11 Health management issues

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 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, as are asthma, cardiovascular health, diabetes mellitus, injury prevention and control, arthritis and musculoskeletal conditions. These are as represent almost 80 per cent of the total burden of disease and injury in Australia, and their management offers considerable scope for reducing this burden (AIHW 2003).

Improvements this year to the reporting of mental health management include presenting Indigenous suicide deaths data averaged over three year periods to smooth volatility in year-on-year movements, particularly for smaller jurisdictions.

Indigenous data in the health management chapter

The health management chapter in the *Report on Government Services 2005* contains the following data items on Indigenous people:

- Participation rates of women aged 50-69 years from selected communities in Breastscreen Australia screening programs, 2002–2003 (24 month period).
- Specialised psychiatric care by Indigenous status, 2001-02.
- Mortality due to suicide, 2000–02.

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 the chapter by an ‘A’ suffix (for example, table 11.A3 is table 3 in the health management attachment to the compendium). As the data are directly sourced from the Report on Government Services 2005, the compendium also notes where the original table, figure or text in the Report on Government Services 2005 can be found. For example, where the compendium refers to '2005 Report p. 11.15' this is page 15 of chapter 11 and '2005 Report, 11A.2' is attachment table 2 of attachment 11 of the Report on Government Services 2005.

Breast cancer

Breast cancer was responsible for 2698 female deaths in 2002, making it the most frequent cause of death from cancer for females (ABS 2003). 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 1998-2002 of 17.2 per 100 000, whereas women aged 75–79 years had an annual average mortality rate of 102.2 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 rate 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 have a higher likelihood of survival.

The 'participation rate of women from selected community groups' — 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 because screening is important in the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. Women from selected community groups may experience particular language, cultural and geographic barriers to accessing breast cancer screening. This indicator measures the performance of the BreastScreen program in overcoming these barriers. Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by

Indigenous, NESB, and rural and remote status across jurisdictions. The data for this indicator is provided on a comparable basis.

For the 24 month period 2002 and 2003, the age standardised participation rate for Indigenous women aged 50–69 years was markedly lower than the rate for all females in that age group, although this may be influenced by problems with the identification of Indigenous status. The largest gap between the participation rates of Indigenous women and all women was in Tasmania (29.0 percentage points); the smallest gap was in the ACT (1.1 percentage points) (table 11.1).

Table 11.1 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2002 and 2003 (24 month period) (per cent)[a]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[b]	39.4	50.9	53.6	39.7	41.2	29.9	55.5	17.7	40.6
Non-English Speaking Background[c]	43.5	40.4	64.7	59.3	59.7	46.5	59.7	25.9	46.6
Metropolitan or capital city[d]	61.0	57.0	76.8	55.1	63.3	56.1	56.7	49.4	61.2
Rural and remote, or rest of State[e]	35.9	60.2	44.5	56.9	64.4	59.3	–	17.5	46.8
All women aged 50–69 years	50.8	57.9	58.5	55.7	63.6	58.9	56.7	45.6	55.8

[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). – Nil or rounded to zero.

Source: State and Territory governments (unpublished); table 11A.1; 2005 Report, table 11A.14; 2005 Report, p. 11.25, table 11.5.

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 include 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 health services provided

Limited data are available on specialised psychiatric care of Indigenous patients in hospital. Comparisons are difficult because data on Indigenous status are incomplete and Indigenous people and other Australians may differ in their use of hospital services relative to other health services. 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 as the rest of the population to be admitted for overnight psychiatric care. The average length of stay for Indigenous people was slightly less, however, than that for the rest of the population (table 11.2).

Table 11.2 **Specialised psychiatric care, by Indigenous status, 2001-02**[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	130	3 567	3 697	72 386	71 723	20.3	20.1
Total population	8 536	102 433	110 969	2 458 483	2 421 286	23.9	23.6
Per 1000 population[c]							
Indigenous	0.4	9.1	9.6	199.3	198.0	..	..
Total population	0.4	5.2	5.6	124.1	122.2	..	..

[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 2001 and the estimated resident population for 30 June 2001. **..** Not applicable.

Source: AIHW (2004); table 11A.2; 2005 Report, p. 11.47, table 11.7.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2001-02 (26.1 per cent). They also accounted for around 47.3 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (47.6 per cent) (table 11A.3).

Mortality due to suicide

'Mortality due to suicide' is an indicator because evidence indicates that people with a mental disorder are at a higher risk of suicide than are the general population. (They are also at a higher risk of death from other causes, such as cardiovascular disease.) The data for this indicator is provided on a comparable basis.

This indicator is reported as the rates per 100 000 people for all people and Indigenous people. 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 — 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 an 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 2002, 2320 deaths by suicide were recorded in Australia — equivalent to 11.8 deaths per 100 000 people. The national rate fell each year from 1997 to 2000, followed by a slight increase in 2001 and then a fall in 2002.

The Indigenous suicide rate is presented for the period 2000–2002 for four jurisdictions: Queensland, WA, SA and the NT. The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The suicide rate for Indigenous people for the period 2000–2002 in the jurisdictions for which data are presented in table 11A.4 is considerably higher than the rate for the total population in 2002.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. Estimating the Indigenous population is difficult given the low number of suicides among Indigenous people and the varying propensity of people across jurisdictions and over time to identify as Indigenous. In addition, Indigenous people are not always accurately identified in administrative collections (such as hospital records, and birth and death registrations) due to definition variations, different data collection methods and failure to record Indigenous status. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Future directions in performance reporting

Mental health

Key challenges for improving the reporting of mental health management include improving the reporting of effectiveness and efficiency indicators for Indigenous, rural/remote and other special needs groups.

References

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