12 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 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). Relevant clinical disciplines include surgery, plastic and reconstructive surgery, pathology, radiation and medical oncology, nursing, diagnostic radiology, radiography, physiotherapy, allied health, and psychological and psychiatric services. Post-acute services include a range of further treatments, such as radiotherapy and chemotherapy (most of which take place on a same day or outpatient basis) and a range of follow-up and palliative care services (DHS 1999).

Improvements made to the chapter this year are that data for Indigenous people on levels of psychological distress (K5) have been included.

Indigenous data in the health management issues chapter

The health management issues chapter in the *Report on Government Services 2008* (2008 Report) contains the following data for Indigenous people:

- participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs, 2005 and 2006 (24 month period)
- K5 level of psychological distress, people aged 18 years and over, 2004-05
- specialised psychiatric care by Indigenous status, 2004-05
- mortality due to suicide, 2001–2005.

Attachment tables

Attachment tables for data within the health management issues chapter of this compendium are contained in attachment 12A of the compendium. These tables are identified in references throughout this chapter by an 'A' suffix (for example, table 12A.3 is table 3 in the health management issues attachment). As the data are directly sourced from the 2008 Report, the compendium also notes where the original table, figure or text in the 2008 Report can be found. For example, where the compendium refers to '2008 Report, p. 12.15' this is page 15 of chapter 12 of the 2008 Report, and '2008 Report, table 12A.2' is attachment table 2 of attachment 12A of the 2008 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 2003).

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 2008 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 12.1. The performance indicator framework shows which data are comparable in the 2008 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

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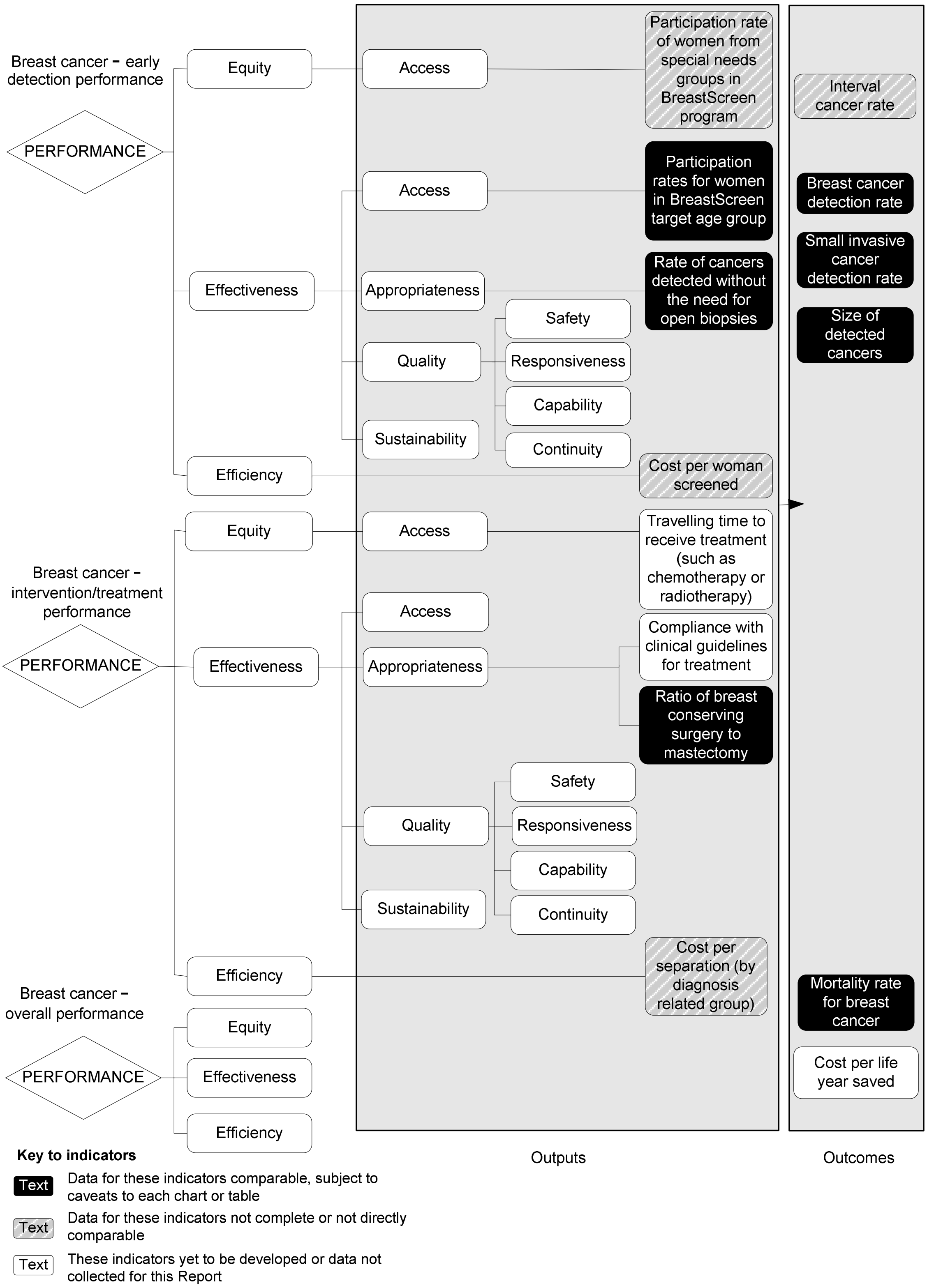
[1] Breast cancer in males is very rare. It is not examined in this Report.

Figure 12.1 **Performance indicators for breast cancer detection and management**



Source: 2008 Report, figure 12.7, p. 12.14.

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 12.1).

Box 12.1 **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 outer regional, remote and very remote areas — in breast cancer screening is an indicator of equity of access. 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.

In 2005-06, the national age standardised participation rate for Indigenous women aged 50–69 (38 per cent) was below the total participation rate in that age group (56.7 per cent), although this may be influenced by problems with Indigenous identification (table 12A.1). For the same 24 month period and age group, the national participation rate for NESB women (49.6 per cent) was also lower than that of the national total female population (table 12.1). 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.

Table 12.1 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2005 and 2006 (24 month period) (per cent)[a, b]**

	NSW	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Aust*
Indigenous[c]	38.6	35.9	49.9	30.4	31.3	33.0	50.4	24.5	38.0
NESB[d]	51.4	37.6	67.0	65.0	58.3	36.2	52.3	38.6	49.6
Major cities and inner regional[e]	53.1	56.9	58.3	58.4	58.5	48.7	60.3	na	na
Outer regional, remote and very remote[e]	78.2	53.6	59.9	56.3	67.3	70.1	..	na	na
All women aged 50–69 years	55.5	56.8	58.0	57.4	59.0	57.1	58.4	40.8	56.7

[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] Non-English speaking background (NESB) is defined as speaking a language other than English at home. [e] Remoteness categories are based on Census Collection Districts (CDs) and defined using the Australian Standard Geographical Classification categories. The Australian Standard Geographical Classification is a measure of the remoteness of a location from the services provided by large towns or cities. **na** Not available. **..** Not applicable.

Source: State and Territory governments (unpublished); table 12A.1; 2008 Report, table 12A.10; 2008 Report, table 12.4, p. 12.16.

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.

Prevalence

As part of the National Health Survey (NHS) in 2004-05, the ABS surveyed adults on the level of psychological distress that they had experienced in the four weeks before the survey. This survey used the Kessler 10 (K10) scale, which consists of 10 questions about non-specific psychological distress and seeks to measure the level of current anxiety and depressive symptoms that a person might have experienced in the four weeks before the interview (ABS 2006b).[2] The 2004-05 data showed

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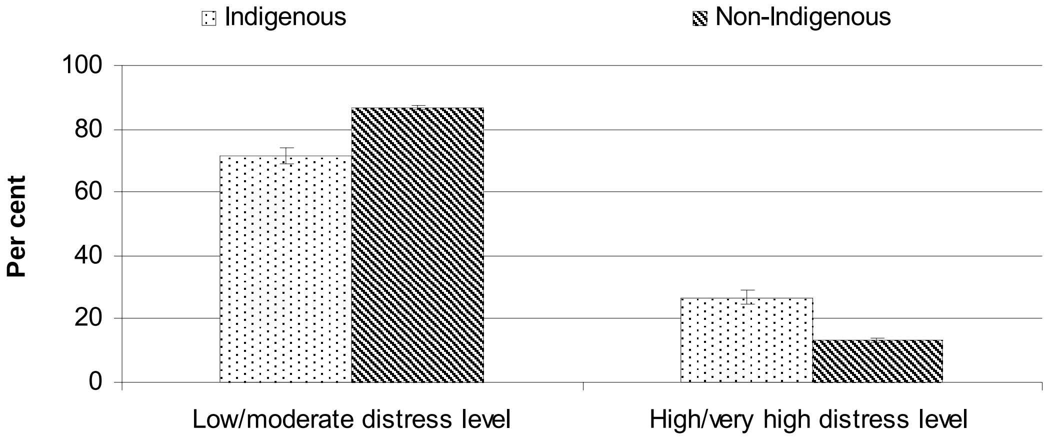
[2] Respondents were asked whether in the previous four weeks they had felt: tired for no good reason; nervous; so nervous nothing could calm them down; hopeless; restless or fidgety; so restless they could not sit still; depressed; everything was an effort; so sad that they could not be cheered up; and worthless. For each question, there is a five level response scale based on the amount of time that the respondent reported experiencing the particular problem. Generally, each item was scored from one for ‘none of the time’, to five for ‘all of the time’. Scores of the 10 questions were then summed, yielding a minimum possible score of 10 and a maximum possible score of 50. Low scores indicated low levels of psychological distress and high scores indicated high levels of psychological distress (ABS 2006b).

that, nationally, 61.8 per cent of those aged 18–64 years had experienced a low level of distress, 24.7 per cent had experienced moderate distress and 13.4 per cent had experienced a high or very high level of distress. Generally, people aged 65 years or over were less likely to experience moderate and high to very high levels of distress, compared with the younger age group (2008 Report, table 12.6).

The 2004-05 National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) included for the first time selected questions from the Kessler Psychological Distress Scale–10 (K10). The K10 was reduced to five questions (K5) to provide an appropriate short set of questions to identify psychological distress (ABS 2006a). The wording of two of the K10 questions was modified slightly for the NATSIHS K5 version. Nevertheless, these modifications are unlikely to significantly affect the comparability of Indigenous and non-Indigenous (K5) data on levels of psychological distress.

In 2004-05, after adjusting for age differences between the Indigenous and non-Indigenous populations, 26.6 per cent of Indigenous people had experienced a high to very high level of psychological distress compared with 13.1 per cent of non-Indigenous people (figure 12.2).

Figure 12.2 **K5 level of psychological distress, people aged 18 years and over, age standardised, 2004-05**[a, b, c]



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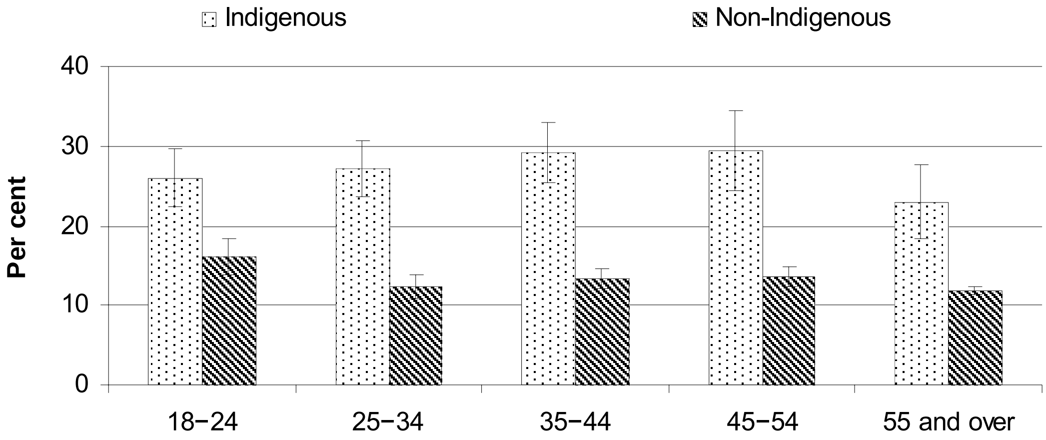
[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] Low/moderate distress level represents a K5 score of 5–11 (maximum score is 25). [c] High/very high distress level represents a K5 score of 12–25 (maximum score is 25).

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); SCRGSP (2007); 2008 Report, figure 12.18, p. 12.38.

In all age groups, Indigenous people were more likely to have experienced high to very high levels of psychological distress than non-Indigenous people in 2004-05 (figure 12.3).

Figure 12.3 **High to very high level of psychological distress, by age, Australia, 2004-05**[a, b]



[a] Error bars represent 95 per cent confidence intervals around each estimate. [b] High/very high distress level represents a K5 score of 12–25 (maximum score is 25).

Source: ABS 2004-05 NATSIHS (unpublished); ABS 2004-05 NHS (unpublished); SCRGSP (2007); 2008 Report, figure 12.19, p. 12.39.

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. For the jurisdictions for which data are available, the total average length of stay for Indigenous people was shorter than for non-Indigenous people (table 12.2).

Table 12.2 **Specialised psychiatric care, by Indigenous status, 2004-05**[a, b]

	Unit	*NSW*	*Vic*	*Qld*	*WA*	*SA*	*Tas*	*ACT*	*NT*	*Total*[c]
Indigenous										
Separations	no.	np	np	1 181	610	332	np	np	494	2 617
Separation rate	per ‘000 people	np	np	9.9	9.1	13.0	np	np	7.7	9.5
Patient days	no.	np	np	30 381	11 153	5 795	np	np	4 037	51 366
Psychiatric care days	no.	np	np	30 228	11 091	5 795	np	np	3 999	51 113
Average length of stay[d]	no.	np	np	27.4	18.3	17.8	np	np	9.2	20.7
Non-Indigenous										
Separations	no.	np	np	26 141	11 121	9 848	np	np	680	47 790
Separation rate	per ‘000 people	np	np	7.0	5.8	6.5	np	np	4.7	6.5
Patient days	no.	np	np	537 377	215 611	199 829	np	np	7 065	959 882
Psychiatric care days	no.	np	np	533 950	213 241	199 829	np	np	7 038	954 058
Average length of stay[d]	no	np	np	23.9	20.4	23.0	np	np	10.9	22.6

[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. [d] Includes data for overnight separations only. **np** Not published.

Source: AIHW (2007); table 12A.2; 2008 Report, table 12.7, p. 12.49.

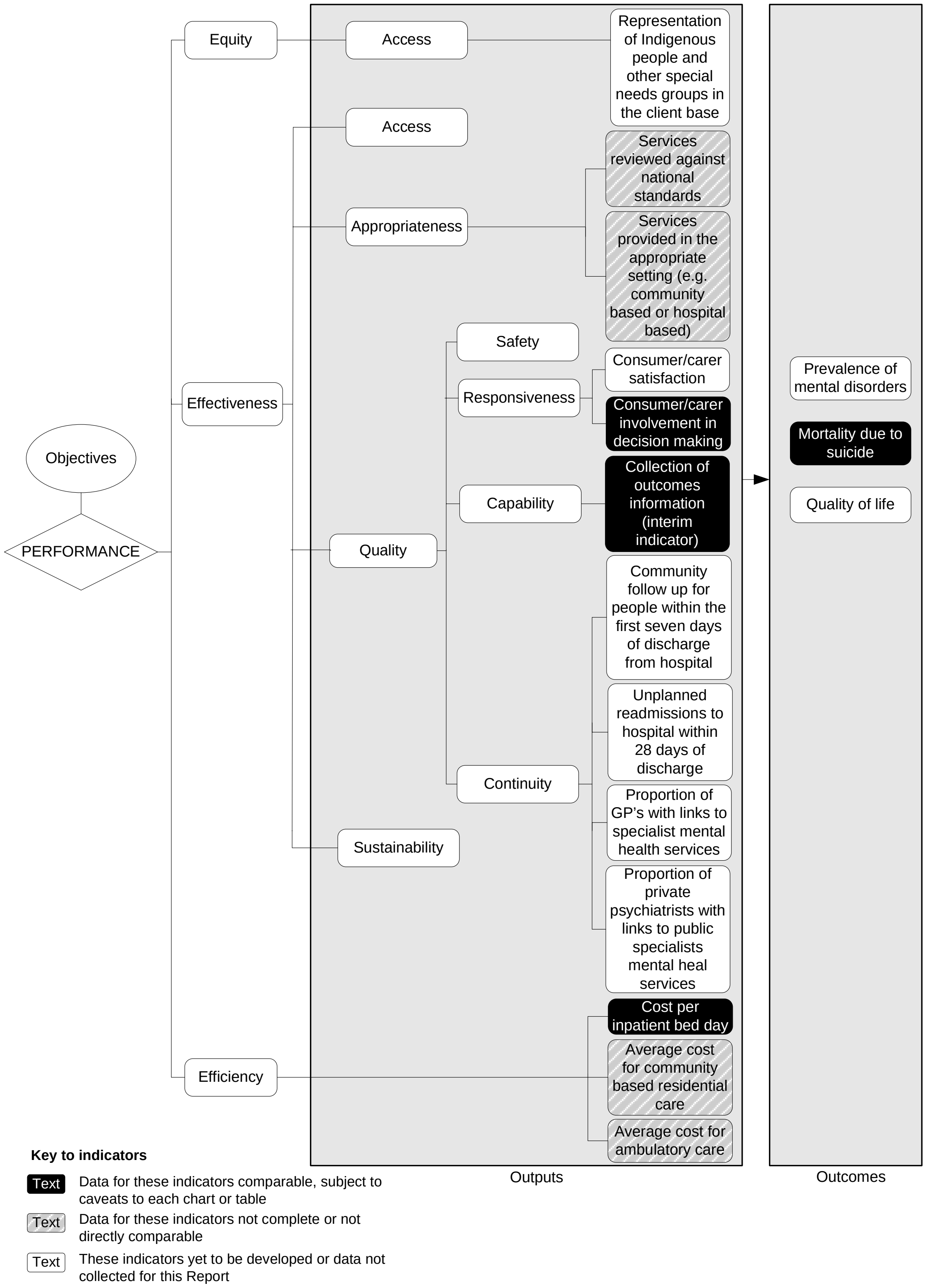
Framework of performance indicators

The framework of performance indicators for mental health services builds on government objectives for mental health service delivery (box 12.2) as encompassed in the NMHS and the Council of Australian Governments (COAG) National Action Plan on Mental Health.

The National Strategic Framework for Aboriginal and Torres Strait Islander People’s Mental Health and Social and Emotional Well Being 2004–2009 (the Social and Emotional Well Being Framework) was endorsed by the Australian Health Ministers’ Advisory Council in December 2004. It aims to provide a framework for action by all governments and communities to improve the social and emotional wellbeing and mental health needs of Indigenous Australians over the next five years.

Data for Indigenous people are reported for a subset of the performance indicators for mental health management in the 2008 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 12.4. The performance indicator framework shows which data are comparable in the 2008 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 12.4 **Performance indicators for mental health management**



Source: 2008 Report, figure 12.27, p. 12.52.

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 12.2).

Box 12.2 **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 12.3).

Box 12.3 **Mortality due to suicide**

Mortality due to suicide’ is a mental health management 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.

(Continued on the next page)

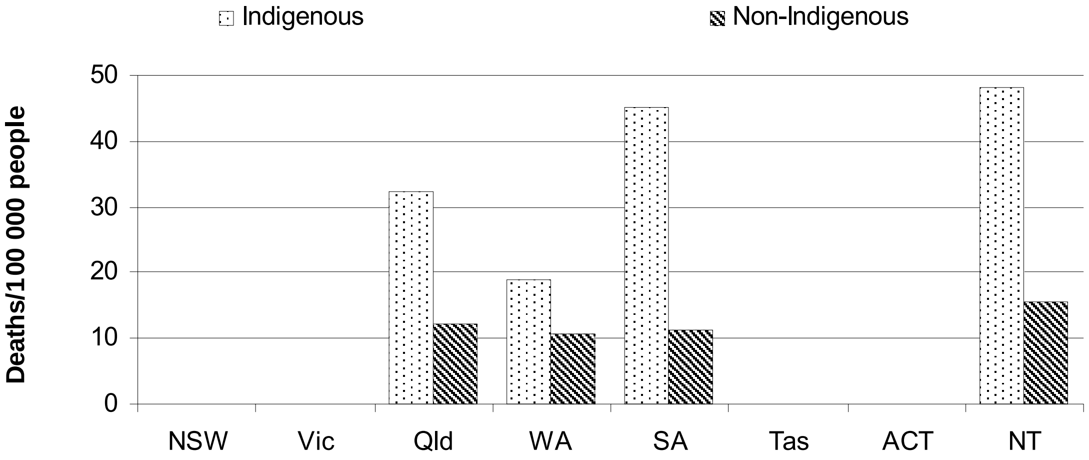
Box 12.3 **(Continued)**

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.

The Indigenous suicide rate is presented for the period 2001–2005 for four jurisdictions: Queensland, WA, SA and the NT (figure 12.5). After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2001–2005 in the jurisdictions for which data are presented are considerably higher than the corresponding rates for non-Indigenous people.

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 (see 2008 Report, p. 12.71 for further details on suicide data quality). The rate calculations have not been adjusted for differences in the completeness of identification of Indigenous deaths across jurisdictions. The 'Health preface' discusses the quality of Indigenous mortality and other data.

Figure 12.5 **Suicide rates, by Indigenous status, 2001–2005**[a]



[a] Indigenous population figures are based on ABS Experimental Projections, Aboriginal and Torres Strait Islander Australians (low series, 2001 base). There are no comparable population data for the non-Indigenous population. The non-Indigenous population figures are based on data derived by subtracting Indigenous population projections from total population estimates and should be used with care. Rates are calculated on an age standardised basis.

Source: ABS (unpublished) *Causes of Deaths, Australia*; table 12A.3; 2008 Report, figure 12.36, p. 12.75.

Future directions for reporting on mental health management

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

Attachment tables

Attachment 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 12A.3 is table 3 in the health management issues attachment). The tables included in the attachment are listed below.

Breast cancer

Table 12A.1	Participation rates of women screened by BreastScreen Australia, by special needs groups (24 month period) (first and subsequent rounds) (per cent)

Mental health

Table 12A.2	Specialised psychiatric care separations reported for Indigenous patients, Australia 2004-05
Table 12A.3	Suicide deaths, by Indigenous status

References

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