

MEASURING THE PERFORMANCE OF CANCER SERVICES

GUEST EDITORIAL

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How do I measure the performance of cancer services? Just answer five questions:

- what am I trying to achieve?
- what tools that work do I have for achieving it?
- how can I tell whether they are doing their job?
- what data do I need to find out?
- how will I collect them?

Your objectives tell you what you are trying to achieve. They should go beyond just 'preventing cancer' or 'increasing survival' to include less readily measurable but equally as important objectives like 'increasing quality of life', 'having satisfied patients', 'increasing the equity of cancer care', and 'increasing the efficiency of cancer care'.

Increasingly, the tools that work are detailed and supported in evidence-based guidelines, like those produced by the Australian Cancer Network (melanoma, colorectal cancer, cancer genetics services, with more in the pipeline) and the National Breast Cancer Centre (early breast cancer, breast cancer pathology reporting, psychosocial care, advanced breast cancer). Knowing whether or not they are working requires the simplest and most economical set of indicators that address:

- the process, whether the tools are in place and being used the way they should be;
- the risk factors, early indicators of a successful outcome, like a reduction in smoking prevalence or an improvement in stage distribution for colorectal cancer;
- the outcomes, like lung cancer incidence, recurrence of melanoma, survival from breast cancer, and quality of life in those who may still ultimately die from cancer.

Analysis of these indicators will tell you the data that you need to collect, and more often than not these data will already be collected routinely (death data, hospital inpatient statistics, cancer registry, the NSW Health Survey), be available by way of some simple

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enhancement (abstraction of, say, breast cancer size, grade and nodal status from pathology reports notified to the cancer registry or linking cancer registry to inpatient statistics data) or by methods for which there are already ample precedents (a clinical cancer data collection, a patterns of care survey, or a survey of patients themselves).

The papers in this special cancer issue show how easy it is. Helen Moore and colleagues outline a structured and rigorous way of arriving at a parsimonious and simple set of indicators for measuring the performance of clinical services for melanoma control. Sounds difficult? Not really. It has to be done with care, but it required only two meetings of about two hours with the expert advisory group to reach a firm consensus on what should be measured. That beats endless meetings debating 'what data we should collect' and risking an uncollectable, unmanageable and often unusable data collection in the end. In other papers, Churches and Lim show what can be achieved in measuring breast cancer services through the linkage of the cancer registry and inpatient statistics collections and Kricker shows what can be done as well when data from pathology reports are added; Taylor and colleagues report the results of linkage of BreastScreen data with cancer registry data to produce interval cancer rates, the key measure of

mammographic screening performance; and Macansh shows what the Pap Test Register has to offer on performance indicators for cervical screening. In an earlier issue (*NSW Public Health Bulletin* 2001; 12 (1): 2–6), Moore and colleagues illustrated the value of the NSW Health Survey in measuring risk factors for cancer.

To move from where we are now in measuring the performance of cancer services in NSW to where, ideally, we should be still requires the introduction of standardised clinical cancer information systems in all the main cancer treatment centres in the State, which are linked to the NSW Central Cancer Registry. Requiring less development, but equally as important, in measuring and improving the performance of cancer services in NSW are:

- a regular program of surveys of cancer care 'consumers'
- a planned approach to analysis of linked cancer registry and inpatient statistics data sets
- a continued program of enhanced analysis of cancer registry data
- patterns of care surveys 'to fill the gaps' in population coverage
- continuation of full exploitation of the richness of the Cancer Registry, Pap Test Register and BreastScreen data sets. ☒

WORKING OUT WHAT TO MEASURE: MELANOMA SERVICES

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This article reports on a process to identify a priority set of indicators to measure the performance of services for melanoma, outlined in the Australian Cancer Network's *Guidelines for the Management of Cutaneous Melanoma* published in June 1997.¹ Melanoma is a major cause of morbidity in NSW. In 1998, the year for which there is the most recently available data, it was the fourth most common cancer diagnosed in NSW residents, with 1,565 cases diagnosed in males and 1,119 in females;² accounting for 362 deaths, three per cent of all deaths caused by cancer. Melanoma was the most common cancer in males and females aged 15–39 years in 1998.

The importance of reducing this morbidity and associated mortality was recognised in 1994 by the Cancer Expert Working Group when they set goals and targets for NSW to reduce the incidence of, and mortality due to, melanoma.³ To assist in achieving these goals, a health

outcomes approach was applied to melanoma to identify areas for intervention across the continuum of care from prevention through to treatment and palliation or rehabilitation.⁴

HEALTH OUTCOMES APPROACH TO REDUCE MORBIDITY AND MORTALITY FROM MELANOMA IN NSW

Specific opportunities to reduce morbidity and mortality due to melanoma are presented in Figure 1. In general, the intervention points that will produce health gains for the population and for people with melanoma are:

- preventing the development of melanoma by reducing exposure to known causal agents: for example, high intensity intermittent exposure to UV radiation;
- detecting and diagnosing cutaneous melanoma as early as possible;
- giving appropriate psychosocial support to patients with suspected or confirmed melanoma and their families;
- managing primary operable melanoma in accordance with international best practice;
- managing advanced melanoma in accordance with international best practice;
- providing best practice palliative care to those who will die from melanoma.

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