this, care plans were fragmented and comprised a mixture of system plans and paper based plans across multiple sites.

Other initiatives include establishing clear pathways and protocols for use across the system, improving coordination mechanisms to assist navigation of complex pathways, and organising services as a single system rather than separate entities.

SA Health also reported a network of specialised mental health service components within the general health system, coordinated across inpatient and community settings, which exists to ensure continuity of care for consumers from an operational viewpoint. The components encompass assessment, crisis intervention, acute care, extended care, treatment, rehabilitation, specialised residential and housing support services, and domiciliary care services. Mental Health Services and Drug and Alcohol Services SA (DASSA) works in partnership to offer services and training across the state.

SA Health indicated that the new models of care incorporate data collection and measures that provide the basis for evaluation. Examples of impact evaluations of rehabilitation and community based services currently underway include:

- > Individual Psychosocial Rehabilitation and Support Services (community based packages of care)
- > The Returning Home program of transition from extended care to community living
- > GP Shared Care
- > Day Activity and Group Rehabilitation Services
- > Carer Support and Respite Services.

Extensive monitoring processes across mental health services are incorporated into clinical and management practice and captured in a variety of client information systems. SA Health stated that *'whilst there is a strong focus on outcomes of care and the client journey, the incompatibility of databases limits the provision of effective continuity of care from a monitoring perspective'*.

SA Health indicated that as part of the process of implementing new mental health reform initiatives it would undertake the following:

- > Independent evaluations of all new services
- > Monthly monitoring of KPIs, some relating to access
- > Implementing the new KPIs in the Fourth National Mental Health Plan released in 2009⁴²
- > Collating consumer satisfaction and mental health improvement outcomes from the new services introduced
- > Measuring consumer physical outcomes as often people with mental illness have other co-morbidities
- > Establishing consumer and carer focus groups to advise on service development and outcomes and contract the Health Consumers Alliance and Carers SA to assist with service evaluation.

Furthermore, the HPC noted SA Health has embarked on the evaluation of a number of services. These include:

- > The Shared Care with General Practitioners' Program – an agreement between SA Health and General Practice SA for the provision of 30 clinicians to work with GPs in their clinics to provide clinical services to people with a mental illness. The main objectives of the program are to:
 - Enhance the health and mental health outcomes of people with significant mental health disorders who are living in the community
 - Increase the number of people with significant mental health disorders who receive services
 - Increase the capacity of GPs to manage people with significant mental health disorders in the community
 - Improve communication, collaboration and referral pathways between general practice, government and non-government mental health services and other relevant services to provide an integrated system of care.

Data provided to SA Health by the Divisions of General Practice indicate that 39 273 episodes of service were provided to 6362 individuals over the three years of the Shared Care Contract (which has since been renewed). SA Health indicated to the HPC that an independent evaluation of the program reported that an unmet need has been partially addressed through the establishment of the program.

- > Community Recovery Centres – the evaluation of the three new 20-bed centres that provide rehabilitation services to consumers in the metropolitan area is due in December 2010.
- > Individual Psychosocial Rehabilitation Support Services – a program that provides funds to NGOs to provide psychosocial services to mental health consumers in the community. SA Health indicated some 550 consumers currently receive these services.
- > Returning Home – the transition to the community of over 60 former long stay patients at Glenside where NGOs will deliver packages of care to these consumers at their residential address. An independent evaluation will include the views of consumers regarding services received and will be completed in early 2011.

Assessing Improvements to the Systems of Care

To assess whether SA Health's better systems of care have improved mental health services the HPC consulted with a number of informed stakeholders and reviewed data provided by SA Health.

A number of stakeholders indicated gaps in the provision of support for carers in rural communities, including respite care, and 24/7 supported accommodation. In relation to continuity of care, these stakeholders also indicated that the health care system was not as responsive to the needs and cultures of Aboriginal people and people from a CALD background. Consequently, the resulting workforce issues that arise in trying to cater to these specific population groups also require consideration.

SA Health has indicated that it is seeking to improve mental health services for Aboriginal people and recently completed a report on its statewide consultation process with Aboriginal people to improve services and access. A detailed action plan has been completed for the 13 recommendations in the report and many actions will be completed by mid 2011. The HPC acknowledges the work to-date and looks forward to assessing achievements that result from the implementation of the action plan.

Furthermore, SA Health reports that a detailed action plan was developed to implement the findings of the Community Mental Health Services Review and progress has been made in a number of areas. These include the development of a new model of care, a new organisational structure, defining six catchment areas for local populations and development of new business rules regarding the clinical operation of community mental health services.

Data provided by SA Health on the percentage of eligible mental health episodes with outcome measures (using the relevant HoNOS) was 70-73% for 2009-10 in the metropolitan area and approximately 55% for country regions. The completion of HoNOS is a key measure, and the variance between metropolitan and country services indicates an ongoing gap in coordination and continuity of care. This is consistent with feedback the HPC received from a number of consulted stakeholders.⁴¹

Improve inter-agency coordination of service delivery to people with a mental illness who have high needs (Objective 3.4)

Key Findings

21. Based on the information provided, it is difficult to assess how current inter-agency coordination initiatives have affected clients, in particular those with complex and chronic needs.

Stepping Up defined 'high and complex need consumers' as 'being those people with a mental health condition who are also either involved in the criminal justice system, experiencing homelessness, those with frequent reliance on the public hospital system and those with a significant co-existing drug and/or alcohol dependency'.³⁷

SA Health provided some commendable examples of activity and achievements around homelessness. A range of information was provided to the HPC about inter-agency committees and working groups, such as the social housing program that aims to address social and economic needs for mental health clients experiencing homelessness. Whilst the HPC noted that SA Health has plans and programs that are under development, the overall approach appears to focus solely on the pursuit of the SASP target on homelessness.⁴

SA Health's strategies for tackling the other indicators relating to high and complex needs clients remain unclear to the HPC. There was very little information provided on inter-agency initiatives that aim to address the other markers identified by the Social Inclusion Board in respect of people with high and complex needs.

The *Health in All Policies* (HiAPs) approach, which extends the consideration of health to include non medical factors, needs to be more deliberately applied to improving inter-agency coordination of service delivery to high needs mental health clients.^{14, 15}

Discussion

SA Health defined 'high needs' as *'equating to complex mental health conditions, in which a person experiencing mental illness is also experiencing other multiple and complex social, emotional and/or physical health problems'*. Complex conditions include mental illness with problematic substance abuse, histories of abuse, intellectual disability, and challenging, at risk, suicidal and criminal behaviours. People with complex conditions often have needs that require a coordinated response from multiple sectors.

SA Health indicated that coordination across agencies is a critical part of responding to people with high needs. SA Health provided a range of examples of work in this area including:

- > The development of a model of care for people with chronic and complex needs, followed by the implementation of a pilot project in 2008 that involved the non-government sector delivering psychosocial packages of care to this group of clients.
- > The Individual Psychosocial Rehabilitation and Support Services program (commenced in April 2009), that provides services to approximately 550 people with mental illness and high and complex needs.
- > Social Housing for Mental Health Consumers, a program that entailed negotiating with Housing SA for the provisions of 250 houses for mental health clients. It is expected to be completed in late 2010.
- > The development of an integrated Homelessness Service System Model, with a strong commitment from health, drug and alcohol, disability and housing support agencies resulting in an increased number of housing support workers for the street to home program.⁴³ The model is being expanded across the metropolitan areas and in the country.
- > Cross-agency planning and program cooperation initiatives at a number of other areas, for example, the Adelaide Health Service (AHS) work with Families SA in relation to the needs of families that have been subject to a Child Protection Notification as well as work on provision of services to older people.

In addition, SA Health indicated that it works with a number of other government departments on initiatives aimed at addressing the needs of Aboriginal people as they represent a significant number of people experiencing homelessness and rough sleeping in the general community, with a large proportion having mental health issues and other indicators of high and complex needs.

An Aboriginal Mental Health Adviser has been appointed within the Mental Health Unit of SA Health, to assist with the monitoring and evaluation of its mental health service response to Aboriginal people.

SA Health indicated the establishment of the Aboriginal Mental Health Team at the Rural and Remote Mental Health Service, has allowed greater inter-agency collaboration to occur with regional services in respect to Aboriginal mental health consumers.

SA Health's Model of Care for Adult Community Mental Health Services identifies minimum standard requirements for people with high and complex needs as a priority basis for service access and response.⁴⁴

SA Health reported that the establishment of an inter-agency work group to oversee the implementation of service enhancements to the high and complex needs client group has resulted in the development of a service capacity model to coordinate care across government and non-government agencies for this client group. The evaluation methodology has been identified and the process is currently being implemented.

Another example of inter-agency collaboration provided by SA Health was the review and evaluation of the Emergency Services Memorandum of Understanding. A new agreement has been drafted that takes account of the evaluation recommendations.

Assessing Inter-Agency Coordination Improvements

Since SA Health reported KPIs that measure the outcomes of inter-agency collaboration are currently under development, the HPC was unable to analyse relevant data pertaining to this objective.

Stakeholder feedback indicated families and carers of people with complex and chronic needs would like greater engagement with the service providers. In general, stakeholders reported experiencing service delivery in silos. The general perception of these stakeholders is that mental health is still seen as separate from the rest of the health system.

Consulted stakeholders provided positive feedback in relation to the cross-agency response to clients who experienced mental health problems resulting from the drought and stated that *'agencies have worked effectively to provide relevant services to these clients'*.

The HPC looks forward to assessing over the next four years, how inter-agency coordination strategies address the service requirements of high and complex need clients.

Increase community understanding of mental health (Objective 3.5)

Key Findings

- 22. It is not clear how the outcomes of mental health promotional programs are assessed, particularly the objective of stigma reduction. However, the HPC noted positive community feedback on SA Health's efforts to build community knowledge and skills about a number of mental health conditions.**

SA Health's partnerships with Beyondblue Australia, Relationships Australia (SA), the Health Consumers Alliance, the Mental Health Coalition of South Australia and the Margaret Tobin Awards are examples of the system's approach to community education and promotion of social inclusion. Although these programs are well regarded in the community, there appears to be a need to develop services and systems that are more responsive to CALD and refugee communities and have greater relevance to and impact on Aboriginal people.

SA Health has the opportunity to influence social attitudes and actions towards people with mental health illness and the HPC looks forward to seeing the results of programs to reduce stigma and encourage social inclusion.

Discussion

SA Health reported on a range of initiatives being implemented to increase community understanding, better recognition of risk factors and greater community acceptance of mental illness. The development of a Mental Health Communications Strategy is currently underway and is likely to provide the basis for initiatives for an anti stigma campaign.

Partnership with Beyondblue facilitates dissemination of material on anxiety and depression as well as the offering of the education and training program Depression of Older People, in partnership with Council on the Ageing (COTA).

Partnership with Relationships Australia facilitates promotion of positive awareness of mental health in the community through the Building Knowledge, Skills and Communities Program, as well as the Mental Health First Aid Training Program.

SA Health funds the Health Consumers Alliance to strengthen its role in consumer education with a focus on mental health, and the Mental Health Coalition of South Australia to undertake training and development programs for the NGO mental health workforce.

SA Health has introduced the Dr Margaret Tobin Awards, which showcase the work of individuals and groups demonstrating outstanding service in promoting positive mental health and wellbeing. Mental Health Week promotes community understanding and social inclusion of people with a mental illness.

In terms of what is currently monitored, SA Health provided baseline survey data assessing the percentage of South Australians aware of signs and symptoms of depression and anxiety (57%, 2008). The HPC would have liked information on the percentage of South Australians who are aware of how to access relevant mental health services, should they need them. SA Health acknowledged there are better measures of progress in achieving community understanding of mental health issues. SA Health is exploring ways to measure the percentage of South Australians who are aware of how to access relevant mental health services and the percentage of South Australians who are aware of signs and symptoms of depression.

Consulted stakeholders were positive about the promotional activities of SA Health. A number of these stakeholders expressed the view that greater effort is needed to ensure the stigma associated with mental illness was diminished.

SA Health has since indicated that it is developing a mental health conditions marketing campaign that aims to reduce stigma in the general community. This will be implemented during the 2011 calendar year as a three-year strategy incorporating an advertising campaign and grass roots community engagement including information for staff, consumers, carers, and other stakeholders.

SA Health Strategic Direction: Improving the Health of Aboriginal People

Aboriginal people experience more life risk factors, poorer health, and less acceptable outcomes in a range of life areas when compared to other South Australians. As a result, Aboriginal people are among the most disadvantaged population groups in the community. SA Health will work to address the health inequities faced by Aboriginal people, reducing the gap in health outcomes between South Australia's Aboriginal people and the rest of South Australia's population... SAHSP p.11

1. What did SA Health commit to do?

a. Strategic Position

The *SA Health Strategic Plan 2008-2010* (SAHSP) underlines the serious state of Aboriginal health by including it as one of its key four strategic directions for reforming the health system.³ The issue of poor health is not new – the poor health status of Aboriginal people has been a conscious issue for health systems across Australia for at least the past 30 years (National Aboriginal Health Strategy 1989).

SA Health has the lead responsibility for the *South Australia's Strategic Plan 2007* (SASP) targets associated with improving the health and wellbeing of Aboriginal people.⁴ This commitment is underlined by the recent execution of the National Indigenous Reform Agreement (Closing the Gap) with its associated agreed performance outcomes.¹¹

The major health status challenges that are addressed by all of these strategic approaches are the identification and reduction of health risk factors, and the provision of culturally appropriate care and services across primary health and hospital care.

b. Key Objectives and Performance Measures

The key objectives presented in SAHSP (p.11) signify the major areas of reform and achievement of outcomes in improving Aboriginal health:

- > Reduce Aboriginal ill health (Objective 4.1)
- > Develop a culturally responsive health system (Objective 4.2)
- > Promote Aboriginal community health and wellbeing (Objective 4.3).

(SAHSP p.11)

In addition, COAG agreements and partnerships have committed SA Health to achieving agreed outcomes that are consistent with the objectives of SAHSP.

SAHSP stated the system performance measures for improving Aboriginal Health included:

- > Morbidity and mortality rates of Aboriginal South Australians
- > Selected potentially preventable hospital admissions rate by Indigenous status (for acute, chronic and vaccine preventable conditions)
- > Number of Aboriginal Health Improvement Plans developed
- > Potentially preventable hospital admissions rate for children less than four years by Indigenous status
- > Level of satisfaction expressed through the Public Hospital Aboriginal and Torres Strait Islander patient satisfaction surveys
- > Rate of Aboriginal hospitalisation for alcohol and substance abuse

- > Rate of Aboriginal hospitalisation for mental health reasons
- > Proportion of Aboriginal low birthweight babies
- > Aboriginal infant mortality rate
- > Percentage of Aboriginal staff in SA Health workforce
- > Hospital admissions of Aboriginal people due to injury and poisoning per 100 000
- > Number of GP health checks
- > Number of Family Home Visiting contacts for Aboriginal people.

(SAHSP p.11)

2. How did SA Health perform?

In considering performance, the HPC made an assessment against the data/information provided by SA Health and particular stakeholders.

In this section the HPC discuss specific findings for each key objective.

Reduce Aboriginal Ill health (Objective 4.1)

Key Findings

23. Reducing the health outcomes gap in mental illness, injury, diabetes, renal and heart disease remains a significant challenge for the health system.

24. SA Health's 2008-2010 performance lacked an effective strategic planning and evaluation focus therefore implementation appeared spasmodic, lacked evidence of evaluation and significant achievements.

While health systems alone cannot be held responsible for the relative differences in health status between Aboriginal and non-Aboriginal people, it is reasonable to expect the health system to have some demonstrable impact on the health and wellbeing of Aboriginal people.

The HPC noted that although a large number of policies and strategies were brought to its attention, it is not clear whether these are derived from effective engagement with Aboriginal stakeholders and coordinated at a strategic level.

In moving forward, building on trusting relationships with Aboriginal community groups and providers will be critical to achieving progress.

The HPC understand that the issues relating to Aboriginal health are not new. It is not the HPC's role to comment on what has happened before, but the HPC does point to lessons from the past, which indicate health status has not significantly improved overall. Simply continuing to do 'more of the same' will not make a difference.

The HPC acknowledges the November 2010 launch of the SA Health Aboriginal Health Care Plan for 2010-2016 as a positive development. SA Health's plan to provide the HPC with annual progress reports is welcomed.

25. Although ongoing efforts to reduce Aboriginal ill health were noted, their overall effectiveness is unclear at this stage.

The HPC noted that there appears to be a heavy reliance on plans that are in preparation and agreements recently finalised. While this indicates intention, it is too early to assess service outcomes or the impact on broader health status.

In reviewing the performance of SA Health, the HPC gained an overall sense that addressing Aboriginal ill health requires further sustained effort by the health system.

In particular, SA Health needs to continue to strengthen its Aboriginal health services emphasis on chronic disease management and mental health issues.

Discussion

This objective focuses on the need to reduce ill health in Aboriginal people and close the gap between Aboriginal and non-Aboriginal health outcomes.

Aboriginal Health Status

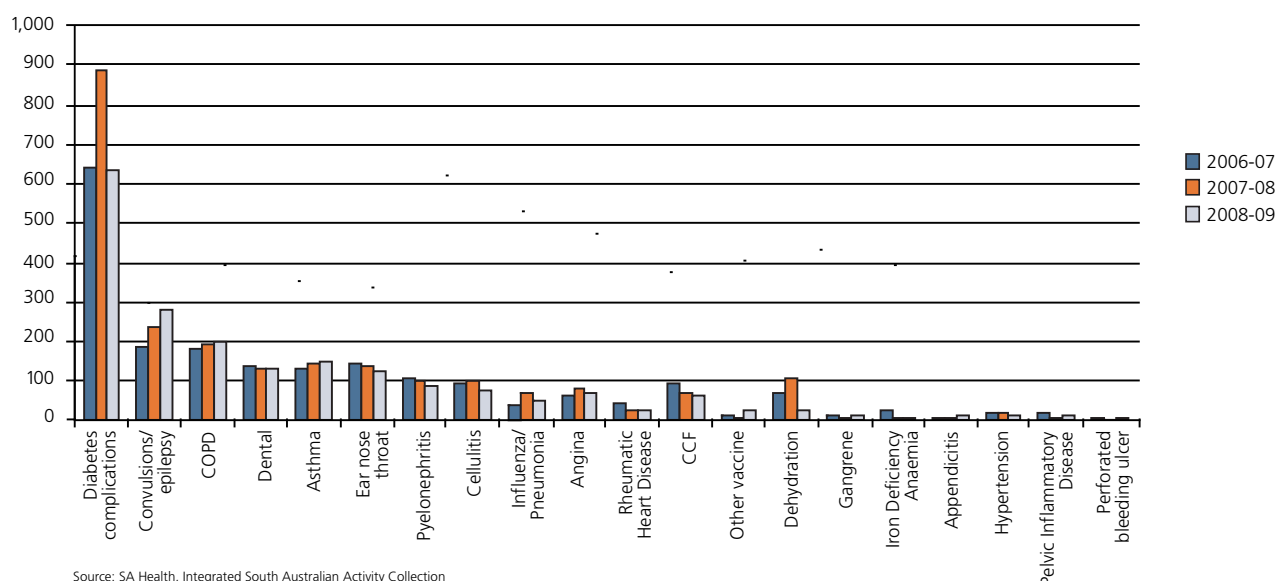
Despite major gains in life expectancy for South Australians over the last 15 years, there remains a significant gap in mortality rates between Aboriginal and non-Aboriginal people. The gap in life expectancy is 11.5 years for males and 9.7 years for females. The age profile for Aboriginal people varies significantly from other South Australians, for example, nearly 40% of the Aboriginal population is under the age of 15 years.

Tobacco smoking, obesity, poor nutrition and lack of physical exercise are leading risk factors that contribute to higher morbidity and mortality rates for heart disease, diabetes, kidney disease and cancer. There are some indications that the proportion of women smoking during pregnancy has been decreasing.

Potentially preventable hospital admissions are likely to result from reductions in Aboriginal ill health. The data on preventable admissions indicates that after adjusting for the age and sex of the population, the rate of admission for selected acute, chronic and vaccine preventable conditions to public hospitals decreased between 2007-08 and 2008-09 for both adults and children and Aboriginal and non-Aboriginal people, albeit the utilisation by Aboriginal people was significantly higher (see Chart 2.4.1).

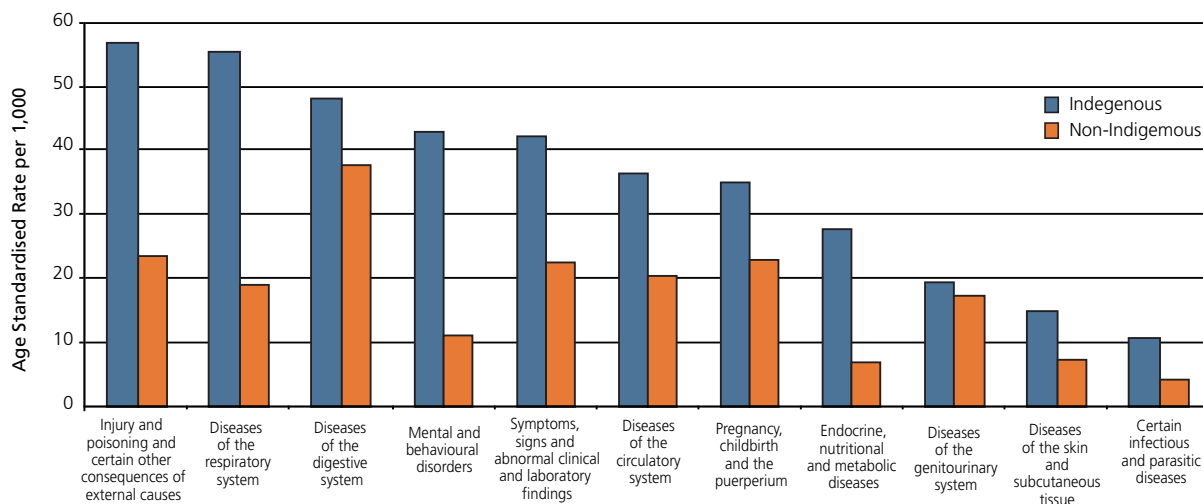
The number of separations (before accounting for changes in population) was only about 1% lower in 2008-09 when compared with 2006-07. Diabetes complications account for nearly a third of all Aboriginal potentially preventable admissions and combined with convulsions/epilepsy and chronic obstructive pulmonary disease accounts for more than 50% of the total.

Chart 2.4.1 ATSI potentially preventable admissions by condition, public hospitals, South Australia, 2006-07 to 2008-09



Aboriginal people in South Australia are hospitalised at nearly four times the rate of non-Aboriginal people with mental and behavioural disorders (3.9) and endocrine, nutritional and metabolic disorders (3.9), including diabetes (see Chart 2.4.2).

**Chart 2.4.2 Leading causes of hospitalisation,
Indigenous and Non-Indigenous Australians, South Australia, 2006-07 to 2007-08**

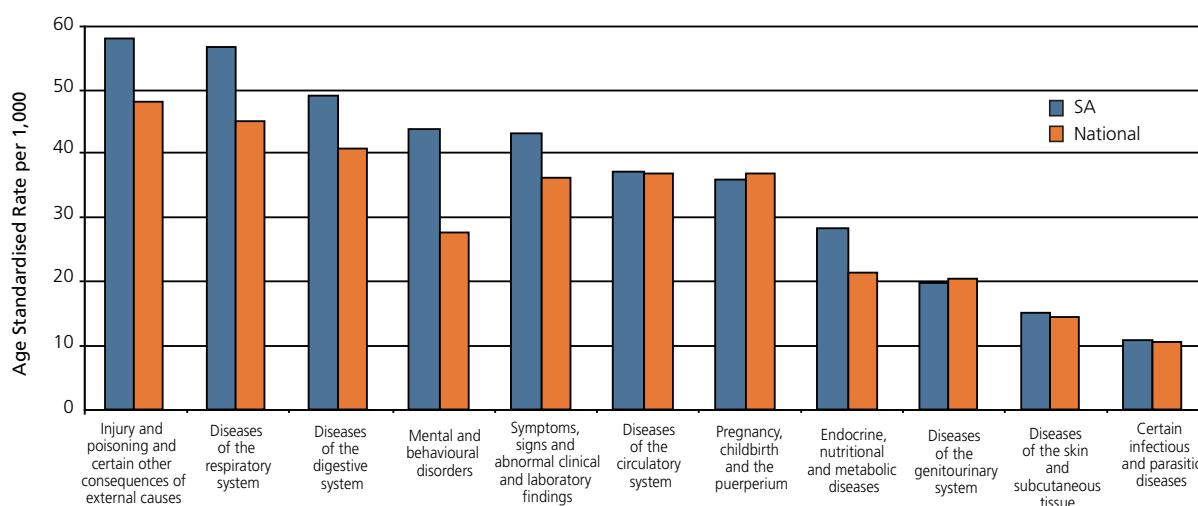


Source: AIHW, National Agreement Performance Information 2008-09: National Indigenous Reform Agreement

For the same conditions, Aboriginal people in South Australia are generally hospitalised at a greater rate than Aboriginal people nationally.

Although this is likely to be partially reflective of South Australia's relatively higher overall hospitalisation rate (10-15%), the HPC noted that the rate of hospitalisation for mental health conditions is about 1.6 times higher than the national level (see Chart 2.4.3).

**Chart 2.4.3 Leading causes of hospitalisation,
Indigenous Australians, South Australia and National, 2006-07 to 2007-08**



Source: AIHW, National Agreement Performance Information 2008-09: National Indigenous Reform Agreement

Aboriginal people are also overrepresented in hospitalisation rates for traumatic brain injury, with 4.3% compared with 1.7% for non-Aboriginal people (Statewide Rehabilitation Service Plan 2009-2017 p.27).⁴⁶

The HPC notes that there have been some improvements in low birthweight numbers (not definitive but encouraging). Overall progress in reducing Aboriginal people's ill health is unsatisfactory (for example, dialysis and mental illness hospitalisation rates are high). It is acknowledged that improvements in Aboriginal health outcomes happen in small increments and are not always measurable over a short period of time.

Aboriginal Health Planning

COAG Partnerships

With the increased focus and targeted resources entailed in the COAG partnerships, SA Health has the opportunity to bring Aboriginal needs and issues to the centre of its planning and service delivery.

This involves coordinating and embedding its approach across the health system; improving data collection and analysis; continuing to improve community engagement and meaningful involvement of Aboriginal communities; measuring and reflecting on performance and using this information to influence decision-making about strategies, policy and service delivery.

Central to this approach, is the need to provide services that are positively respectful and appropriate so that the people who most need them will access and benefit from them.

SA Health acknowledged that the SA Implementation Plan for the National Partnership Agreement on Closing the Gap in Indigenous Health was developed in an environment that limited opportunities to align with or determine Aboriginal health priorities for investment.¹¹

SA Health advised that the nature of negotiations between the State and the Australian Government, determined by the latter and designated 'in-confidence', did not allow for broad consultation that included the Aboriginal Community Controlled Health Sector. The short time frames, dictated by the COAG process, did not allow for a comprehensive review of the content and to a significant extent circumvented the established Aboriginal health strategic planning structures within SA Health.

Aboriginal Health Care Plan for 2010-2016

SA Health reported that improved planning processes to generate greater focus on Aboriginal health, involve the development of a *Primary Prevention Plan* (in preparation) and an *Aboriginal Health Care Plan for 2010-2016* (AHCP), released in November 2010.⁴⁵ The intent is to address the full spectrum of health services in order to increase their relevance and accessibility for Aboriginal people. This will range from primary prevention, early detection and intervention, effective management of chronic disease, through to acute care, rehabilitation and palliative care.

The AHCP includes detailed analysis of the health needs and service utilisation by Aboriginal people for all health regions.⁴⁵ This is critical information that informs the SA Health Aboriginal Health Care model and priorities for action.

Community and socioeconomic factors such as housing, education, employment and income are major determinants of the current burden of health. It is noted that the AHCP now considers these factors.⁴⁵

SA Health is explicit in identifying that, because of the number of policies, frameworks and plans already in place in SA, there is little need for more broad brush planning on Aboriginal health in South Australia. Therefore, the plan draws together a variety of existing documents, policies, programs, agreements and service directions with the intention of improving Aboriginal health; and presents these within a single document.

Under the AHCP, SA Health will establish a monitoring committee to report annually to the Health Portfolio Committee and through them to the HPC.⁴⁵

The AHCP includes up to five priority initiatives, related to governance and accountability that will be monitored. In year one (2011), the focus will be to:

- > Routinely monitor and report on self-discharge rates of Aboriginal people across all health services
- > Ensure regional health services and departmental divisions develop Aboriginal Health Improvement Plans aligned to this plan and submit annual reports on progress
- > Implement an annual Aboriginal Health Integrated Planning Process at the state level and through Country Health SA and Adelaide Health Service⁴⁵
- > Ensure regional progress reports are provided on achieving the target of 2.1% annual reduction in smoking during pregnancy for Aboriginal women
- > Increase the number of child health checks of both rural and urban Aboriginal children up to age 14 years by ensuring a proactive, coordinated screening including comprehensive follow-up services. Attention will be given to oral, ear and eye health needs. Each health region will set clear targets.

Program and service initiatives appear to operate in isolation from one another, rather than from a strong, coordinated base, that evidences a comprehensive SA Health approach. One such example was the past lack of coordinated action in addressing the relatively high number of Aboriginal people leaving SA hospitals against medical advice. The HPC noted that a key priority in the AHCP is for statewide clinical networks to ensure that Aboriginal people receive specific attention in the development of evidence based care pathways.⁴⁵ It also includes a target for reducing the number of Aboriginal people leaving SA hospitals against medical advice.

The HPC found little evidence that innovative and successful Aboriginal Health service models from elsewhere, including the Aboriginal community controlled sector, had been adapted for SA during 2008-2010.

A number of stakeholders consulted by the HPC reported some progress in awareness of Aboriginal issues. Many stakeholders provided examples where practices and ways of viewing Aboriginal people have not been culturally respectful, or have been discriminatory and in some instances dismissive. One such example has been the way in which research that supports the effectiveness of Aboriginal healers has been dismissed or ignored by the health system.

However, the AHCP states that *'all regional health services will be orientating the provision of health services through Aboriginal community controlled health services as the preferred delivery option for Aboriginal people'*.⁴⁵ The HPC notes this positive development and acknowledges that the Aboriginal Community Controlled Health Services sector has a long history in the provision of culturally responsive primary health care services for Aboriginal people.

Statewide Clinical Service Plans

SA Health has developed and is now implementing statewide clinical service plans for chronic disease management, rehabilitation, stroke, cardiology, older people and palliative care, that include consideration of Aboriginal health care needs.^{46, 47, 48, 49, 50, 51} However, they provide minimal details on Aboriginal specific strategies and expected outcomes.

Aboriginal people were consulted and involved to varying degrees in the development of these plans. For example, the Rehabilitation Network Steering Committee held a workshop involving service providers, individuals, and a number of organisations, to develop views in relation to specific requirements for designing and delivering rehabilitation services to Aboriginal people. The results are reflected in their statewide service plan.

The Renal Clinical Network also identified that the needs of Aboriginal people for renal services were so significant that a specific subgroup was set up to examine services and make recommendations.

In their advisory capacity on implementing the SA Cancer Control Plan, the Cancer Clinical Network has established an Aboriginal subcommittee, chaired by a prominent Aboriginal person.⁵¹ This subcommittee is developing a companion pathway that will identify the barriers and enablers that impact on Aboriginal and Torres Strait Islander people accessing timely cancer care.

Regional Health Services

With the Aboriginal Health Division becoming the key strategic cultural adviser in SA Health and services and accountability being located with health regions, the HPC noted that significant changes have been made to service delivery for Aboriginal people. This will improve development and coordination of policy, strategy and programs that address the needs and issues of Aboriginal people.

This approach has been a strategic move by SA Health to locate delivery and accountability within mainstream service areas. Whilst there is commitment from the leadership of SA Health to ensuring that Aboriginal health development is not marginal to the main business, there is an impression that in the transition of responsibilities to other portfolio areas, including regional health services, the coordination of SA Health's overall approach has weakened and this may be impacting the effectiveness of programs.

System Improvements

SA Health indicated that planning process improvements have resulted in a number of initiatives, in particular, providing services as close to home as possible for community members, resulting in the expansion of renal health services in country locations (for example, Berri, Ceduna, Clare, Gawler, Mt Gambier, Pt Augusta, Pt Pirie, Tanunda and Whyalla).

SA Health also reported on the establishment of the Renal Clinical Network to consider strategies that will lead to improvements in health outcomes for both Aboriginal and non-Aboriginal people with kidney disease. The network is collaborating with Country Health SA to make dialysis services more accessible to rural and remote South Australians, particularly for people and their families who are affected by the inability to access services at Alice Springs.

Other achievements mentioned by SA Health included commitment of COAG funds (\$5.76 million over four years) to tackle smoking and development of non-residential substance misuses rehabilitation day centres. These centres will provide a one-day diverse program for clients and families and will work with a range of service agencies in coordinating case management of clients with complex substance misuse issues.

In relation to mental health, SA Health reported that new initiatives have commenced in response to the recommendations of its Statewide Mental Health Aboriginal Consultation conducted in 2009. The development of a Rural and Remote Aboriginal Mental Health Team and incorporation of cultural needs in the redesign of the Glenside Campus buildings and services are two examples.

The HPC's consultations with Aboriginal stakeholders revealed that access to mental health services remains a major concern especially for rural/remote communities.

Positive feedback was given to the HPC about training peer workers in mental health and the process of consultation about the redevelopment of Glenside.

SA Health advised that Statewide Clinical Networks utilise a range of engagement mechanisms with Aboriginal individuals, communities and organisations in developing Statewide Service Plans. Each Statewide Clinical Network is required to have Aboriginal representatives on their Steering Committee to provide advice regarding appropriate engagement mechanisms.

Consulted stakeholders were positive about improvements in some health services, particularly in Yorke Peninsula in relation to dialysis, mental health services, nicotine cessation programs, and the training of 'peer workers' to provide mental health support. Aboriginal Health Advisory Committees in country communities were reported as being generally more consultative.

However, these stakeholders remain concerned about the continuing disparity between Aboriginal and non-Aboriginal health status and frustrated at lack of progress to improve the health of Aboriginal people. Specific mention was made about uncertainty created by project-based funding (although the Closing the Gap initiatives are now funded for four years), and inappropriate application of mainstream approaches, which can lead to unanticipated negative outcomes.¹¹ One of the many examples provided to the HPC was of pregnant Aboriginal women who do not attend a country GP clinic because of the likelihood of the baby being considered 'at risk' and therefore having to be born in Adelaide, away from family and community.

Stakeholders considered that although there have been some improvements in community consultation in the country, statewide and metropolitan service planning is still not usually responsive to their needs. This is a significant gap given that nearly half the Aboriginal population live in urban communities. In addition, there is a need for community education programs that provide a lead up to the introduction of new services and programs, for example, *GP Plus* replacing community based services.⁶

Develop a culturally responsive health system (Objective 4.2)

Key Findings

26. Community engagement is sporadic. More effort is required to achieve a culturally responsive service connected to Aboriginal communities and their health and wellbeing organisations.

The HPC noted the positive development that, according to those stakeholders consulted by the HPC, community engagement has improved for some rural Aboriginal communities. The regular consultations by Country Health SA with the Aboriginal Health Advisory Councils across rural SA provide positive information flow and feedback to SA Health. The picture is not so clear for consultation and collaboration with urban Aboriginal communities.

27. Efforts were made to increase the cultural competence of the workforce but outcomes are unclear and more needs to be done to ensure competence levels are achieved and maintained across the workforce.

Aboriginal employment trends over the last five years indicate that SA Health is unlikely to meet the SASP Aboriginal Employment target.⁴

The competence of the health workforce to deliver responsive health services for Aboriginal people is not systematically monitored and evaluated.

Improvements are needed in the delivery of hospital services as Aboriginal people are discharging themselves against medical advice at nearly five times the rate of non-Aboriginal people.

28. Although there is evidence of some performance monitoring, a more robust suite of key strategic performance measures relating to improving Aboriginal health are required.

There is insufficient alignment of the limited number of indicators that do exist, to the population targets set for SA. Although not an insurmountable problem, it is acknowledged that persistent challenges exist in identifying Aboriginal people in routine data collection and securing robust sampling of the Aboriginal population through health related surveys.

The data provided by SA Health illustrates that data availability and quality is limited. A lack of specific data code criteria to record Aboriginal status renders some promising routine datasets unhelpful, irrespective of the challenges in identifying Aboriginal people.

Other regularly collected population data, for example, the South Australian Monitoring and Surveillance System (SAMSS), despite asking about Aboriginality, have included very small numbers of Aboriginal people, which limit their usefulness. From 2002 to 2010, SAMSS conducted annual Computer Assisted Telephone Interviews that included between 21 and 95 Aboriginal people each year (0.8% of the sample, on average). As the sample size was insufficient, and possibly biased due to lack of household phones in many cases, it is understood that SAMSS in future will include over-sampling of Aboriginal people, including face-to-face interviews.

Discussion

SA Health recognises that cultural sensitivity and security are key elements in achieving better access to care and services and their more effective use by Aboriginal people. This in turn, would reasonably be expected to impact on some health outcomes.

The information presented to the HPC demonstrated a commitment to improving these elements and highlights that there are some appropriate plans and activities underway. It is not clear to the HPC how effective these approaches are and how SA Health will assess its success in this area as monitoring and evaluation of current Aboriginal health program outcomes appears to be limited. There is a broad need to integrate monitoring and evaluation processes into the planning of Aboriginal health improvement initiatives.

SA Health reported that during 2008-2010 it promoted a culturally responsive health system for Aboriginal people by:

- > Maintaining strong working relationships across the three health jurisdictions through the SA Aboriginal Health Partnership, that is, State and Australian Government Health and Aboriginal Community Controlled Health Services
- > Implementing its Aboriginal Health Policy, Aboriginal Cultural Respect Framework, Aboriginal Health Impact Statement and Statement of Reconciliation.^{52, 53, 54, 55}

The Cultural Respect Framework required the development of regional Aboriginal Health Improvement Plans, to identify gaps and priority areas in addressing Aboriginal Health at the regional level.⁵³

The HPC was advised that these plans were still being developed and would feed into the development of the AHCP.⁴⁵

SA Health reported Cultural Awareness Training at the Royal Adelaide Hospital and the Lyell McEwin Hospital as implementation examples of the Cultural Respect Framework.⁵³

The Aboriginal Health Impact Statement is an assessment tool for policy and program development. It ensures Aboriginal needs are considered when new or renewed policies or initiatives are being developed, and that appropriate engagement of Aboriginal people occurs in the process. Aboriginal Health Impact Statements are increasingly used to inform SA Health executive decision-making (Jan to April 2010, 32.5% of Portfolio Executive meeting agenda items included Aboriginal Health Impact Statements).⁵⁵

Cultural Responsiveness in Health Care

Primary Health Care

Comprehensive PHC services are provided by a number of SA Health services, including Ceduna Koonibba Aboriginal Health Service and Whyalla Community Health Service. SA Health also indicated it has strong partnerships with Aboriginal Community Controlled Health Services.

SA Health indicated that *GP Plus* centres will provide for individuals including Aboriginal people to be better supported to take control of their health care, stay healthy and out of hospital. However, little indication is provided about access to these centres for rural, remote, or metropolitan Aboriginal people. In addition, it is not clear what this support will be. *GP Plus* health networks are expected to play a significant role in monitoring and proactively working to identify and advocate for the removal of barriers that reduce the access Aboriginal people have to necessary services.⁶

SA Health reported that the Better Care in the Community *GP Plus* program is showing early signs of improved access for Aboriginal people in Port Augusta where 49 of the 85 clients for June 2010, were from Aboriginal backgrounds.⁶

The HPC noted SA Health's recent recruitment and training of 10 Aboriginal Patient Pathway Officers in 2010 to assist people with chronic and complex conditions to access appropriate services.

There are a number of initiatives under the *National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes: SA Implementation Plan* (SA Closing the Gap Plan).¹¹ For example, the Aboriginal Well Health Checks, the audit of Chronic Disease Management practice and the Aboriginal Family Wellness Groups. Each of these strategies aims to identify and address chronic disease in Aboriginal communities. The COAG initiatives also include the Indigenous Environmental Health Worker program, which has the potential to impact risk factors for a range of chronic conditions. These are at an earlier stage of development than some of the work around children. It is also a major focus of the ACHP and thus the HPC expects to see progress in the future.

Acknowledging the reluctance of many Aboriginal people to access non-appropriate mainstream services and complaint mechanisms, the HPC will monitor the engagement of Aboriginal people with *GP Plus* services and how this develops, as *GP Plus* rolls out.⁶

The HPC also intends to monitor the impact of the *GP Plus* centres and services on local Aboriginal Community Controlled Health Services and their links with these groups.⁶ Consulted Aboriginal stakeholders expressed some concerns about the impact of these new centres on existing Aboriginal community controlled services, where access to culturally responsive primary health care services is readily available to them.

Mental Health Care

The Emergency Services Memorandum of Understanding (MOU) has identified the needs of Aboriginal people as a priority for service response. The MOU sets out the requirements of each participating agency (SA Police, SA Ambulance Service, and SA Health) in ensuring a coordinated emergency mental health response in metropolitan and country areas.

A particular focus has been the arrangements required in isolated and remote communities to ensure Aboriginal consumers receive a timely and appropriate service response commensurate with their needs.

The appointment of a Principal Aboriginal Mental Health Policy Adviser aims to ensure that Aboriginal people involved in the mental health system (from either a provider, consumer or a carer perspective) have input into monitoring and evaluating the quality of service responses to Aboriginal people. Aboriginal stakeholders commented that this was a positive step forward.

Hospital Care

In addition to the SA Closing the Gap Implementation Plan, health regions are undertaking a number of initiatives to improve mainstream and Aboriginal specific services.¹¹ Some examples mentioned were:

- > Establishing discharge planning working groups to improve the patient journey
- > Continuing Aboriginal Hospital Liaison Unit services and Patient Escort Programs for Aboriginal patients and their families
- > Establishing remote area supports to inform the patient about their planned hospital visit, in their own language and in their own environment
- > Establishing units of compulsory cultural awareness training for staff
- > Enabling Aboriginal people, from rural and remote SA and interstate, requiring specialist services within the metropolitan area to access the Aboriginal Step Down Unit 'Kanggawodli'; a purpose built facility providing culturally appropriate accommodation and care to Aboriginal clients and their carers and escorts
- > Establishing a country, metropolitan liaison service designed to enhance the quality, safety and continuum of care for individual Aboriginal patients referred to metropolitan and country general hospitals
- > Enhancing country Step Down services that aim to improve accommodation options, improve access to appropriate health services and support transition of care between parts of the health system for people from Aboriginal and Torres Strait Islander backgrounds
- > Piloting a specialist service support program that aims to streamline and improve processes for Indigenous Australians from metropolitan, rural and remote areas accessing a range of specialist services.

The HPC will seek supporting evidence from SA Health in its next review phase that demonstrates SA Health continuously evaluates the effectiveness of these initiatives in delivering a more culturally responsive service.

Hospital Experiences

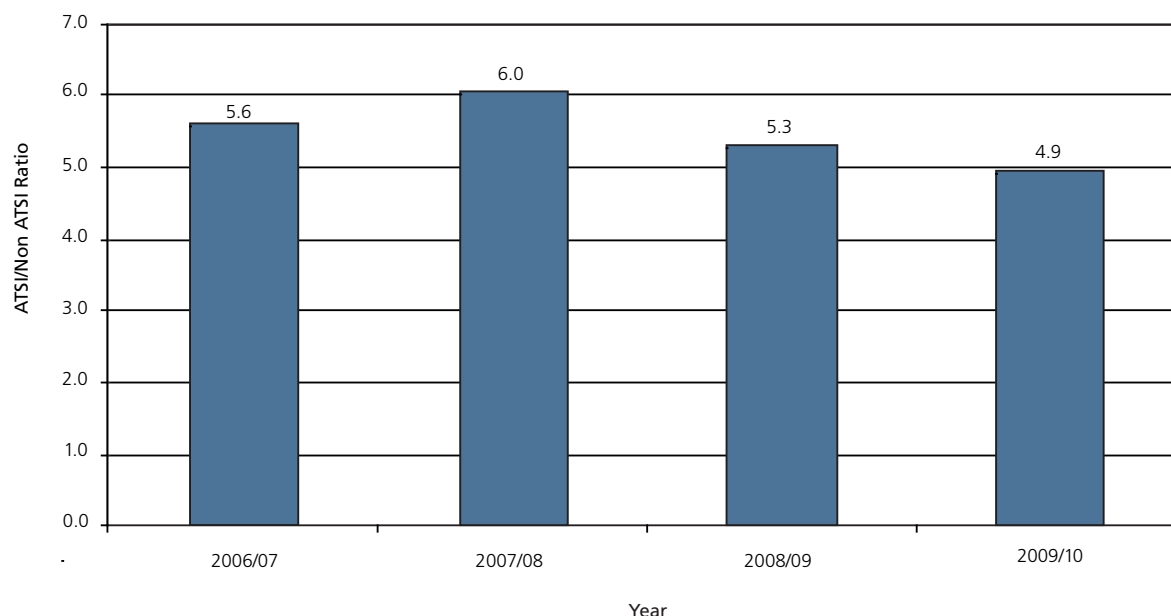
SA Health conducted a Cultural Support and Respect Indicator survey to gather baseline data from Aboriginal and Torres Strait Islander patients on their hospital experiences (1 July to 30 December 2008).⁵⁶ Results published in March 2010 indicated 86% of participants (194 participants from eligible population of 992) felt they were treated differently by the hospital staff because they were Aboriginal or Torres Strait Islander. When asked whether they were treated better or worse 57% replied worse and 33% better. The 'don't know' responses were not included. The HPC is not aware of any further surveys by SA Health.

According to the *2008 Aboriginal and Torres Strait Islander National Health Performance Framework Report*, SA is the second highest state (after Northern Territory) with discharge against medical advice for Aboriginal people.⁵⁷ This indicates to the HPC that the hospital sector lacks effective engagement with this group of clients.

It is noted that the proportion of Aboriginal patients who self discharge has improved relative to non-Aboriginal patients over the period 2006-07 to 2009-10 (YTD), even though the ratio at January 2010 was 4.9 (see Chart 2.4.4). It is not clear to the HPC what actions have influenced the improvement and therefore where the priority focus should be in the future.

The HPC will continue to monitor this indicator in the future.

Chart 2.4.4 Ratio of ATSI to non ATSI proportion of patient who self discharge 2006-07 to 2009-10 (YTD Jan 2010)



Source: SA Health, Integrated South Australian Activity Collection

In general, Aboriginal consumers do not access patient advisers and complaints systems. More needs to be done to address low levels of awareness and, more importantly, develop a culturally sensitive feedback and complaints management system.

Funding Issues

Statewide funding grants for NGOs to provide specific Aboriginal health services have declined since 2004-05. SA Health indicated this is due to changes in priorities and funding levels of the programs concerned. Regional expenditure trends indicate a minimal increase between 2007-08 and 2008-09. The COAG Partnership has now increased funding provided to improving Aboriginal health.

Consulted stakeholders indicated that the complex funding arrangement and associated accountability requirements for Aboriginal health programs remains a problem. This is especially an issue for the Aboriginal Community Controlled Health Services (ACCHS) who have limited administrative capacity.

Community Engagement

SA Health provides funding to the Aboriginal Health Council of South Australia (AHCSA) to support its role as the peak body for ACCHS in South Australia. The AHCSA advocates for the provision of health and related services with the aim of improving the quality of health for Aboriginal people in the state. Under this arrangement, SA Health funds the:

- > Aboriginal Hospital Liaison Program to ensure that metropolitan hospitals provide adequate mechanisms to culturally support Aboriginal patients and facilitate appropriate, quality health care.
- > Aboriginal Primary Health Care Certificate Program, which is nationally accredited and provides Aboriginal Health Workers with appropriate competencies to deliver high quality services to the clients in their respective ACCHS.

In relation to consultation, CHSA has established an Aboriginal Health Advisory Forum (which affords membership to the AHCSA), and the Chairpersons of the seven country regional Aboriginal Health Advisory Committees.

The CHSA Aboriginal Health Forum and Aboriginal Advisory Committees contribute to improving the cultural safety aspects of health service development and thereby assist in increasing Aboriginal peoples' confidence in using health care services. They also work with CHSA on issues and solutions to addressing Aboriginal health priorities.

There is no Aboriginal Health Advisory Council providing advice to metropolitan regional health services.

Consulted stakeholder groups pointed to a number of concerns including inadequate access to renal services particularly to renal dialysis for APY Land and other Aboriginal communities in the northern regions of the state.

These stakeholders also raised concerns about what they see as 'mainstreaming' of Aboriginal programs and services which in their opinion, reduces the quality and effectiveness of health services to Aboriginal people.

Consultations with other Aboriginal stakeholders indicated:

- > A continuing reluctance by Aboriginal people to use mainstream health services.
- > Aboriginal communities in the metropolitan regions have been largely ignored. Feedback received suggests they feel undervalued and overlooked. There was no evidence available to the HPC concerning SA Health's engagement with metropolitan based Aboriginal communities.
- > There is a lack of effective coordination between Health, Education, Housing, Transport and other State and Australian Government departments, especially in rural and remote communities.
- > The specialised mental health care and treatment needs of children and adolescents in the APY Land communities remain largely unmet.
- > Concern that adequate maintenance of transport infrastructure (for example, roads and airstrips) and utilities was not being undertaken and that this was adversely impacting the delivery of health services.

Aboriginal community controlled health service stakeholders that were consulted by the HPC indicated SA Health needs the support of these organisations to meaningfully and accurately report on Aboriginal community health. There is considerable dissatisfaction with SA Health's consultation at the program implementation level. They indicated short timelines, inadequate preparation of staff, inadequate community consultation, and the increasing demands to demonstrate high levels of formal accountability, as the reasons for feeling marginalised. They hold the opinion that there has been a loss of community control due to a lack of meaningful community engagement.

Workforce Improvements

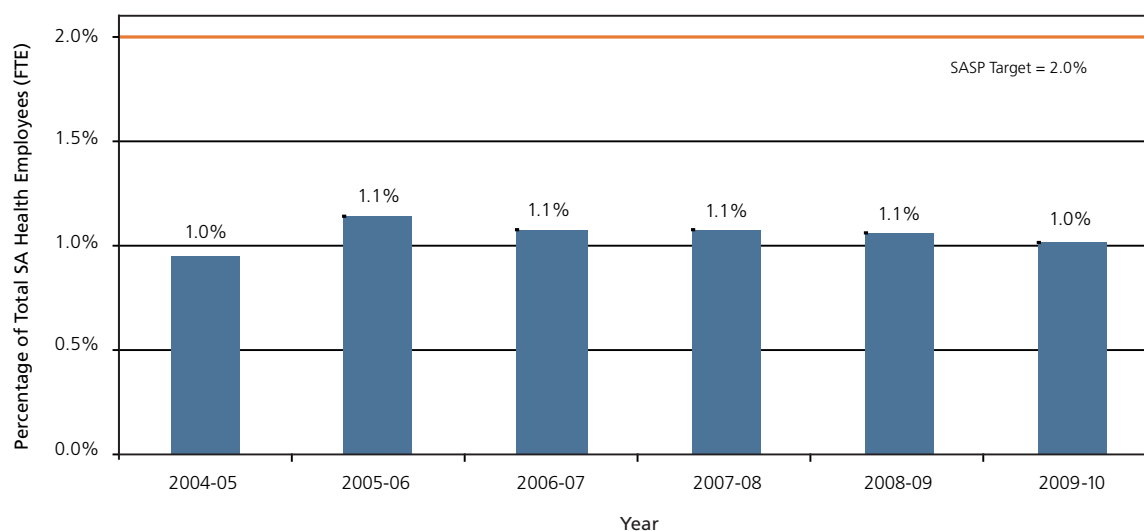
Increasing the proportion of Aboriginal people in the SA Health workforce is a targeted strategy to increase the cultural sensitivity and respect of the health care environment. SA Health's *Aboriginal Workforce Reform Strategy 2009-2013* aims to harness innovation and best practice models to develop employment pathways for Aboriginal people into health and administrative services, as well as address Aboriginal employment levels and retention.⁵⁸

Recent initiatives to influence attraction and retention of Aboriginal staffing include the Aboriginal Cadetships Program, particularly in enrolled nursing, pathology, and business administration; the Aboriginal and Torres Strait Islander Scholarship Investment Fund, which saw 46 recipients studying an undergraduate degree in 2008-09; and providing leadership and development opportunities for existing Aboriginal employees.

In relation to workforce initiatives, the HPC noted the use of scholarships and cadetships to provide opportunities in professional employment across a range of classification levels.

There has been a slight but consistent decrease in Aboriginal employment since 2006 when SA Health achieved 1.17% Aboriginal employment (see Chart 2.4.5). The SASP target is to achieve 2% Aboriginal employment across all levels of classification by 2010 and maintain or better those levels through to 2014.⁴ SA Health has indicated that it is unlikely to reach the 2% target by end of 2010 overall, let alone across classification levels.

Chart 2.4.5 Aboriginal employment as a percentage of total SA Health employees (FTE) 2004-05 to 2009-10 YTD

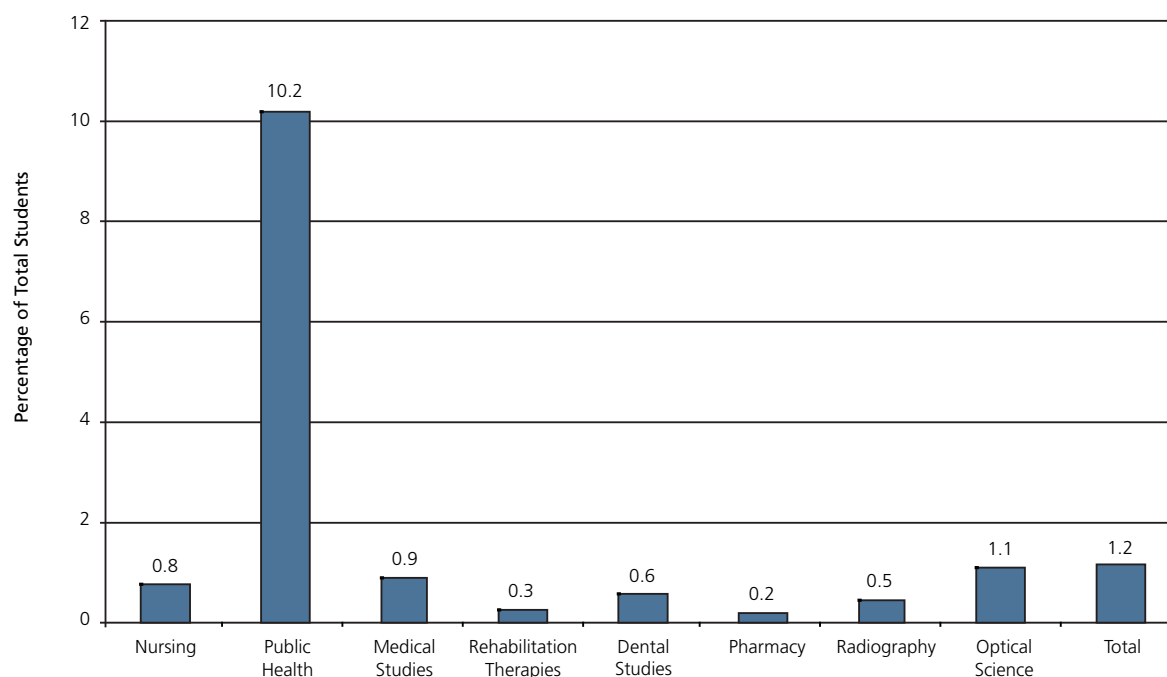


Note: Annual figures are taken in pay period in June except for 2009-10 (February)

Source: SA Health, Workforce Division, HR Data Warehouse

It appears unlikely that SA Health will meet the SASP target by June 2010, particularly given the level of Aboriginal people obtaining the skills and qualifications to work in the health sector at the national level (1.2% of total) (see Chart 2.4.6).⁴

Chart 2.4.6 Aboriginal students as percentage of total students completing undergraduate health-related courses in tertiary education sector, Australia, 2006



Source: Table 59 in Aboriginal and Torres Strait Islander Health Performance Framework Report 2008, AHMAC, Canberra.

Promoting Aboriginal community health and wellbeing (Objective 4.3)

Key Findings

29. SA Health is actively engaged in a whole of government response (COAG) to reduce the health outcomes gap by 2031.

30. The main focus has been on a healthy start to life for children, with a secondary focus on reducing risk factors and improving chronic disease management for adults.

It appears that SA Health is working to improve access to care during pregnancy, birth and the post-natal period for Aboriginal women and thereby is addressing a range of risk factors that will affect future health outcomes. The evaluation results from the Anangu Bibi project in Port Augusta indicate high levels of engagement with Aboriginal women with some positive outcomes (see Chart 2.4.8). These include increased early presentations in pregnancy, increased frequency in antenatal visits, and improvements in birthweight. The HPC was not provided with similar examples of progress in tackling risk factors and chronic diseases for other Aboriginal people.

Discussion

The focus through COAG presents an opportunity to take a more coordinated and system wide approach throughout SA Health. The HPC notes that COAG agreements include development of performance measures that will provide information about progress over the next reporting period. The HPC will be interested in the progress to meet agreed targets over the next four years and the capacity to develop and sustain a coordinated system wide approach as opposed to a series of unconnected programs and initiatives.

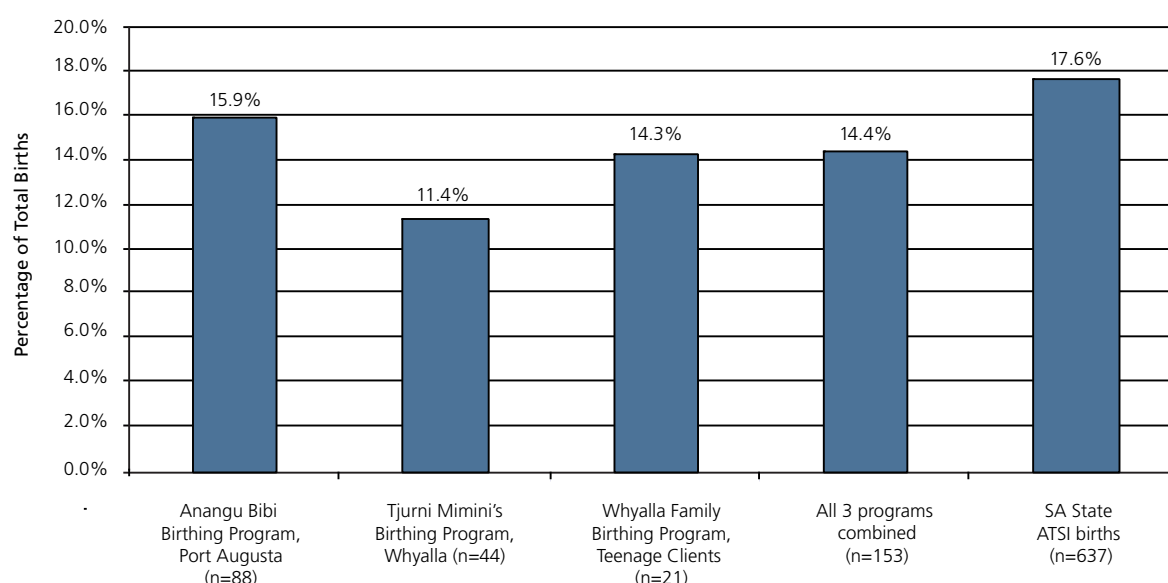
SA Health is engaged in a range of promotional programs and activities for Aboriginal people and communities. It also participates in a number of cross-agency processes that entail planning and influencing the approaches and activities of other agencies. It is not clear to the HPC how effective this engagement is, as no systematic outcome information has been provided.

SA Health reported working to improve access to care during pregnancy, birth and the post-natal period for Aboriginal women and thereby address a range of risk factors that will impact on future health outcomes.

Birthing outcomes data indicated that the low birthweight rate for Aboriginal mothers in SA is around 18% and has been steady in recent years (see Chart 2.4.7).

Country Health SA's Aboriginal Family Birthing Program has provided data from services provided since 2004. Although the numbers are small, the data from this program indicates some promising signs of improvement.

Chart 2.4.7 Aboriginal low birthweight babies as a percentage of total births, South Australia, 2004-2008



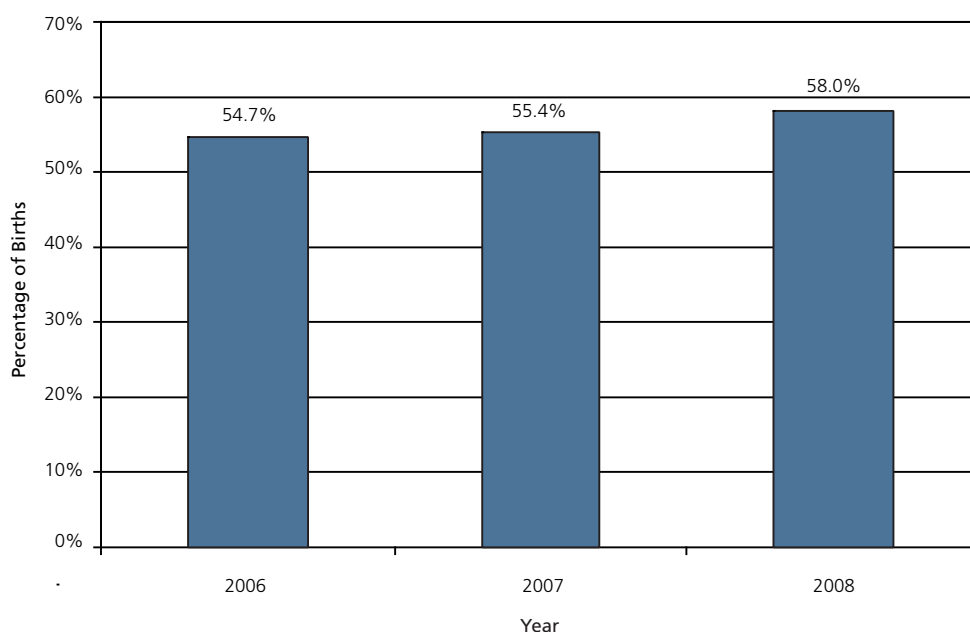
Source: SA Health, Pregnancy Outcome Statistics Unit

The Anangu Bibi Birthing Program initiative is an example of the SA Health system acting in a positive evidence-based approach to the delivery and expansion of its services to Aboriginal people.

The HPC noted the expansion of this project across other areas in rural SA and the commencement of the Metropolitan Adelaide Aboriginal Family Birthing program in mid 2010.

Access to antenatal care for Aboriginal women has been steadily improving, providing greater opportunity to identify risk factors early in the pregnancy and assist with lifestyle modification aimed at enhancing birth outcomes (see Chart 2.4.8).

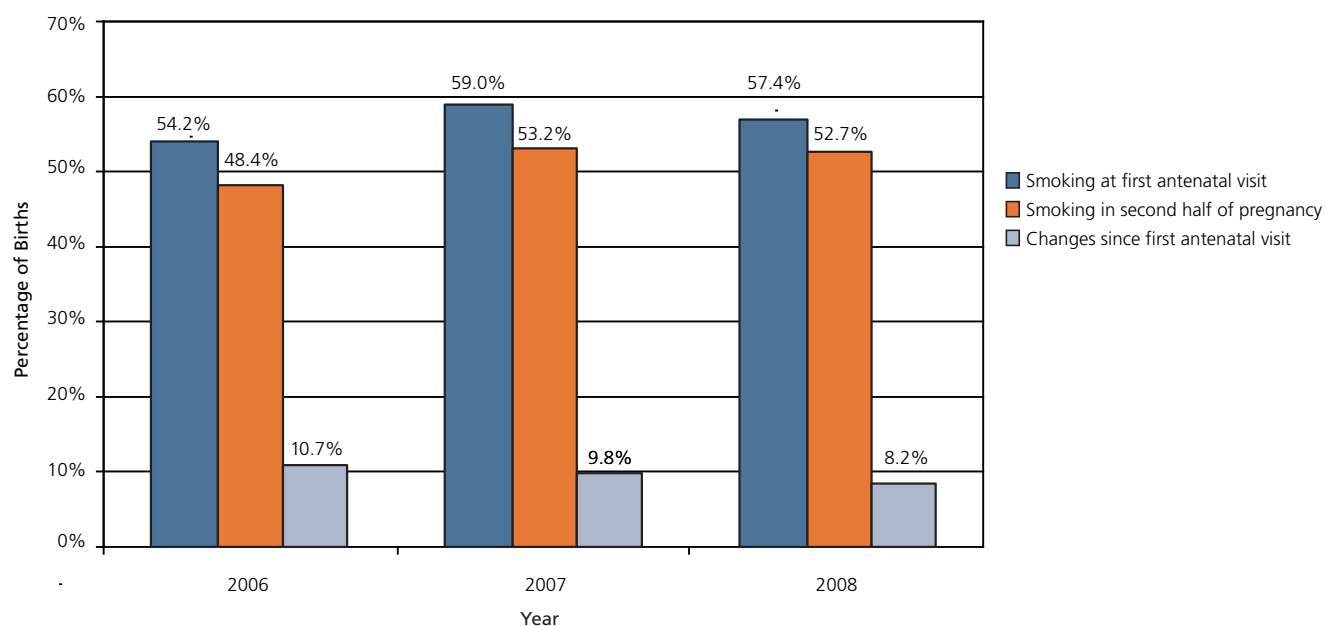
Chart 2.4.8 Aboriginal women: at least 7 antenatal visits during pregnancy, South Australia, 2006-2008



Source: SA Health, Pregnancy Outcome Statistics Unit

While the data indicates that the rate of smoking during pregnancy tends to fall when measured from the first antenatal visit to a visit in the second half of the pregnancy, the percentage of Aboriginal mothers quitting smoking appears to be steadily decreasing, putting into question the marginal effectiveness of antenatal care in improving quit rates in recent years. Although less pronounced, this situation is also evident for non-Aboriginal women (see Chart 2.4.9).

Chart 2.4.9 Aboriginal women: smoking during pregnancy, South Australia, 2006-2008



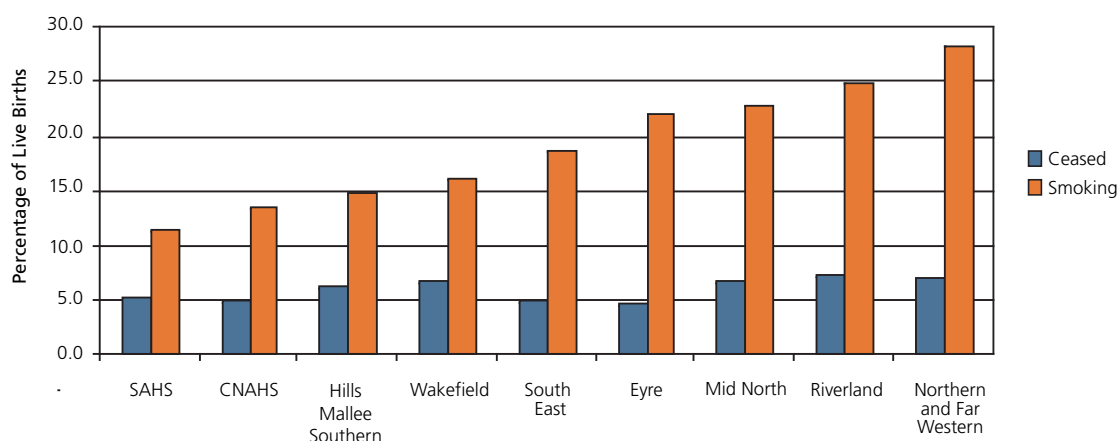
Source: SA Health, Pregnancy Outcome Statistics Unit

Smoking rates derived from those who quit before their first antenatal visit and those who were smoking at first antenatal visit and were then not smoking any cigarettes per day in the second half of pregnancy, indicated that the quit rate for Aboriginal and non-Aboriginal women has remained relatively stable (that is, marginal decrease from 2006 to 2008 from 5.4% to 5.2%).

While more Aboriginal women smoke during pregnancy, their quit rate is 30% higher than non-Aboriginal women.

Data provided on health regional variations in quit rates (Aboriginal and non-Aboriginal) in the period 2006-08 (see Chart 2.4.10).

Chart 2.4.10 Smoking rate and self reported smoking cessation rate during pregnancy by region, South Australia, 2006-2008



Abbrev: SAHS (Southern Adelaide Health Service), CNAHS (Central Northern Adelaide Health Service)

Source: SA Health, Pregnancy Outcome Statistics Unit

The smoking rates increase in line with relative remoteness and quit rates are generally higher in rural and remote areas, with perhaps the notable exceptions being the Eyre and South Eastern regions.

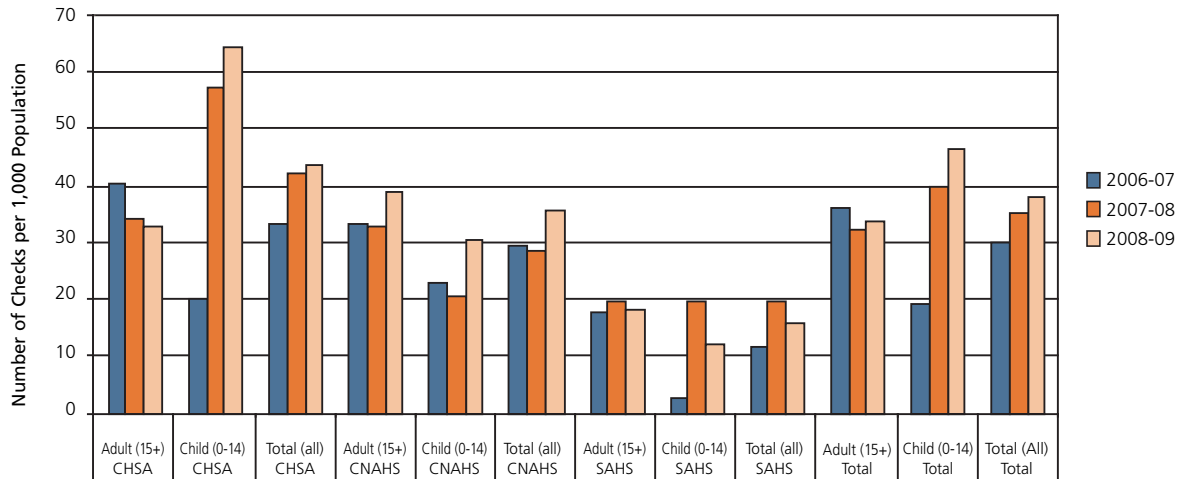
As presented in the Health Status chapter, a lower percentage of Aboriginal women in South Australia have at least one antenatal visit during the first trimester of their pregnancy when compared with Aboriginal women in other states and territories. It is also evident that a higher percentage of Aboriginal women in South Australia smoke during their pregnancy. However, within this context, the HPC noted with interest that both Aboriginal perinatal mortality and infant mortality rates in South Australia were lower than in other states and territories for the period 2003-2007 (latest available data). Linked with the downward trend in infant mortality rates observed in recent years, this is an encouraging outcome for South Australia.

Number of GP Health Checks

GP health checks are Medicare services for Aboriginal and Torres Strait Islander people. The purpose of the health checks is to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging prevention, early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

While there has been a steady increase in the rate of Aboriginal health checks in South Australia, this increase is largely due to the increase in child health checks. It is noted that the levels vary across the state with higher and growing levels recorded in country and central northern regions (see Chart 2.4.11).

Chart 2.4.11 Aboriginal health checks per 1,000 population, South Australia 2006-07 to 2008-09

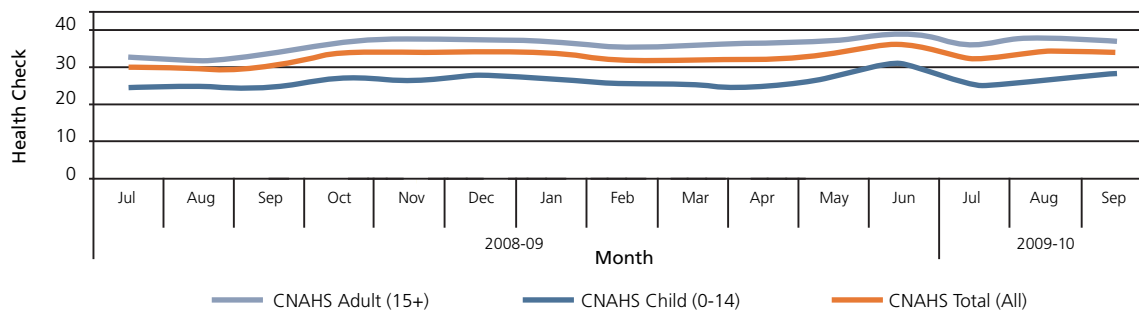


Abbrev: CHSA (Country Health SA), CNAHS (Central Northern Adelaide Health Service), SAHS (Southern Adelaide Health Service)

Source: SA Health, Medicare Australia data report

There are indications that the utilisation of the Medicare item numbers for Aboriginal health checks for adults and children have generally stabilised during 2008-09 and the early part of 2009-10, although a marginal increase was evident in the central and northern regions of metropolitan Adelaide (see Charts 2.4.12, 2.4.13 and 2.4.14).

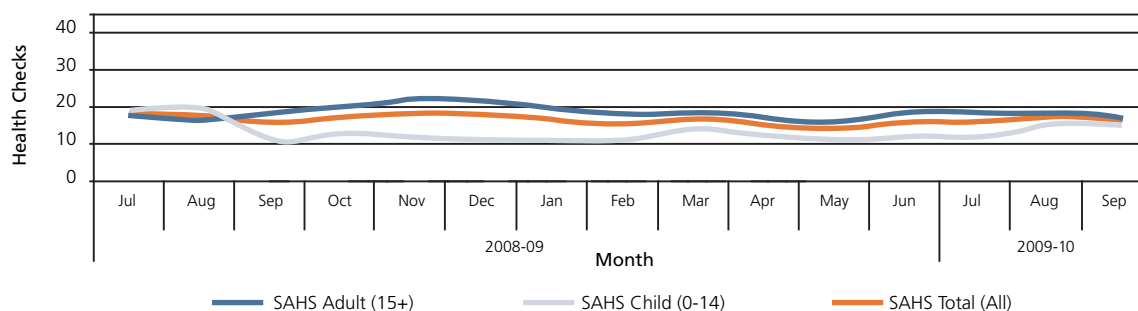
Chart 2.4.12 CNAHS – GP Health Checks (rolling 12 months) per 1,000 people, PA KPI 3.07/SAHSP SD 4



Abbrev: CNAHS (Central Northern Adelaide Health Service)

Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

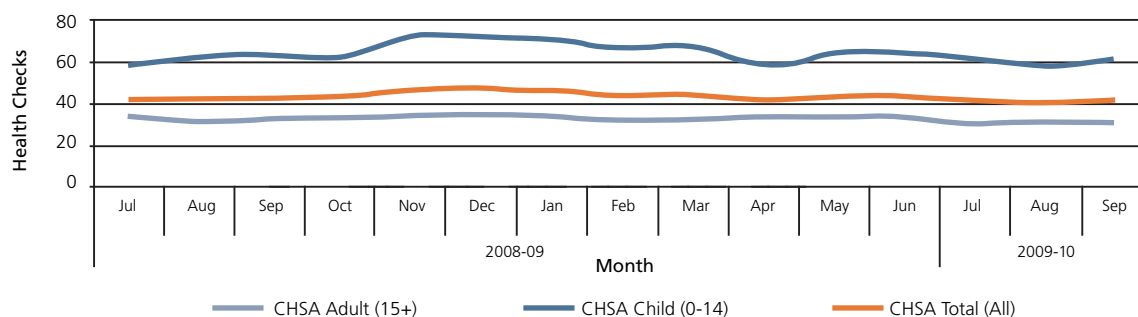
Chart 2.4.13 SAHS – GP Health Checks (rolling 12 months) per 1,000 people, PA KPI 3.07/SAHSP SD 4



Abbrev: SAHS (Southern Adelaide Health Service)

Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Chart 2.4.14 Country – GP Health Checks (rolling 12 months) per 1,000 people, PA KPI 3.07/SAHSP SD 4



Abbrev: CHSA (Country Health SA)

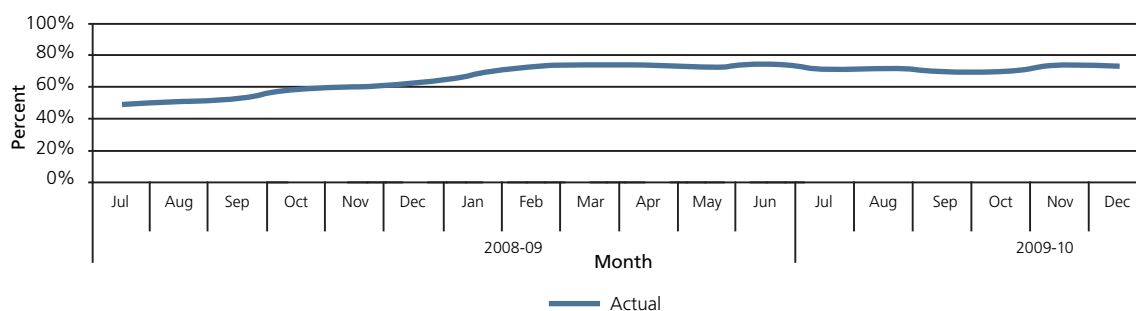
Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

Number of Family Home Visiting Contacts for Aboriginal People

The number of Aboriginal families receiving sustained home visiting services steadily increased during the period July 2008 to early 2009. The number of families then steadied and while a marginal decrease is evident in early 2009-10, the level has remained above 70% during this period.

SA Health reported that just over 75% of Aboriginal families offered the home visiting service are currently taking it up (see Chart 2.4.15).

Chart 2.4.15 CYWHS – Vulnerable Aboriginal families with young children accepting sustained home visiting services – YTD, SAHSP SD 4



Source: SA Health, Portfolio Performance Review Committee Report (February 2010)

SA Health reported that it has a number of effective linkages with other government departments to develop whole of government strategies focusing on Aboriginal early childhood issues, including child neglect and abuse. It links with other agencies (including Education, Families and Communities, and the Attorney General's Department) to progress this work.

SA Health also provides a number of promotional and preventive programs across South Australia to reach Aboriginal people that target lifestyle risk factors. Examples include:

- > OPAL: A mainstream community-based childhood obesity prevention program involving comprehensive social marketing, along with a variety of programs and activities to support healthy eating and physical activity. The HPC was not provided with specific activities within the OPAL program that target Aboriginal people.
- > Healthy Ways: A program which through employment of dietitians and Aboriginal Health Workers in selected Aboriginal communities focuses on improving nutrition for Aboriginal mothers, babies and young children as well as supporting positive child development.
- > Statewide Aboriginal Health Worker Training Initiative: An Aboriginal Health Worker training package to enhance their skills in promoting good nutrition, adequate physical activity and healthy weight among Aboriginal people.
- > The Wakefield Youth Alcohol Diversion (YARN): In the 24-month pilot period of YARN, 132 individuals were diverted on 141 occasions. The learning resulting from the evaluation of YARN has been used to develop the Early Intervention Pilot Program (not yet finalised).
- > Smoke-free Pregnancy Project (funded by DASSA and delivered by Quit SA): This program works with maternal health services to increase the incidence of smoke-free pregnancies particularly among Aboriginal women and their families.
- > Clean Needle Program: Focuses on reducing the spread of blood borne viruses including HIV, hepatitis B and hepatitis C through diversified models of service delivery to marginalised people who inject drugs.
- > The Aboriginal Tobacco Control Project: Outcomes expected from this project include:
 - An increased number of Aboriginal Health workers trained to provide brief intervention on smoking cessation
 - An increased number of quit smoking brief interventions provided to Aboriginal people through health and community services
 - An increased number of Aboriginal health and community agencies adopting a comprehensive approach to tobacco control, which incorporates actions to support quit smoking, and achieve smoke-free environments for both staff and clients.

Several of the initiatives mentioned involve Aboriginal Health Workers (AHW). The percentage of AHWs who smoke/quit in all these programs could be a useful indicator of progress.

Community Engagement

We will work with other government agencies and the community to address the environmental, socioeconomic, biological and behavioural determinants of health, and to achieve equitable health outcomes for all South Australians... SAHSP p.3

1. What did SA Health commit to do?

a. Strategic Position

The South Australian Government is committed to effective community engagement with *South Australia's Strategic Plan 2007* (SASP) seeking to foster sustainable, inclusive and involved communities.⁴

SA Health, as the lead agency for achieving the health targets in SASP, recognises the importance of processes which effectively engage with individuals and groups who have an interest in how the health system operates.⁴ This has been identified as a key method for achieving the four priority strategic directions set out in the *SA Health Strategic Plan 2008-2010* (SAHSP).³

Through the SAHSP, SA Health acknowledges that it is accountable for providing services to the community by managing limited resources effectively and efficiently, through transparent and accessible processes.³

Community engagement provides SA Health with an opportunity to assess the general impact its services have on members of the community, and more specifically, for individuals and groups who have cultural or specific needs.

b. Commitments Made

In recognition of the importance of community engagement, SA Health developed a *Consumer and Community Participation Guideline* (CCPG) and a *Consumer and Community Participation Policy Directive* (CCPPD) which health regions have been tasked with implementing since September 2009.^{59, 60}

The *Consumer and Community Participation Guideline* sets down SA Health's general approach to community engagement including the adoption of key principles ratified by the Minister for Health in 2006. These are:

- > **Consumer Voice** – all people, not only the most influential or loudest, should have the opportunity to be involved in decision making activities that may affect their own health and wellbeing
- > **Access and Equity** – everyone has a right to access and receive information and education about their health and wellbeing in a way that meets their individual needs
- > **Transparency** – it is critical to be open and honest when communicating with consumers and the community. Non negotiables should be explicitly stated up front
- > **Flexibility** – staff needs to be flexible and clear about the type of participation to be used in order to optimise consumers' capacity and availability and the likely impact of the process
- > **Diversity** – it is important to support a diverse range of consumer and community participation opportunities
- > **Timeliness** – involve consumers and the community at the beginning, not towards the end
- > **Benefits of Participation** – local, national and international evidence confirms that effective consumer and community engagement strategies benefit both health services and consumers
- > **Supporting Participation** – resources are crucial to enabling or restricting appropriate participation
- > **Capability Building for Consumers and Staff** – community and staff should have opportunities to gain new skills and knowledge

- > **Feedback** – there must be timely feedback to consumers and the community on any decisions made during their participation
- > **Evaluation** – consumer and community participation strategies must be monitored and evaluated to enhance service improvement and organisational learning.

(CCPG p.2-3)

By working in accordance with the principles outlined above, SA Health aims to ensure accountability for community participation.

In addition to the principles, in the *Community Participation Policy Directive* SA Health committed to:

- > Ensuring there are mechanisms in place to actively engage with consumers and the community to identify their needs and develop appropriate services
- > Partnering with consumers and the community in the planning, implementation and evaluation of its service
- > Building a culture within the organisation that is responsive to the differing perspectives and needs of a diverse range of consumers and community members
- > Providing accessible, timely participation strategies that are relevant to a broad range of consumers and the community
- > Developing a culturally responsive health system.

(CCPPD p.1)

Furthermore, SA Health's *Community Participation Policy Directive* establishes the monitoring and compliance requirements by which the system will assess itself on an annual basis. In doing this SA Health has established standards by which all organisations and services will be audited. These standards require that:

- > All consumers:
 - Have access to high quality care and treatment
 - Have access to privacy and confidentiality around care and treatment
 - Can participate in decisions and choices about their individual care and treatment
 - Give informed consent to decisions and choices about their individual care and treatment.
- > Consumers and the community are involved in priority-setting, development, planning, implementation and evaluation of health services
- > Consumers and the community are well informed and supported in order to participate in priority settings, development, planning, implementation and evaluation of health services on behalf of their communities
- > SA Health employees or persons who provide health services on behalf of SA Health understand and respect the role of consumers and ensure processes are in place for their support
- > Appropriate resources are provided for education and training of employees and consumers on consumer engagement and participation.

(CCPPD p.3)

2. How did SA Health Perform?

While the release of the Consumer and Community Participation Guideline and Policy in late 2009 is a positive step, it is important that implementation is regularly monitored as part of the overall evaluation of its effectiveness in achieving improved public participation.^{59, 60} It is difficult to foresee how the health outcomes planned for South Australians (including those from at risk populations) can be achieved without effective ongoing engagement with community organisations, in relation to service development, delivery and evaluation.

Over the next four years, the HPC will review the effectiveness of SA Health's Consumer and Community Participation Guideline and Policy Implementation.^{59, 60} In particular, the HPC will be interested in the development of a more robust, timely, participative, and equitable approach.

The HPC believe that improvements in community engagement effectiveness will be achieved when:

- > The community raises issues of importance and is confident that input is valued
- > South Australians are better informed about, and more involved in, shaping SA Health's policies, programs and services
- > South Australians are routinely offered significant opportunities to take part in SA Health's decision-making and programming
- > SA Health's planning better reflects the views of South Australians' communities.

Overall Findings

31. The release of SA Health's Consumer and Community Participation Guideline and Policy in late 2009 marked a positive step towards increasing system wide public participation in health. To-date, SA Health's pursuit of community engagement as a core method of achieving all four strategic directions has not been robust or effective.

SA Health advised that in 2009, the Consumer and Community Participation Policy Directive was released with the aim of bringing together some nine existing policies into the one framework to provide a consistent approach.⁶⁰ The HPC noted the principles on which SA Health's policy was based were agreed, circulated and endorsed by the Minister for Health in 2006, yet it has taken SA Health another three years to develop policy documents.

Regional Health Services are required to report annually on implementation of the policy directive and compliance with the standards under the current Performance Agreement. SA Health has indicated that the policy's implementation evaluation is scheduled for December 2010.

The HPC recommends the application of the policy be broadened beyond the current focus on quality and safety issues to ensure the range of strategic priorities for the system are adequately addressed. It will then be possible to put into effect a system wide approach to community participation in the planning, implementation and evaluation of programs relating to all four SA Health strategic directions.

32. Stakeholders involved in engagement activities reported limited access to relevant information (including the data) on how the system reviews and improves its services and systems.

SA Health indicated that clinical governance improvement strategies have been supported with the establishment of Statewide Clinical Networks across a wide spectrum of the system. In support of this, SA Health provided the following examples:

- > Complaints to the Health and Community Complaints Commissioner are monitored regularly using the SA Health Consumer Feedback and Complaints Management Toolkit. The Incident and Complaint Management Tool is also used.^{61, 62}
- > A patient survey was introduced in 2008 aimed at monitoring consumer satisfaction and as a result of this survey, informed consent is being reviewed.
- > Work is being undertaken with the SA Consumer and Community Participation Advisory Committee and the SA Open Disclosure Advisory Committee to identify a strategy for improvement of processes for open disclosure, which will be rolled out during 2009-10.

Professional organisations consulted by the HPC perceive that Statewide Clinical Networks and advisory committees tend to work in isolation and remain as an advisory body to the operations of the health system with little or no influence over the strategic direction of SA Health.

SA Health indicated that the eleven Statewide Clinical Networks represent key specialties and population groups including high prevalence conditions, hence these are influencing a considerable proportion of the care provided by the system. Details of any evaluation regarding the effectiveness of the networks will be required by the HPC for future reporting.

Consulted stakeholders reported to the HPC that access to information that either relates to monitoring or the evaluation of SA Health's strategic initiatives is very limited. A number of stakeholders discussed the difficulties experienced in trying to engage with SA Health and indicated the limited sharing of data between SA Health and NGOs as an example.

For other stakeholders the quality of data remains an issue. These stakeholders were critical of SA Health's failure in informing communities about what it is doing to improve its systems. The circulation of information to a number of at risk populations, in particular Aboriginal people, and those from a CALD background, was also considered an issue.

In relation to consumer feedback, SA Health indicated that in January 2010 systems that provide a framework of clear governance, including individual and health service responsibilities in the management of consumer feedback and complaints, were introduced. The framework establishes mechanisms for using complaints and consumer feedback to improve services.

The HPC was unable to determine how SA Health develops and implements strategies to change trends evidenced by consumer complaints. SA Health indicated that complaints to the Health and Community Services Complaints Commissioner are monitored regularly and the HPC looks forward to reviewing the systemic changes that occur in response to complaints and/or feedback received.

33. There are examples of individual regions, units and services that have implemented community and stakeholder engagement processes. There is little evidence of SA Health developing an overall strategic approach to its relationships with community organisations and others, for the purpose of achieving its goals and demonstrating its accountability.

SA Health reported that it undertakes a wide range of engagement activities. Health Advisory Councils (HACs) have been established in Country SA to provide input and advice on policy, programs, services and procedures that will better serve local communities. The Safety and Quality in Health Care Council's Consumer and Community Advisory Committee has broad representation from community peak organisations and health consumer advisory structures, and provides advice on the development of programs.

Other examples given by SA Health on community engagement activities included:

- > SA Health's ongoing engagement with the Health Consumers Alliance (HCA)
- > A number of community advisory committees that engage with senior executives in each region on strategic health matters on an 'as needed' basis
- > Examples of how SA Health engaged relevant community representatives over a particular plan, such as the former SAHS Aboriginal Specific Health Improvement Plan and the Older Person's Service Delivery Framework.

SA Health also indicated that it engages with a number of government agencies to implement the *Health in All Policies* agenda.^{14, 15} The Flinders University has been commissioned to evaluate each project in relation to how well the partnership functioned, the project outcomes, the efficacy of the 'health lens' analysis and the impact on SASP implementation plans and other key policy documents.⁴

The HPC positively acknowledges SA Health's support for the HCA, its ongoing engagement of the Country HACs, the collaboration with the universities and the cooperation with other government and NGOs, particularly in relation to the *Health in All Policies* projects.^{14, 15}

Many stakeholders consulted by the HPC reported that SA Health has in some instances failed to appropriately, or adequately, consult with NGOs and communities who are not traditional partners of SA Health. In some instances, there were reports of communities who were directly or indirectly affected by service changes, who had not been consulted.

As a result of consultation with stakeholders and information provided by SA Health, the HPC found no evidence to support that SA Health has an effective strategic framework for community/stakeholder engagement. The HPC recommends SA Health develop a framework that establishes a consistent best-practice approach for the strategic engagement of key community/stakeholders including a step-by-step guide of the engagement planning process.

In response to HPC's preliminary review assessment, SA Health reported that the Mental Health Unit undertook a statewide consultation process to develop its Aboriginal Health Impact Statement.⁵⁵ The HPC noted the proactive approach of the Mental Health Unit that has resulted in the issues raised by the Aboriginal community/stakeholders being incorporated into the Action Plan, guiding the changes necessary within South Australia's mental health services and systems of care. The HPC noted this as an example of what can be achieved by having a community/stakeholder engagement plan embedded in the strategic planning process.

34. SA Health's support for the Health Consumers Alliance is acknowledged, but is insufficient. Representation is only one part of and one indicator of engagement. It is possible to have substantial representation and limited engagement. Engagement does not appear to be a core enabler for health.

SA Health's approach to community engagement is gradually advancing with the development of policy, the funding of peak bodies and the provisions of training. Stakeholders consulted by the HPC, including Aboriginal representatives, were generally positive about the operation of the Country HACs and were of the view that they are having some useful influence through these processes. The HPC will be reviewing the effectiveness of the Country HACs governance arrangements in 2011 as required under the *Health Care Act 2008*.¹

There are many examples of sporadic activity that demonstrate some willingness to consult with community representatives and other relevant stakeholders at the individual program level. From a system wide perspective, the HPC noted that SA Health's primary focus has been to provide training for consumers to sit on departmental committees. The HPC views this as only a very limited aspect of community engagement.

Engagement with the community and with community agencies other than the HCA about program planning, development, implementation and evaluation appears to be non-existent. The stakeholders the HPC consulted indicated that as consumer representatives they have variable influence in the Statewide Clinical Networks, although many have participated in training.

These stakeholders expressed frustration with SA Health's approach to engagement, stating that there is often no consultation on major changes, such as the *GP Plus* and the first country Health Care Plan. There is a tendency to involve community and stakeholders after decisions are made.⁶ Stakeholders generally believe that SA Health does not have an effective engagement approach, and perceive that community engagement training is directed to individuals representing the community and not SA Health personnel. Stakeholders expressed the view that the approach is not systematic and well developed, and that the principles set down in guidelines are often not applied. Stakeholders representing Aboriginal and CALD communities expressed frustration at SA Health's lack of engagement following decisions.

In summary, relevant stakeholders and community representatives indicated that it is difficult to have the voice of rural and remote consumers heard across the system. For the key stakeholders the HPC consulted, the most frustrating aspects of SA Health's community engagement processes are summarised as follows:

- > Lacking a department wide implementation plan for community engagement to assist policy development and program implementation.
- > Providing minimal opportunities for communities and other stakeholders, to engage and contribute to the identification process that leads to priority setting that results in negotiated policies and programs, which are supported by all.
- > Giving limited time for community and stakeholders to respond to proposed plans, programs and other initiatives.
- > Giving limited feedback by SA Health in response to community concerns. When it is available, it is not sufficient.
- > Lacking in understanding shown by SA Health representatives of the key points made by community and stakeholder groups resulting in these issues not being responded to in the policies and programs that are developed and implemented.

Conclusions

This section summarises the HPC conclusions and findings on how SA Health is meeting the key objectives and targets it has set within the 2008-2010 strategic directions to improve health outcomes for South Australians.

In reflecting on the overall results of the review, the HPC makes the following points:

There are good results in many areas...

1. The majority of South Australians are living longer in good health

The general health of the South Australian population compares favourably with the rest of Australia and many other countries. Both life expectancy and the length of life lived in good health, are increasing.

While the health of South Australians is improving, significant areas of premature and chronic disease, injury and mortality remain in the community. Considerable disparities in health status persist across population groups, particularly Aboriginal people. Chronic conditions including asthma, chronic obstructive pulmonary disease, renal disease, diabetes and heart failure are creating increasing health burdens in the community and present major challenges for the health system.

As it is estimated that nearly a third of all causes of deaths in Australia are amenable to health care interventions, there is clearly further scope for the health system to generate improvements in the health status of South Australians.

2. The SA health system is changing to meet future health needs

SA Health is continuously improving the public health system to respond to future health care needs. While the SA public health system has much strength, like other health systems worldwide, it is under pressure to respond to increasing demands arising from significant demographic, cultural, economic and social changes as well as changes in health care delivery and technology.

SA Health is tackling these challenges by undertaking major reforms to the health system. During 2008-2010, there has been significant activity across the whole system to support the achievement of these strategic objectives. These reform initiatives are being implemented in the challenging context of increasing demand for services, health workforce shortages, efficiency reviews, regional governance restructures and the emerging national health care reforms.

In addition to the SAHSP, four other documents define key elements of the SA Health reform approach – *South Australia's Health Care Plan 2007-2016 (SAHCP)*, *GP Plus Health Care Strategy 2007 (GP Plus) the Strategy for Planning Country Health Services in SA* and the *Stepping Up: A Social Inclusion Action Plan for Mental Health Reform 2007-2012 Report (Stepping Up)*.

3. SA Health is making progress in improving services to the SA community

On any day in 2009-10, on average 1049 people were admitted to public hospitals, 1515 people were treated in accident and emergency departments, while 5412 people were seen in outpatient clinics. Against this backdrop of increasing activity, SA Health has undertaken the following service improvements. It has:

- > Strengthened its focus on health protection and promotion through its efforts in tackling health risk factors as early as possible and improving the services outside the hospital setting
- > Increased avenues for illness prevention and early intervention that improve early childhood health outcomes by targeting risk factors in pregnant women
- > Developed new models of mental health care in line with Social Inclusion *Stepping Up* recommendations
- > Worked to improve the safety culture and monitored adverse events within the public hospital system
- > Invested in capital projects to improve hospital and health service infrastructure.

4. Health services in the community are taking shape

There is evidence of substantial activity and commitment in the development of a wide range of plans, strategies and programs to strengthen primary health care. SA Health has taken a strategic approach in concentrating its focus on major health risk factors and chronic disease management to provide continuity of care within the system, thereby achieving alignment with the *South Australia's Strategic Plan 2007* (SASP) targets. SA Health's efforts to strengthen primary health care rely heavily on *GP Plus*. This is seen as a 'linchpin' in the development of a better-integrated and responsive health system that aims to reduce the need for hospitalisation, increase client self-management and improve health outcomes.

Some new programs are in the early stages of implementation and have not yet demonstrated significant health outcomes or system improvements, including linkages across primary health care and other parts of the system.

The total public hospital separations (metropolitan and country hospitals) were up 2.27% in 2009-10, which is just over the statewide target of holding growth to 2%. This is compared with average annual increase of 3.5% for the previous three years. SA Health attributes this result to the impact some *GP Plus* programs are having in reducing hospital separations across a number of service areas for some selected conditions.

SA Health has demonstrated a commitment to achieving mental health reform with its infrastructure programs and the introduction of a recovery focused stepped model of care that seeks to strengthen community care and support.

5. A strong focus on maintaining a sustainable and safe hospital sector

SA Health is focused on achieving greater sustainability in the delivery of health services. It has made specific progress with improved access to elective surgery, emergency care and reduced length of stay in acute care.

There have also been significant efforts to enhance hospital care through capital infrastructure programs such as the planned new Royal Adelaide Hospital and Glenside projects, and new consumer focused models of care. Other initiatives focused on strengthening the safety and quality of services, and workforce reform.

SA Health has focused on measuring safety and activity in the hospital sector. Whilst this is important, the perspectives and experiences of consumers are equally important in determining the impact and quality of health care services.

...While achieving results in other areas remains a challenge

It would appear there is less focus on developing incentives to improve service delivery through reflection on measured patient outcomes or processes of clinical care. The HPC considers that the systematic collection and analysis of client data and information on the client/patient's experience and quality of care outcomes in the health system are not well developed.

6. A greater focus on continuity of care needed

Continuity of care is a challenge that all Australian health care systems are dealing with. An efficient and effective health system needs to create a model of integrated care if optimum health outcomes are to be achieved in an efficient manner. The lack of integration and communication with providers, within and across services, in both the public and private sectors, has resulted in service gaps, duplication and delays in care. Service efficiency, safety and consumer satisfaction are all at risk of compromise.

The HPC notes that there are some early signs that hospitalisation for some chronic conditions is decreasing (for example, diabetes complications) suggesting continuity of care might be improving for people with these conditions.

Whilst individual episodes of care might generally be well handled, it is at points of clinical handover and at interfaces with different services in the system, that continuity of care is not monitored well.

The HPC found information technology connectivity was underdeveloped and stakeholder feedback suggested that effective communication was regularly hampered by delays in transfer of information.

7. Inadequate alignment between strategic intent and performance monitoring

A strong performance reporting and review culture at the executive level is noted. However, the HPC found that the majority of performance measures reviewed at this level were more focused on activity and outputs rather than the effectiveness and outcomes of the system.

In addition, the HPC considers that the existing measures are not well aligned with the strategic intent of SA Health. This made it difficult to obtain relevant data and information that demonstrated progress attributable to the strategic intent of SAHSP during the timeframe under review.

The HPC found an indirect connection between the long-term targets established under the SAHSP and the operational targets routinely monitored.

The amount of available data is significant but is not sufficient for determining the quality of health care outcomes.

The development of performance measures that demonstrate effectiveness and system outcomes is challenging, however in the HPC's view, this is essential to the achievement of greater public accountability and system improvement.

8. More dynamic community relationships needed

SA Health has established Health Advisory Councils in country regions and continues to support the Health Consumers Alliance. The Chief Executive meets regularly with key stakeholders and there are examples of individual regions, units and services having implemented community engagement processes.

However, there was limited evidence of SA Health developing an overall strategic approach to its relationships with key stakeholders, community organisations and consumers.

While the release of the Consumer and Community Participation Guideline and Policy in late 2009 is a positive step, it is important that implementation be regularly monitored as part of the overall evaluation of its effectiveness in achieving improved public participation. Achievement of planned health reforms (including those focused on 'at risk' populations) will require effective community engagement by SA Health in service development, delivery and evaluation.

9. 'One size does not fit all' for South Australia's diverse population

South Australia has a diverse population with a range of health care needs. SA Health is progressively implementing statewide clinical service plans that include specific strategies to meet the different health care needs of diverse populations within SA.

This is a positive development, as information provided by some stakeholders suggests that SA Health's services have not been adequately responsive to the differing needs of particular population groups. They include individuals from low socioeconomic backgrounds, culturally and linguistically diverse (CALD) communities, refugees, people with disabilities, people living in remote and rural communities, the aged, individuals with mental health illnesses and Aboriginal people.

SA Health's 2008-2010 performance target of improving Aboriginal health lacked an effective plan; hence implementation appeared spasmodic and was devoid of evidence relating to evaluation and significant achievements.; The HPC views the release in November 2010 of the *Aboriginal Health Care Plan 2010-2016* (AHCP) as a promising development.

Aboriginal health outcomes remain unacceptable and there is limited access to services that are perceived by Aboriginal people to be culturally appropriate and relevant to their needs. While there were some encouraging instances of program successes, the overall achievement of improved health outcomes for Aboriginal people was not demonstrated.

SA Health has advised that it expects its involvement in the *National Indigenous Reform Agreement (Closing the Gap)* partnerships to deliver improvements in the future.

There is also need for additional focus on addressing mental health issues for young people, CALD communities, refugees and Aboriginal people if significant health outcomes are to be achieved.

During the next four years the HPC expects to see a strong, coordinated system for mental health care established that implements the *Stepping Up* principles for all people with mental illness.

There was some evidence that SA Health has been developing statewide clinical service plans for specific health conditions that are designed to be more responsive to the needs of the specific populations mentioned earlier.

Next Steps

Over the next four years, the HPC will actively build on this baseline review and the lessons learnt from ongoing analysis.

The most important priority for the HPC in its role as special adviser to the Minister for Health is the usefulness of its reports in contributing to improvements in the health system and health outcomes for South Australians.

The HPC will continue to refine its review processes so that it provides robust and coherent evidence based analysis of the health system's performance to South Australians every four years.

Summary of Findings

Strengthen Primary Health Care

Focus on health protection and promotion (Objective 1.1)

1. SA Health has strengthened its focus on health protection and promotion through its efforts in tackling health risk factors as early as possible and improving services provided outside the hospital setting. The HPC notes the ongoing monitoring of many of these initiatives and acknowledges SA Health has plans to evaluate their impact on population health outcomes.

Provide effective avenues for prevention and early intervention (Objective 1.2)

2. SA Health has increased avenues for illness prevention and early intervention that improve early childhood health outcomes by targeting risk factors in pregnant women through the Universal Contact Visit and Family Home Visiting Programs. Whilst significant efforts have been noted, it is too early to determine the effectiveness of these programs in producing improved health outcomes.

Facilitate effective coordination and continuity of care (Objective 1.3)

3. Although a variety of programs are operating across the health system to improve continuity of care, particularly for those suffering from a chronic disease, the HPC consider performance measures currently available to assess performance in this area to be insufficient. A greater focus on measuring patient experiences across the continuum of care is needed.

Minimise the burden of disease on the health system (Objective 1.4)

4. The investment in *GP Plus* strategies over the last three years represents a significant commitment to strengthening primary health care in South Australia. Sound evaluation of these strategies will be required.⁶
5. There are signs and early trends that some of the *GP Plus* strategies are having an impact on service utilisation for selected chronic conditions, with preliminary evidence that they are reducing pressure on the public hospital system.⁶

Provide appropriate services closer to where people live (Objective 1.5)

6. While the development of hospital networks, Intermediate Care Centres for mental health clients, *GP Plus* centres and related services and programs are progressively strengthening services in metropolitan areas, planned service developments in rural and remote communities are in their formative stages and not ready for evaluation at this point.⁶

Enhance Hospital Care

Provide a coordinated hospital system across metropolitan and country regions (Objective 2.1)

7. Initial steps have been taken toward the planned clinical service reconfiguration across the hospital system with a number of the remaining changes dependent on future capital developments. The Statewide Clinical Networks offer significant potential for clinical service improvements and enhanced collaboration; however, some are still in their formative stages.
8. Although ongoing efforts to improve continuity of care across and within health services are noted, their overall effectiveness is not demonstrated at this stage. The timely transfer of client/patient information requires greater rigour as consulted stakeholders indicated that information was not provided when required, which affected the ability to provide optimal care. A strategic review of information exchange at points of clinical handover would be valuable.

Improve health outcomes and safety and quality for people in hospital care (Objective 2.2)

9. While substantial work is underway to improve the safety culture and to monitor adverse events within the public hospital system, further work to both understand and improve patient experiences and clinical effectiveness of in hospital and out of hospital care is indicated.
10. Structural incentives to improve hospital service quality, based on measured patient outcomes or processes of clinical care, were not clearly demonstrated.

Improve efficiency and effectiveness of hospital care (Objective 2.3)

11. The focus on improved efficiency has resulted in SA Health having the lowest *Cost per Casemix-Adjusted Separation* in Australia. In part, this is attributable to reduced lengths of stay and increased day of surgery rates. This significant achievement does however require evaluation in the context of relatively high public hospital bed utilisation and out of hospital care provided by carers.
12. Continued efforts to improve effectiveness were difficult to assess, particularly in relation to the quality of care and patients' outcomes for priority population groups.

Reduce dependency on hospitals (Objective 2.4)

13. The evidence suggests a containment of demand escalation and more appropriate treatment outcomes, significantly in access to primary health care and out of hospital services. However, it is important that in the face of escalating demand for hospital services, investment continue in primary health care and out of hospital services, notwithstanding the long lead times for demonstrable success.

Provide an attractive learning environment for health professionals (Objective 2.5)

14. There is evidence that alignment of workforce development with health care reforms has commenced with the introduction of new roles (for example, nurse practitioner, allied health assistant and physician assistant) now underway.
15. While significant improvements in professional development opportunities for hospital medical staff are noted, indications of providing similar opportunities to nursing and allied health staff are less apparent.
16. The development of a new medical research facility should further strengthen overall research in South Australia.

Reform Mental Health Care**Provide integrated services in community, residential and hospital settings (Objective 3.1)**

17. New models of care were developed in line with *Stepping Up* recommendations.³⁷ Plans to establish community mental health centres as hubs for mental health integration are progressing with the aim of improving access to appropriate care.
18. It is unclear how SA Health plans to measure and evaluate the system wide access improvements and delivery of recovery outcomes achieved because of implementing integration strategies.

Improve access to appropriate care at an early stage (Objective 3.2)

19. The information provided by SA Health underpins the priority given to early identification and provision of services particularly in relation to young people and people in aged care. There is evidence to indicate a priority focus on improving capacity for country services to manage the broad spectrum of mental health presentations locally. These are in line with the *Stepping Up* recommendations and the focus of SAHSP.^{3, 37}

Improve mental health services better systems of care (Objective 3.3)

20. Many activities were developed to improve systems of care and in some cases, these were implemented. However, it is difficult at this early stage to assess the impact of these initiatives. The focus thus far has been on capital infrastructure development and the HPC received minimal evidence to indicate access to services for consumers and carers has improved.

Improve inter-agency coordination of service delivery to people with a mental illness who have high needs (Objective 3.4)

21. Based on the information provided, it is difficult to assess how current inter-agency coordination initiatives have affected clients, in particular those with complex and chronic needs.

Increase community understanding of mental health (Objective 3.5)

22. It is not clear how the outcomes of mental health promotional programs are assessed, particularly the objective of stigma reduction. However, the HPC noted positive community feedback on SA Health's efforts to build community knowledge and skills regarding a number of mental health conditions.

Improve the Health of Aboriginal People

Reduce Aboriginal ill health (Objective 4.1)

23. Reducing the health outcomes gap in mental illness, injury, diabetes, renal and heart disease remains a significant challenge for the health system.
24. SA Health's 2008-2010 performance lacked an effective strategic planning and evaluation focus; therefore, implementation appeared spasmodic, lacked evidence of evaluation and significant achievements.
25. Although ongoing efforts to reduce Aboriginal ill health were noted, their overall effectiveness is unclear at this stage.

Develop a culturally responsive health system (Objective 4.2)

26. Community engagement is sporadic. More effort is required to achieve a culturally responsive service connected to Aboriginal communities and their health and wellbeing organisations.
27. Efforts were made to increase the cultural competence of the workforce but outcomes are unclear and more needs to be done to ensure competence levels are achieved and maintained across the workforce.
28. Although there is evidence of some performance monitoring a more robust suite of key strategic performance measures relating to improving Aboriginal health are required.

Promote Aboriginal community health and wellbeing (Objective 4.3)

29. SA Health is actively engaged in a whole of government response (COAG) to reduce the health outcomes gap by 2031.
30. The main focus has been on a healthy start to life for children, with a secondary focus on reducing risk factors and improving chronic disease management for adults.

Community Engagement

31. The release of SA Health's Consumer and Community Participation Guideline and Policy in late 2009 marked a positive step towards increasing system wide public participation in health. To-date, SA Health's pursuit of community engagement as a core method of achieving all four strategic directions has not been robust or effective.
32. Stakeholders involved in engagement activities reported limited access to relevant information and data on how the system reviews and improves its services and systems.
33. There are examples of individual regions, units and services that have implemented community and stakeholder engagement processes. There is little evidence of SA Health developing an overall strategic approach to its relationships with community organisations and others, for the purpose of achieving its goals and demonstrating its accountability.
34. SA Health's support for the Health Consumers Alliance is acknowledged, but is insufficient. Representation is only one part of and one indicator of engagement. It is possible to have substantial representation and limited engagement. Engagement does not appear to be a core enabler for health.

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Abbreviations

ABS:NHS	Australian Bureau of Statistics/National Health Survey
ACCHS	Aboriginal Community Controlled Health Services
ACEM	Australasian College for Emergency Medicine
AHCP	Aboriginal Health Care Plan
AHCSA	Aboriginal Health Council of South Australia
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
AIDS	Acquired immune deficiency syndrome
APPO	Aboriginal Patient Pathway Officer
APY Lands	Anangu, Pitjantjatjara & Yankunytjatjara Lands (spanning an area of over 100 000 square kilometres in north-western South Australia)
ATSI	Aboriginal and Torres Strait Islander
CAFHS	Child and Family Health Service
CALD	Culturally and Linguistically Diverse
CAMHS	Child and Adolescent Mental Health Service
CCPPD	Consumer and Community Participation Policy Directive
CCPPG	Consumer and Community Participation Policy Guideline
CHSA	Country Health SA
CNAHS	Central Northern Adelaide Health Service
COAG	Council of Australian Governments
COPD	Chronic Obstructive Pulmonary Disease
CYWHS	Children, Youth and Women's Health Service
DALY	Disability Adjusted Life Years
DASSA	Drug and Alcohol Services South Australia
ED	Emergency Department
EPC	Enhanced Primary Care
ESRG	Extended Service Related Groups
EQUiP	Evaluation and Quality Improvement Program
EWBA	Eat Well Be Active
FHV	Family Home Visiting
FTE	Full-Time Equivalent
GP	General Practitioner
<i>GP Plus</i>	<i>GP Plus</i> Health Care
HAC	Health Advisory Council
HASP	Housing and Support Program
HiAP	Health in All Policies Approach
HIPs	Health Improvement Plans
HIV	Human Immunodeficiency Virus
HPC	Health Performance Council
HoNOS	Health of the Nation Outcome Scale

KPI	Key Performance Indicator
LBW	Low Birthweight
LSAC	Longitudinal Study of Australian Children
MBS	Medicare Benefits Schedule
MOU	Memorandum of Understanding
NGO	Non-Government Organisation
NHCC	National Health Call Centre
OCWRC	Organisational Change and Workforce Reform Committee
OPAL	Obesity Prevention and Lifestyle program
PHC	Primary Health Care
PPRC	Portfolio Performance Review Committee
RSI	Relative Stay Index
SA	South Australia
SAHCP	South Australia's Health Care Plan 2007–2016
SAHS	Southern Adelaide Health Service
SAHSP	SA Health Strategic Plan 2008–2010
SAMSS	South Australian Monitoring and Surveillance System
SASP	South Australia's Strategic Plan
SA MHWP	South Australia's Mental Health and Wellbeing Policy
YTD	Year-to-Date

Glossary

Aboriginal Community Controlled Health Services – Primary health care services initiated and managed by local Aboriginal communities to deliver holistic, comprehensive, and culturally appropriate care to the community which controls it (through a locally elected Board of Management).

Acute – Of relatively short duration and relatively high severity.

Adverse event – A situation in which an individual receiving health care has been harmed in some way, as a direct or indirect effect in relation to that care.

Acute Hospitals – Public and private hospitals that provide treatment or care to patients for a condition requiring immediate care or intervention. The average length of stay is relatively short.

Average length of stay (ALOS) – The average number of days patients stay in hospital; admissions and separations from hospital on the same day count as one day.

Avoidable mortality – The deaths of people aged between birth and 74-years-old, or causes that led to deaths that could have been avoided by preventative or therapeutic means.

Benchmark – A systematic approach to improving health and social care services by identifying best practice, and bringing in a program of change to improve a service beyond a known fixed point of quality or performance. It may involve comparison of local services with similar service elsewhere.

Birthweight – The weight of a newborn, immediately after birth.

Burden of disease – The complete effect of disease on society is measured by years of life lost to ill health (see YLL) and 'health' years of life lost due to disability (see YLD).

Capacity building – An approach to the development of sustainable skills, organisational structures, resources and commitment to health improvement in health and other sectors, to prolong and multiply health gains many times over.

Capacity – The totality of the levels of service provision within a local health and social care economy – beds, staffing, clinics etc (the structure) and the means by which they are used (the process) within the context of the demands experienced.

Cardiovascular disease (CVD) – Diseases of the circulatory system, including the heart, veins, arteries and capillaries; for example, myocardial infarction (heart attack), congestive heart failure, and trans ischaemic attack (stroke).

Casemix – A means of classifying hospital patients to provide a common basis for comparing cost effectiveness and quality of care across hospitals.

Cerebrovascular disease – Stroke, in which the brain is damaged by the effects of blocked, burst or malfunctioning blood vessels in the head.

Chronic – Persisting over a long period.

Chronic Diseases – Diseases and disorders characterised by being of relatively long duration and persistence, often with low-level and/or ongoing symptoms that are not immediately life threatening.

Clinicians – The totality of health professionals including nurses, allied health professionals, physicians, surgeons, general practitioners and other medical specialists.

Cohort – A group whose individuals have defined characteristics in common, such as age and risk factors, or age and gender, used in statistics to limit the parameters of a generational group for the purposes of study (for example, all children born in 1999, women within childbearing age).

COPD – The acronym for chronic obstructive pulmonary disease, a respiratory disease in which breathing becomes forced and laboured, such as in emphysema.

Early intervention – Strategies that will affect positively on the development or health status of people who are discovered to have, or to be at risk of developing, a condition or other special need.

Equity – Fairness. Equity in health means that people's needs guide the distribution of opportunities for wellbeing.

Depression – A disorder characterised by prolonged periods of sadness, despair and feelings of inadequacy, in which sufferers may experience the symptoms ranging from pronounced ennui and lack of energy, disinterest in the normal activities of life, and an inability to see an end in sight to feeling low, through to suicidal thoughts and action.

Disability – A loss or restriction of functional ability or activity, because of impairment of the body or mind.

Disability-adjusted life year (DALY) – Years of healthy life lost through premature death or living with disability due to illness or injury.

Efficient price of care – Where price equals the minimum cost of caring for a certain category of patient. That is, where the optimal set of inputs is chosen that minimises the cost of producing the best possible outcome for the patient.

Elective procedure – A procedure which is clinically necessary but which can be delayed for at least 24 hours. Sometimes referred to as a 'booked' or 'planned' procedure.

Elective surgery – Elective care in which patient procedures are listed in the surgical operations section of the Medicare Benefits Schedule, excluding specific procedures performed by non-surgical clinicians as well as some procedures where the associated waiting time is strongly influenced by factors other than the supply of services.

End of life care – End of life care is care provided to people who are living with, and impaired by, an eventually fatal condition. It is not limited by prognosis. End of life care can be provided by all health care professionals and is not limited to care provided by palliative care services or specialists.

Episode of care – A period of health care of a certain type with a defined start and end.

General practitioner – A medical professional who provides primary, comprehensive and continuing care to patients and their families within the community. (Royal Australian College and General Practitioners)

GP Plus Health Care Centres – (an SA Health initiative), have been built to complement the services offered by General Practice. The aim of these centres is to help consumers to take control of their health care, stay healthy and out of hospital. These centres form the foundation for increased support to manage chronic disease, provision of support for more in-home care and help for those who want to stay healthy.

The services offered at each GP Plus Health Care Centre are designed to meet the needs of the local community. The services work closely with general practitioners to provide a broad range of additional health care services. The focus of these services is on avoiding hospital visits or stays, and to play an important role in early intervention and prevention.

GP Plus Health Care Strategy – A strategy to provide a fully integrated and accessible health care system that increases prevention and early intervention services to promote good health.

GP Super Clinics – An Australian Government initiative, GP Super Clinics form a key element of the Australian Government's plan to build a stronger national primary care system, including a greater focus on health promotion and illness prevention and better coordination between privately provided GP services, community health and other state and territory government funded services.

The aim of GP Super Clinics is to bring together general practitioners, nurses, visiting medical specialists, allied health professionals and other health care providers to deliver better health care, tailored to the needs and priorities of the local community.

GP Super Clinics are designed to provide a high quality clinical training environment for medical, nursing and allied health professional students and new graduates, in addition to prevocational doctors and GP registrars.

Health – A term relating to the state of a person's physical, mental, and psychosocial wellbeing.

Health adjusted life expectancy (HALE) – A measure of quality of life, as well as quantity (also referred to as 'Healthy life expectancy', defined by the Australian Institute of Health and Welfare as an estimate of the average years of equivalent 'healthy' life that a person can expect to live at various stages.

Health literacy – The knowledge and skills required to understand and use information relating to disease prevention and treatment, safety and accident prevention, first aid, emergencies, avoiding health risks and staying healthy. It also refers to an individual's understanding of the services available within the health system and how to access and navigate processes to seek appropriate care.

Health outcome – A change in the health of an individual or population due wholly or partly to a preventive or clinical intervention.

Health promotion – Activities to improve health and prevent disease, often described as the process that helps individuals or communities to increase control over the determinants of health.

Health status – A description and/or measurement of the health of an individual or population at a particular point in time against identifiable standards.

Health Region – A regional area comprising one or more health services.

Health System – All health services provided to the people of South Australia.

Hospital – A health care facility established under Australian Government, state or territory legislation as a hospital or a free-standing day procedure unit and authorised to provide treatment and/or care to patients.

Incidence – The number of instances of illness, or individuals who fall ill, during a specified period in a particular population.

Indicator – A specific measure for assessing progress towards goals; a statistic or other unit of information that reflects, directly or indirectly, the performance of an intervention, facility, service or system in maintaining or increasing the wellbeing of its target population.

Infant mortality – The death of a child before his or her first birthday.

Inpatient – Person admitted to hospital or health facility.

Ischaemic heart disease – Disease characterised by reduced blood supply to the heart muscles, often because of blockages in the arteries; it may lead to angina (chest pain) and heart attack; also known as coronary heart disease.

Length of stay (LOS) – The duration of a patient's stay in hospital from admission to separation, minus any time the patient was 'on leave'. Patients admitted and separated on the same day are assigned a stay of one day.

Life expectancy (LE) – The likelihood of living an average number of further years at a particular age.

Low birthweight babies – Live birthweight babies with a birthweight less than 2,500 grams.

Median – The middle point in a series of values.

Medicare – Australia's universal health care system which provides access to free treatment as a public (Medicare) patient in a public hospital and free or subsidised treatment by medical practitioners including general practitioners, specialists, participating optometrists or dentists (for specified services only). Medicare is financed through progressive income tax and an income-related Medicare levy.

Morbidity – A term that refers both to an individual's ill health and to ill health within a population or group; usually expressed as a rate or incidence.

Mortality rate – The rate of death in a population in a given area and period of time, expressed as a ratio of deaths per 1000 people.

Non-government organisations (NGOs) – Private, not for profit, community managed organisations that receive government funding specifically for the purpose of providing community support services.

Nurse Practitioner – A nurse whose registration has been endorsed by the Nursing and Midwifery Board of Australia 2010 as a nurse practitioner under section 95 of the National Law (Nursing and Midwifery Board 2010). Registration Standard for Endorsement of Nurse Practitioners, Australian Health Practitioner Regulatory Agency.

Outcome – A measurable change in the health of an individual, a group of people or a population, which is attributable to an intervention or services of interventions.

Out-of-pocket costs – The total costs incurred by individuals for health care services over and above any refunds from Medicare and private health insurance funds.

Outpatient – Person who receives, medicate, surgical, allied health or diagnostic services who is not formally admitted to a hospital at the time of receiving the service.

Palliative care – Palliative care is specialist care provided for all people living with, and dying from, an eventually fatal condition and for whom the primary goal is quality of life.

Patient days – The number of full or partial days of stay for patients who were admitted for an episode of care and who underwent separation during the reporting period. A patient who is admitted and separated on the same day is allocated one patient day.

Performance indicators – Measures of the efficiency and effectiveness of health services in providing health care.

Perinatal – Pertaining to or occurring in the period shortly before or after birth (usually up to 28 days after).

Population health – A philosophy of promoting health and reducing the incidence of preventable disease and disability by improving access to opportunities and prerequisites for good health.

Potential years of life lost (PYLL) – Number of potential years of life lost in a population because of premature death.

Potentially preventable hospitalisations – Hospitalisations for conditions, which might be avoided if appropriate, necessary and timely care is given elsewhere.

Practice nurse – A practice nurse is a registered nurse or an enrolled nurse who is employed by, or whose services are otherwise retained by, a general practice. Practice nurses deliver primary health care in a general practice setting.

Prevalence – The proportion of the population with a disease or disorder.

Prevention (of disease or ill health) – Action to reduce or eliminate the onset, causes, complications or recurrence of disease or ill health.

Primary care – Care that provides integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practising in the context of family and community.

Primary health care – Services in the community accessed directly by consumers. It includes primary medical care (general practice), nursing and other services such as community health services, pharmacists, Aboriginal health workers, physiotherapists, podiatrists, dental care and other registered practitioners. It includes community mental health, domiciliary nursing, maternity and early childhood, child and family health, sexual and reproductive health, and other services.

Primary health care system – A system with a population focus, that addresses the social determinants of health, includes inter-sectoral approaches, focuses on health promotion, illness prevention and early intervention, ensures equitable access to health services, and has a community involvement and participation approach to health care.

Prevalence – The total number of instances of a particular disease or condition in a specified population at a defined time.

Principal diagnosis – The diagnosis established after study to be chiefly responsible for occasioning an episode of admitted patient care.

Public health – A term that variously refers to the level of health in the population, to actions that improve that level or to related study. Activities aimed at benefiting a population tend to emphasise prevention, protection and health promotion as distinct from treatment tailored to individuals with symptoms. Examples include provision of a clean water supply and good sewerage, conduct of anti-smoking education campaigns, and screening for diseases such as cancer of the breast or cervix.

Public hospital – A hospital controlled by state or territory health authority. Public hospitals offer free diagnostic services, treatment, care and accommodation to all eligible patients.

Public patient – A patient admitted to a public hospital who has agreed to be treated by doctors of the hospital's choice and to accept shared ward accommodation. This means that the patient is not charged any fees.

Risk factor – Any factor that represents a greater risk of experiencing a health disorder or other unwanted condition or event. Some risk factors are regarded as causes of disease, others are not necessarily so. Along with their opposites, protective factors, risk factors are known as *determinants*.

Risk factors – Those characteristics, variables or hazards that, if present for a given individual, make it more likely for this individual, rather than someone selected at random from the general population, to develop a disorder.

SA Health – South Australian public health system, services and agencies.

Separation – The point at which a patient's episode or care in hospital has ended, either through discharge, transfer to another health facility, death or change in episode of care.

Social inclusion – A socially inclusive society is defined as one where all people feel valued, their differences are respected, and their basic needs are met so they can live in dignity.

Socioeconomic disadvantage – A situation where one or more groups in a community has fewer financial and material resources, as measured against others within that community; individuals who are socioeconomically disadvantaged typically have reduced access to education, health, information, food and housing, and so on, compared to others of their age and gender in the same community.

Socioeconomic status – Relative position in the community as determined by occupation, income and education.

Specialist – Usually refers to a medical graduate who has undertaken a further course of study recognised by an accredited College. It may also refer to a midwife, allied health professional, pharmacist, dental/oral health professional who is an expert in a particular field of health care.

Sub-acute services – Includes rehabilitation and geriatric evaluation and management care. Some sub-acute care is colloquially referred to as 'low dependency' or 'step up' and 'step down' care, meaning that it can either precede (and potentially avoid) a hospital admission or follow an acute hospital admission. Sub-acute services also include care provided under the new Transition Care program. Most sub-acute services can be provided on either an inpatient or ambulatory basis.

Triage category – A method of indicating the urgency of the patient's need for clinical care in emergency departments. Patients are triaged into one of five categories specified in the Australian National Triage Scale.

Whole of government approach – Government initiatives to encourage closer working relationships between departments and agencies and between the levels of government to meet a common end.

Years lost to disability of illness (YLD) – A measure of the morbidity burden of disease in a population. YLDs represent a number of 'healthy' years of life lost due to disability. Disability refers in this definition to any departure from an ideal health state. Each stage of each condition is given a severity weight between 0 and 1 (for example, 0.5 or 0.3 or 1); in this severity weight 1 is the most severe. YLD are the product of the number of incident cases of the conditions in the reference period, the severity weight for the condition and the average duration in years of the condition; for example, 10 incident cases of a disease which has a severity of 0.5 and lasts on average for two years would have a morbidity burden of $10 \times 0.5 \times 2 = 10$ YLD.

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Consulted Stakeholders List

For the 2010 Review of SA Health, the HPC determined to engage the following stakeholders:

- > The Minister for Health
- > The Chief Executive SA Health and relevant SA Health Representatives
- > The Minister for Mental Health and Substance Abuse
- > The Minister for Aboriginal Affairs and Reconciliation
- > The organisations named in the *Health Care Act 2008*:
 - Aboriginal Health Council of South Australia Inc.
 - Australian Medical Association (SA) Inc.
 - Carers SA
 - Consultative Council of Ex-Service Organisations (SA)
 - Council on the Ageing (SA) Inc.
 - Health Consumers Alliance of South Australia Inc.
 - Multicultural Communities Council of South Australia Inc.
 - Regional Communities Consultative Council (SA)
 - Rural Doctors Association of South Australian Inc.
 - General Practice SA Inc. (GPSA)
 - The Flinders University of South Australia
 - The Returned & Services League of Australia (SA Branch) Inc.
 - The South Australian Country Women's Association Inc.
 - The University of Adelaide
 - University of South Australia
 - Volunteering SA and NT Inc.
- > The Australian Nursing and Midwifery Federation (SA Branch)
- > The Country Health Advisory Councils:
 - Country Health SA Board Health Advisory Council
 - Balaklava and Riverton Health Advisory Council Inc.
 - Barossa and Districts Health Advisory Council Inc.
 - Berri Barmera District Health Advisory Council Inc.
 - Bordertown and District Health Advisory Council Inc.
 - Ceduna District Health Services Health Advisory Council Inc.
 - Ceduna Koonibba Aboriginal Health Advisory Council Inc.
 - Coorong Health Service Health
 - Country Health SA Board Health Advisory Council Inc.
 - Eastern Eyre Health Advisory Council Inc.
 - Eudunda Kapunda Health Advisory Council Inc.
 - Far North Health Advisory Council
 - Gawler District Health Advisory Council Inc.
 - Hawker District Memorial Health Advisory Council Inc.
 - Hills Area Health Advisory Council Inc.
 - Kangaroo Island Health Advisory Council Inc.
 - Kingston/Robe Health Advisory Council Inc.
 - Leigh Creek Health Services Health Advisory Council
 - Lower Eyre Health Advisory Council Inc.
 - Lower North Health Advisory Council Inc.
 - Loxton and Districts Health Advisory Council Inc.
 - Mallee Health Service Health Advisory Council Inc.
 - Mannum District Hospital Health Advisory Council Inc.
 - Mid North Health Advisory Council Inc.
 - Mid-West Health Advisory Council Inc.

- Millicent and Districts Health Advisory Council Inc.
- Mount Gambier and Districts Health Advisory Council Inc.
- The Murray Bridge Soldiers' Memorial Hospital Health Advisory Council Inc.
- Naracoorte Area Health Advisory Council Inc.
- Northern Yorke Peninsula Health Advisory Council Inc.
- Penola and Districts Health Advisory Council Inc.
- Pika Wiya Health Advisory Council Inc.
- Port Augusta, Roxby Downs, Woomera Health Advisory Council
- Port Broughton District Hospital and Health Services Health Advisory Council Inc.
- Port Lincoln Health Advisory Council
- Port Pirie Health Service Advisory Council
- Quorn Health Services Health Advisory Council
- Renmark Paringa District Health Advisory Council Inc.
- South Coast Health Advisory Councils Inc.
- Southern Flinders Health Advisory Council
- Waikerie and Districts Health Advisory Council Inc.
- Whyalla Hospital and Health Services Advisory Council
- Yorke Peninsula Health Advisory Council Inc.
- > The organisations comprising the Human Services Peak Bodies Forum
 - Aged & Community Services SA & NT Inc. (ACS SA & NT)
 - Association of Major Charitable Organisations (AMCO)
 - Association of Non-Government Organisations of SA Inc. (ANGOSA)
 - Child and Family Welfare Association of South Australia (CAFWSA)
 - Community Housing Council of SA Inc.
 - Community and Neighbourhood Houses and Centres Association Inc. (CANH)
 - Connecting Foster Carers
 - Create Foundation
 - Homelessness SA
 - Mental Health Coalition of SA Inc.
 - National Disability Services
 - SA Council of Social Service (SACOSS)
 - South Australian Network of Drug and Alcohol Services (SANDAS)
 - Shelter SA
 - Youth Affairs Council of SA (YACSA)
 - Carers SA
 - Council on the Ageing (SA) Inc.
 - Health Consumers Alliance of South Australia Inc.
 - Volunteering SA and NT Inc.
- > Ministerial and SA Health Advisory Councils
 - Veteran's Health Advisory Council
 - The South Australian Council on Safety and Quality
 - SA Ambulance Service (SAAS) Volunteer Health Advisory Council
- > The Health and Consumer Complaints Commissioner
- > The Chair of the South Australian Social Inclusion Board
- > The HPC also engaged representatives from the following organisations:
 - Port Lincoln Aboriginal Health Services
 - Aboriginal Sobriety Group Inc.
 - Nganampa Health Council
 - The Australian Institute of Health and Welfare – Social and Indigenous Group
- > The HPC also extended an invitation to members of the Local Government Association of South Australia to provide evidence based feedback about their experiences of working with SA Health. Responses were received via a questionnaire.

For more information

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If you do not speak English, request an interpreter from SA Health and the Department will make every effort to provide you with an interpreter in your language.



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