Chapter 11: Health management (HM)

The health management chapter

Health management is concerned with the management of diseases, illnesses and injuries using a range of services (promotion, prevention/early detection and intervention) in a variety of settings (for example, public hospitals, community health centres and general practice). This chapter reports on the management of breast cancer and mental health, and represents only some of the activities of Commonwealth, State and Territory governments in health management.

Breast cancer and mental illness are significant causes of morbidity and mortality in Australia. Cancer control and mental health are identified by governments as National Health Priority Areas, along with diabetes mellitus, cardiovascular health, injury prevention and the control of asthma, arthritis and musculoskeletal conditions. These areas represent a significant proportion of the burden of illness in Australia and their management offers considerable scope for reducing this burden (Australian Institute of Health and Welfare [AIHW] 1998).

Indigenous data in the health management chapter

The health management chapter in the *Report on Government Services 2003* (ROGS) contains the following data items on Indigenous people:

- Participation rates of women aged 50-69 years from selected communities in BreastScreen Australia screening programs, 1998-99 to 2000-01 (24 month period);
- Specialised psychiatric care by Indigenous status, 1999-2000; and
- Mortality due to suicide, 2000.

Supporting tables

Supporting tables for data within the health management chapter of the compendium are contained in the attachment to the compendium. Supporting tables are identified in references throughout this chapter by the abbreviated chapter name (for example, HM.A5 is table 5 in the health management attachment to the compendium).

As the data are directly sourced from the *Report on Government Services 2003*, the compendium also notes where the original table, figure or text in the Report can be found. For example, where the compendium refers to ‘ROGS 2003, p. 6.15’ this is page 15 of chapter 6 of the Report and ‘ROGS 2003, 6A.2’ is attachment table 2 of attachment 6 of the Report.

Breast cancer - Participation rates of women from selected community groups in BreastScreen Australia programs

The focus of breast cancer control is on the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 can reduce deaths from breast cancer. According to the National Breast Cancer Centre (NBCC), if breast cancer is detected early while still localised in the breast, chances of five-year survival are around 90 per cent. The survival rate drops to 18 per cent if the tumour has spread to other parts of the body (NBCC 2002). It is generally argued that cancers detected early may be treated more conservatively and these women generally have a higher likelihood of survival.

BreastScreen Australia, jointly funded by the Commonwealth, State and Territory governments, undertakes nationwide breast cancer screening. BreastScreen Australia targets women aged 50–69 years for screening once every two years. The program aims to have 70 per cent or more women aged between 50 and 69 participating in screening over a 24-month period. All recruitment activities undertaken by BreastScreen Australia specifically target women in this age group, although women aged 40–49 years and those over 70 years may also use the service.

The participation rate of women from selected groups in the community (that is, Indigenous women, women from non-English speaking backgrounds (NESB), and women living in rural and remote areas) in breast cancer screening is an indicator of the effectiveness (in terms of access and equity) of the breast cancer screening program. Data for this indicator are presented in table HM.1. Crude rates are reported because age-standardised rates are not available for a number of jurisdictions for women aged 50–69 years.

Differences across jurisdictions in the collection of Indigenous, NESB and rural and remote status make comparisons difficult. Care needs to be taken when comparing data across jurisdictions.

In most jurisdictions, participation rates for Indigenous women aged 50–69 years are lower than for all females in that age group, however this may be influenced by problems with identification of Indigenous status. Participation rates of women in nonmetropolitan areas are generally higher than the rates for women in metropolitan areas. The rates for women from NESB aged 50–69 years are higher than for the total female population aged 50–69 years in Victoria and Queensland and lower in other States for the 24-month periods 1999–2000 and 2000–2001.

Table HM.1 **Participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1998–1999 (24-month period)								
Indigenous[c]	35.1	**na**	54.4	42.7	43.0	42.5	52.0	**na**
NESB[d]	46.7	57.2	65.6	56.0	57.7	33.8	59.0	**na**
Metropolitan or capital city[e]	52.1	55.8	53.5	51.4	60.3	58.6	61.0	**na**
Rural and remote or rest of State[f]	57.3	63.7	59.8	63.8	68.2	58.6	**na**	**na**
Total 50–69 years	52.8	56.9	56.1	54.5	62.1	59.3	60.5	**na**
1999–2000 (24-month period)								
Indigenous[c]	29.1	49.0	47.1	35.6	41.9	59.1	48.0	**na**
NESB[d]	42.4	61.0	65.6	48.0	53.8	28.1	**na**	**na**
Metropolitan or capital city[e]	50.7	56.0	55.0	50.7	61.4	60.9	**na**	**na**
Rural and remote or rest of State[f]	56.6	66.0	61.0	60.9	64.2	59.9	..	**na**
Total 50–69 years	52.8	58.9	58.0	54.3	64.0	59.9	**na**	**na**
2000–2001 (24-month period)								
Indigenous[c]	32.6	51.0	48.8	35.4	43.6	66.2	36.0	**na**
NESB[d]	42.4	65.0	67.1	50.6	53.7	28.9	57.1	**na**
Metropolitan or capital city[e]	51.6	58.0	57.1	54.7	63.5	62.7	57.3	**na**
Rural and remote or rest of State[f]	59.4	66.0	62.4	58.5	67.7	62.8	..	**na**
Total 50–69 years	52.3	60.2	58.5	56.0	66.0	60.1	57.3	**na**

[a] First and subsequent rounds. [b] Crude rates. [c] ‘Indigenous’ is defined as women who have self identified as being of Aboriginal or Torres Strait Islander descent. [d] ‘NESB’ is defined as persons who speak a language other than English at home. [e] ‘Metropolitan’ includes ‘capital city’ (State and Territory capital city statistical divisions) and ‘other metropolitan centre’ (one or more statistical subdivisions that have an urban centre with a population of 100 000 or more). [f] ‘Rural and remote’ includes ‘large rural centre’ SLAs where most of the population resides in urban centres with a population of 25 000 or more); ‘small rural centre’ (SLAs in rural zones containing urban centres with populations between 10 000 and 24 999); ‘other rural area’ (all remaining SLAs in the rural zone); ‘remote centre’ (SLAs in the remote zone containing populations of 5000 or more) and ‘other remote area’ (all remaining SLAs in the remote zone). **na** Not available **..** Not applicable.

Source: State and Territory governments (unpublished); ROGS 2003, p. 11.19; tables HM.A1 and HM.A2.

Mental Health - Services provided

Mental health relates to an individual’s ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioural incapacity (Department of Health and Aged Care [DHAC] *et al.* 1999). Problems and disorders that interfere with this ability and diminish quality of life and productivity cover cognitive, emotional and behavioural disorders. Some of the major mental disorders perceived to be public health problems are schizophrenia, depression, anxiety disorders, dementia and substance use disorders (DHAC *et al.* 1999). Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

There are very limited data available on specialised psychiatric care provided by hospitals to Indigenous patients. Comparisons are difficult because data on Indigenous status are incomplete and there may be differences in the use of hospital services relative to other health services by Indigenous status. The data reflect a range of factors, such as the spectrum of public, primary care and post hospital care available, Indigenous access to these as well as hospital services, social and physical infrastructure services for Indigenous people, and differences in the complexity, incidence and prevalence of disorders. Indigenous Australians were nearly twice as likely to be admitted for overnight psychiatric care compared with the rest of the population. The average length of stay for Indigenous people was, however, similar to that for the rest of the population (table HM.2).

Table HM.2 **Specialised psychiatric care by Indigenous status, Australia 1999-2000[a, b]**

	Same day separations	Overnight separations	Total separations	Total patient days	Total psychiatric care days	Average length of stay (overnight)	Psychiatric care days per overnight separation
No.							
Indigenous	503	3 204	3 707	76 531	76 053	23.7	23.6
Total pop.	72 219	99 329	171 548	2 494 675	2 440 474	24.4	23.8
Per 1000 population							
Indigenous[c]	1.5	9.2	10.7	255.8	255.1	..	..
Total pop.	3.8	5.2	9.1	131.7	128.9	..	..

[a] The completeness of data on Indigenous status varies; hence these, data need to be used with care. [b] Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. [c] Separations per 1000 population are indirectly age-standardised rates based on the projected Aboriginal and Torres Strait Islander population for 30 June 1999 and the estimated resident population for 30 June 1999. **..** Not applicable.

Source: AIHW (2002b); ROGS 2003, p. 11.50; table HM.A3.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 1999-2000 (22.3 per cent). Schizophrenia disorders also accounted for around 40.1 per cent of patient days for Indigenous patients, and a similar percentage of psychiatric care days (40.3 per cent) in 1999-2000 (table HM.A4).

Mortality due to suicide

Evidence indicates that people with a mental disorder are at a higher risk of suicide than the general population (although it is worth noting that they are also at a higher risk of death from other causes, such as cardiovascular disease).

While the performance of mental health services is important in reducing suicide, other government services also play a significant role. Public mental health programs are primarily concerned with providing treatment and support services for individual clients affected by serious mental illness, some of whom have either attempted or indicated the intention to commit suicide. Suicide prevention targeted at the wider population is also addressed through the initiatives of a range of other government departments and non-government organisations and other special interest groups. Therefore, any impact on suicide will be as a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice, and community services.

In addition, there are many factors outside the control of mental health services that may influence a person’s decision to commit suicide. These include environmental, sociocultural and economic risk factors. For example, adverse childhood experiences, such as sexual abuse, can increase the risk of suicide, particularly in adolescents and young adults. Alcohol and other drugs are also often associated with increased risk of suicidal behaviour. Other factors can also influence suicide rates, such as economic growth rates that affect unemployment rates and social disadvantage. Often the risk of suicidal behaviour can be increased by a combination of these factors.

It needs to be noted that not all of those who commit suicide are patients of mental health services. An improved indicator would be restricted to suicide by patients of mental health services.

In 2000, 2363 deaths by suicide were recorded in Australia — equivalent to 12.2 deaths per 100 000 people. The rate for males was around four times that for females in 2000 — a ratio that was constant over the 10 years to 2000 (ROGS 2003, table 11A.42). The NT had the highest suicide rate in 2000 (20.1 suicides per 100 000 people). The ACT had the lowest rate (8.9) (table HM.A5).

In 2000, the suicide rate for Indigenous people was considerably higher than the rate for the total population. Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some States are not considered of publishable standard.[1] Estimating the Indigenous population is difficult because the propensity for people to identify as Indigenous varies across jurisdictions and over time. In addition, Indigenous people are not always accurately identified in administrative collections, such as hospital records and birth and death registrations, due to variations in definitions, different data collection methods and failure to record Indigenous status. See the Health preface for a discussion of the quality of Indigenous mortality data collected by the ABS.

The 2000 Indigenous suicide rate in WA was 41.4 per 100 000 Indigenous people compared with around 13.7 per 100 000 for the total WA population. In the NT in 2000, the Indigenous suicide rate was 23.3 per 100 000 Indigenous people compared with 20.1 per 100 000 people for the total population (tables HM.A6 and HM.A5).

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[1] While the ABS considered data for Queensland, WA, SA and the NT to be of publishable standard, the trend figures for Indigenous suicides should still be interpreted with care because of the low number of suicides among Aboriginal people and uncertainty about the accuracy of Aboriginal population estimates.