Chapter 11: Health management

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). The health management chapter reports on the management of breast cancer and mental health, and represents some activities of the Australian, 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 (AIHW 1998).

Indigenous data in the health management chapter

The health management chapter in the *Report on Government Services 2004* contains the following data items on Indigenous people:

- Participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs, 1999–2000 to 2001–02 (24 month period).
- Specialised psychiatric care by Indigenous status, 2000-01.
- Mortality due to suicide, 2001.

Supporting tables

Supporting tables for data within the health management chapter of the compendium are contained in the attachment to the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 11A.3 is table 3 in the health management attachment to the compendium). As the data are directly sourced from the Report on Government Services 2004, the compendium also notes where the original table, figure or text in the Report on Government Services 2004 can be found. For example, where the compendium refers to 'ROGS 2004, p. 11.15' this is page 15 of chapter 11 and 'ROGS 2004, 11A.2' is attachment table 2 of attachment 11 of the Report on Government Services 2004.

Breast cancer

Breast cancer, the most frequent cause of death from cancer for females, was responsible for 2505 female deaths in 1999, 2511 female deaths in 2000 and 2585 female deaths in 2001 (ABS 2002). There is a strong relationship between age and the mortality rate from breast cancer. Women aged 40–44 years had an annual average mortality rate over the period 1997–2001 of 18.2 per 100 000, whereas women aged 75–79 years had an annual average mortality rate of 103.5 per 100 000.

Breast cancer detection and management services comprise a number of major components: primary care and community-based services, including general practitioner (GP) services and community-based women's health services; screening services; acute services based in hospitals, including both inpatient and outpatient services; private consultations for a range of disciplines; and post-acute services, including home-based and palliative care (DHS 1999).

Early detection — participation rates of women from selected community groups in BreastScreen programs

A fundamental component of breast cancer control is the use of screening mammography to enable early detection of breast cancer. There is evidence that population-based screening of women aged 50–69 years can reduce deaths from breast cancer. According to the National Breast Cancer Centre, women whose cancer is diagnosed before it has spread outside the breast have a 90 per cent chance of surviving five years. The five year survival rate drops to 20 per cent if the cancer spreads to other parts of the body before diagnosis (NBCC 2003). It is generally argued that cancers detected early may be treated more conservatively and that these women generally have a higher likelihood of survival.

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

For the 24 month period 2001 and 2002, the age standardised participation of Indigenous women aged 50–69 years was markedly lower than that of all females in that age group, although this may be influenced by problems with identification of Indigenous status. The largest difference between Indigenous and other females' participation was in SA (26.2 percentage points). The smallest difference was in Queensland (10.4 percentage points).

Table 11.1 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*
1999–2000 (24 month period)								
Indigenous[b]	29.1	na	46.6	36.7	42.3	na	48.0	na
NESB[c]	42.7	na	66.2	56.2	54.0	na	na	na
Metropolitan or capital city[d]	50.8	na	55.2	51.0	63.0	na	na	na
Rural and remote or rest of State[e]	56.7	na	61.0	61.1	66.5	na	..	na
Total aged 50–69 years	52.9	58.8	58.1	54.5	63.9	na	na	na
2000–2001 (24 month period)								
Indigenous[b]	32.6	51.4	48.8	35.9	43.9	na	36.6	37.7
NESB[c]	42.3	65.4	67.2	50.9	53.1	na	57.2	na
Metropolitan or capital city[d]	51.6	58.0	57.1	60.8	63.5	62.7	57.3	41.1
Rural and remote or rest of State[e]	59.2	66.0	62.4	58.4	67.7	62.8	..	67.6
Total aged 50–69 years	52.3	60.2	58.5	55.7	64.6	60.1	57.4	53.3
2001–2002 (24 month period)								
Indigenous[b]	41.3	42.1	48.3	31.3	38.6	33.4	41.4	25.3
NESB[c]	45.1	52.1	69.1	56.4	62.4	45.4	70.7	na
Metropolitan or capital city[d]	51.4	58.4	56.6	53.9	63.8	61.1	58.9	34.1
Rural and remote or rest of State[e]	57.7	64.4	61.8	63.7	67.7	59.1	..	53.5
Total aged 50–69 years	53.0	60.0	58.7	55.2	64.8	59.1	59.0	51.2

[a] First and subsequent rounds. [b] Those women who self identify as being of Aboriginal or Torres Strait Islander descent. [c] Women who speak a language other than English at home. [d] 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). [e] Includes ‘large rural centre’ statistical local areas where most of the population resides in urban centres with a population of 25 000 or more); ‘small rural centre’ (statistical local areas in rural zones containing urban centres with populations between 10 000 and 24 999); ‘other rural area’ (all remaining statistical local areas in the rural zone); ‘remote centre’ (statistical local areas in the remote zone containing populations of 5000 or more) and ‘other remote area’ (all remaining statistical local areas in the remote zone). **na** Not available **..** Not applicable.

Source: State and Territory governments (unpublished); ROGS 2004, p. 11.24; Tables 11A.1 and 11A.5.

Mental health

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 (DHAC and AIHW 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 and AIHW 1999). Each of these disorders is unique in terms of its incidence across the lifespan, causal factors and treatments.

Mental disorders are a major cause of chronic disability. In 1996 (the most recent year for which data are available), mental disorders accounted for 1 per cent of years of life lost as a result of mortality, but were the leading cause of years of healthy life lost as a result of disability (nearly 30 per cent of the non-fatal burden of disease) (Mathers and Stevenson 1999). Most of this burden has been attributed to affective disorders (35 per cent of the calculated burden), anxiety disorders (24 per cent) and substance use disorders (20 per cent).

Mental health services provided

Very limited data are available on specialised psychiatric care of Indigenous patients in hospital. 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 used by Indigenous people compared with other Australians. The data reflect a range of factors, such as the spectrum of public, primary care and post-hospital care available; Indigenous people’s 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 compared with the rest of the population to be admitted for overnight psychiatric care. The average length of stay for Indigenous people was similar, however, to that for the rest of the population (table 11.2).

Table 11.2 **Specialised psychiatric care, by Indigenous status, 2000-01**[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	569	3 343	3 912	65 307	64 495	19.4	19.1
Total pop.	79 471	99 016	178 487	2 151 441	2 128 042	20.9	20.7
Per 1000 population[c]							
Indigenous	1.7	9.3	11.1	209.1	206.1	..	..
Total pop.	4.1	5.2	9.3	112.3	111.1	..	..

[a] The completeness of data on Indigenous status varies, so 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 2000 and the estimated resident population for 30 June 2000. **..** Not applicable.

Source: AIHW (2003); ROGS 2004, p. 11.47; Table 11A.2.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2000-01 (27.0 per cent). They also accounted for around 45.8 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (46.1 per cent) in 2000-01 (table 11A.3).

Mortality due to suicide

Evidence indicates that people with a mental disorder are at a higher risk of suicide than the general population (although 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 other government departments, non-government organisations and other special interest groups. Any impact on suicide rates, therefore, will be a result of a coordinated response across a range of collaborating agencies, including police, education, housing, justice and community services agencies.

In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors. Adverse childhood experiences such as sexual abuse, for example, 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 that can influence suicide rates include economic growth rates, which affect unemployment rates and social disadvantage. Often, a combination of these factors can increase the risk of suicidal behaviour.

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 2001, 2454 deaths by suicide were recorded in Australia — equivalent to 12.5 deaths per 100 000 people. The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001.

In 2001, 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 jurisdictions are not 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. The Health preface discusses the quality of Indigenous mortality data collected by the ABS.

The 2001 Indigenous suicide rate in Queensland was 42.5 per 100 000 Indigenous people compared with around 13.8 per 100 000 for the total Queensland population. In WA, the suicide rate was 19.0 per 100 000 Indigenous people compared with 14.2 per 100 000 for the total population. In SA, the suicide rate was 38.9 per 100 000 Indigenous people, compared with 13.7 per 100 000 for the total population. In the NT, the suicide rate was 35.1 per 100 000 Indigenous people compared with 22.6 per 100 000 for the total population (table 11A.4).

References

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NBCC (National Breast Cancer Centre) 2003, http://www/nbcc.org.au/bestpractice/statistics/index.htm (accessed 15 November 2003).

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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 still need to be interpreted with care, given the low number of suicides among Indigenous people and uncertainty about the accuracy of Indigenous population estimates.