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, which represent 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 areas 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 2003b).

Indigenous data in the health management issues chapter

The health management issues chapter in the *Report on Government Services 2007* (2007 Report) contains the following data for Indigenous people:

- participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs, 2004 and 2005 (24 month period)
- specialised psychiatric care by Indigenous status, 2003-04
- mortality due to suicide, 2000–2004.

Supporting tables

Supporting tables for data within the health management issues chapter of this compendium are contained in attachment 11A of 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 issues attachment). As the data are directly sourced from the 2007 Report, the compendium also notes where the original table, figure or text in the 2007 Report can be found. For example, where the compendium refers to ‘2007 Report, p. 11.15’ this is page 15 of chapter 11 of the 2007 Report, and ‘2007 Report, table 11A.2’ is attachment table 2 of attachment 11A of the 2007 Report.

Breast cancer

Breast cancer is a disease whereby uncontrolled or malignant cell division leads to the formation of a tumour or tumours in a woman’s breast.[1] Tumours may expand locally by invading surrounding tissue, or they may spread via the lymphatic or vascular systems to the rest of the body. If left untreated, most malignant tumours result in the death of the affected person (AIHW 2003a).

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).

Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for breast cancer detection and management in the 2007 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 11.1. The performance indicator framework shows which data are comparable in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

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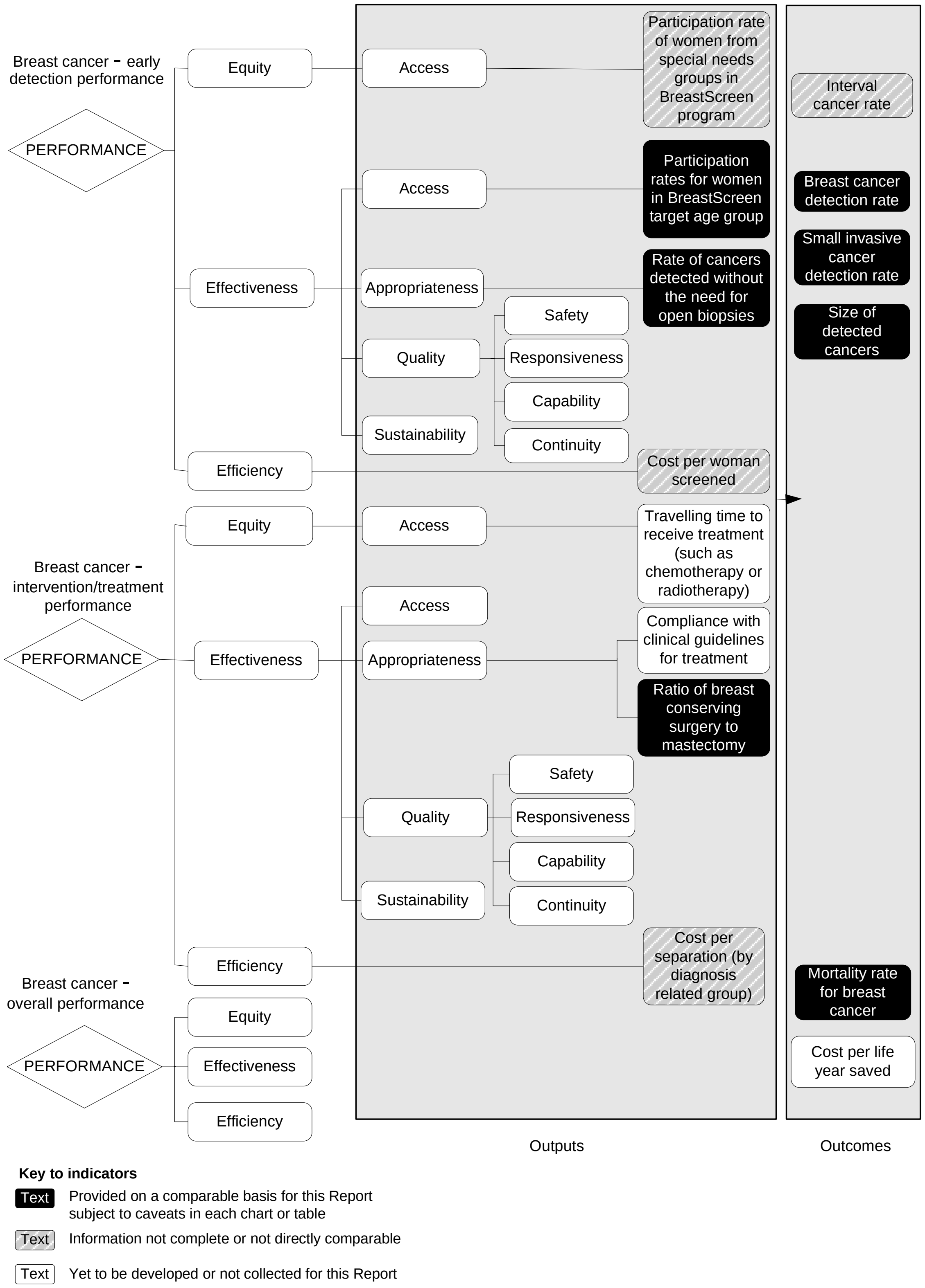
[1] Breast cancer in males is very rare. It is not examined in this Report.

Figure 11.1 **Performance indicators for breast cancer detection and management**



Source: 2007 Report, figure 11.6, p. 11.13.

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

The ‘participation rate of women from selected community groups in BreastScreen programs’ is an indicator of equity of access (box 11.1).

Box 11.1 Participation rate of women from selected community groups in BreastScreen programs

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 women from these 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. This reflects the importance of screening to the early detection of breast cancers. Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality.

The participation rate measures the proportion of the eligible population in the community group attending the screening program within a 24 month period. Participation rates for community groups that are at, or close to, those for the total population indicate success in overcoming group-specific barriers to access.

The national age standardised participation rate for Indigenous women aged 50–69 years has tended to increase in recent years, but remains below the non-Indigenous participation rate in that age group, although this may be influenced by problems with the identification of Indigenous status (table 11A.2). For the same 24 month period and age group, the national participation rate for NESB women (42.7 per cent) was also lower than that of the national total female population, as was that of women living in rural and remote areas (50.5 per cent) (table 11.1). 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.

Table 11.1 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2004 and 2005 (24 month period) (per cent)**[a, b]

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[c]	33.9	37.3	50.2	29.8	33.1	34.9	44.8	18.9	36.1
Non-English Speaking Background[d]	43.0	33.6	63.1	55.2	52.5	41.5	73.4	11.1	42.7
Metropolitan or capital city[e]	61.7	57.9	58.7	54.9	60.7	56.0	55.6	47.3	59.0
Rural and remote, or rest of State[f]	36.2	56.7	58.7	57.6	65.7	57.5	..	40.3	50.5
All women aged 50–69 years	51.2	57.5	58.6	55.6	62.1	57.4	55.3	43.9	55.7

[a] First and subsequent rounds. [b] Rates are standardised to the 2001 Australian population standard. [c] Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. [d] Women who speak a language other than English at home. [e] 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] 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). .. Not applicable.

Source: State and Territory governments (unpublished); tables 11A.1 and 11A.2; 2007 Report, table 11.4, p. 11.16.

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). There is a wide range of mental disorders that can affect an individual’s functioning and quality of life. 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. The average length of stay for Indigenous people was slightly more than that for the total population (table 11.2).

Table 11.2 **Specialised psychiatric care, by Indigenous status, 2003-04**[a, b, c]

	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	109	2 295	2 404	54 406	54 051	23.7	23.6
Total population	3 492	30 779	34 271	941 723	934 985	20.7	30.4

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** Data are for Queensland, WA, SA and the NT only.

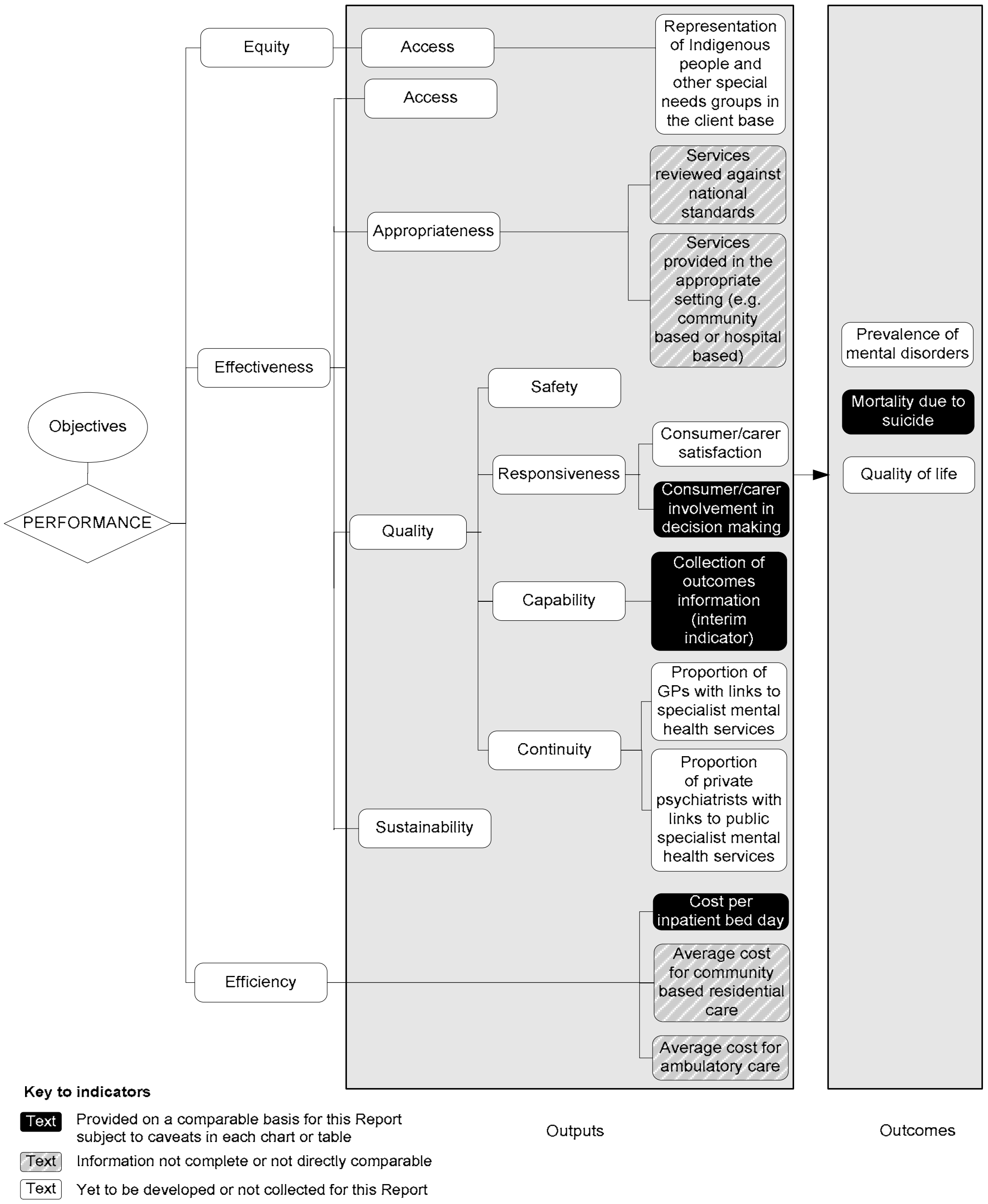
Source: AIHW (2005); table 11A.3; 2007 Report, table 11.7, p. 11.46.

Schizophrenia disorders accounted for a large proportion of overnight specialised psychiatric care separations reported for Indigenous patients in Australia in 2003-04 (30.7 per cent). They also accounted for around 37.4 per cent of patient days for Indigenous patients and a similar percentage of psychiatric care days (37.6 per cent) (table 11A.4).

Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for mental health management in the 2007 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 11.2. The performance indicator framework shows which data are comparable in the 2007 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 11.2 **Performance indicators for mental health management**



Source: 2007 Report, figure 11.24, p. 11.48.

Representation of Indigenous people and others in the client base

The Steering Committee has identified the ‘representation of Indigenous people and other special needs groups in the client base’ as a key area for development in future reports (box 11.2).

Box 11.2 **Representation of Indigenous people and other special needs groups in the client base**

The ‘representation of Indigenous people and other special needs groups in the client base’ is an indicator of governments’ aim to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people.

Mortality due to suicide

‘Mortality due to suicide’ is an outcome indicator of mental health management (box 11.3).

Box 11.3 **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.)

This indicator is reported as the suicide rate per 100 000 people for all people, people aged 15–24 years, people living in capital cities, people living in other urban areas, people living in rural areas 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.

The Indigenous suicide rate is presented for the period 2000–2004 for four jurisdictions: Queensland, WA, SA and the NT (table 11A.5). The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2000–2004 in the jurisdictions for which data are presented in table 11A.5 are at least twice as high as the rates for the non-Indigenous populations in those jurisdictions in the period 2000–2004.

Care needs to be taken when interpreting these data because data for Indigenous people are incomplete and data for some jurisdictions are not published. 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 for reporting on mental health management

One key challenges for improving the reporting of mental health management is improving the reporting of effectiveness and efficiency indicators for Indigenous people.

Supporting tables

Supporting tables for data within this chapter 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 issues attachment). The tables included in the attachment are listed below.

Breast cancer

Table 11A.1	Participation rates of women in BreastScreen Australia, (24 month period)
Table 11A.2	Participation rates of women screened by BreastScreen Australia, by special needs groups (24 month period) (first and subsequent rounds) (per cent)

Mental health

Table 11A.3	Specialised care separations reported for Indigenous patients, Australia 2003-04
Table 11A.4	Specialised psychiatric care separations reported for Indigenous patients, Australia 2003-04
Table 11A.5	Suicide deaths, by Indigenous status

References

AIHW (Australian Institute of Health and Welfare) 2003a, *BreastScreen Australia Monitoring Report 2000-2001*, Cat. no. CAN 20, Cancer Series no. 25, Canberra.

—— 2003b, *National Health Priority Areas* www.aihw.gov.au/nhpa/index.html (accessed 12 November 2003).

—— 2005, *Mental Health Services in Australia 2003-04,* Cat. no. HSE 31, Mental Health Series no. 5, Canberra.

DHAC (Australian Government Department of Health and Community Services) and AIHW 1999, *National Health Priority Areas Report: Mental Health 1998,* AIHW Cat. no. PHE 13, Canberra.

DHS (Department of Human Services Victoria) 1999, *Breast Disease Service Redevelopment Strategy. A Report by the Breast Care Implementation Advisory Committee 1999-2003,* Victorian Government Publishing Service, Melbourne.