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## 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).

Specialised mental health management services include a range of government and non-government service providers offering promotion, prevention, treatment and management, and rehabilitation services. Community mental health facilities, psychiatrists, clinical psychologists, psychotherapists, mental health clinicians in private practice, counsellors, Aboriginal health workers, Aboriginal mental health workers, public hospitals with specialised psychiatric units and stand-alone psychiatric hospitals all provide specialised mental health care. In addition, a number of health services provide care to mental health patients in a non-specialised health setting — for example, GPs, Aboriginal community controlled health services, public hospital emergency departments and outpatient departments, and public hospital general wards (as opposed to specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

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## Indigenous data in the health management issues chapter

The health management issues chapter in the *Report on Government Services 2009* (2009 Report) contains the following data for Indigenous people:

- participation rates of women aged 50–69 years from selected communities in BreastScreen Australia screening programs, 2006 and 2007 (24 month period)
- specialised psychiatric care by Indigenous status, 2005–06
- mortality due to suicide, 2002–2006.

### *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 2009 Report, the compendium also notes where the original table, figure or text in the 2009 Report can be found. For example, where the compendium refers to ‘2009 Report, p. 12.15’ this is page 15 of chapter 12 of the 2009 Report, and ‘2009 Report, table 12A.2’ is attachment table 2 of attachment 12A of the 2009 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.<sup>1</sup> 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).

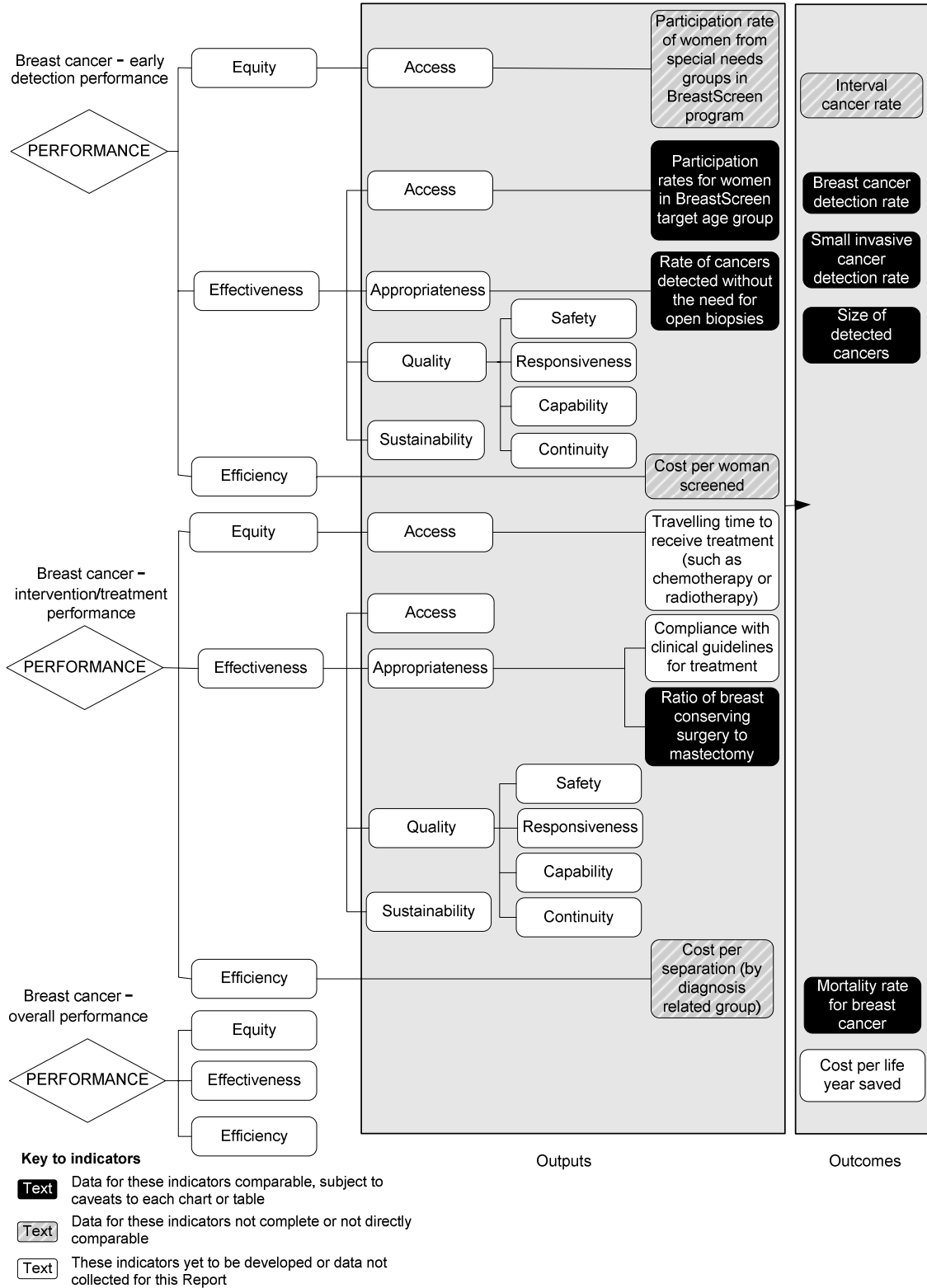
## Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for breast cancer detection and management in the 2009 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 2009 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

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<sup>1</sup> 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: 2009 Report, figure 12.7, p. 12.14.

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

‘Participation rate of women from selected community groups in BreastScreen Australia programs’ is an indicator of governments’ objective to reduce morbidity and mortality attributable to breast cancer through early detection strategies, in a manner that is equitable (box 12.1).

### Box 12.1 Participation rate of women from selected community groups in BreastScreen Australia programs

The ‘participation rate of women from selected community groups in BreastScreen Australia programs’ is defined as the proportion of the eligible population in each selected 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 equitable access to early detection services.

Data reported for this indicator are not directly comparable.

Early detection is associated with better outcomes for women with breast cancer, in terms of morbidity and mortality. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas may experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In 2006–07, the national age standardised participation rate for Indigenous women aged 50–69 (40.3 per cent) was below the total participation rate in that age group (56.1 per cent), although this may be influenced by the quality of Indigenous identification in screening program records (table 12.1, table 12A.1). Care needs to be taken when comparing data across jurisdictions, given differences in the collection of data by Indigenous status.

Table 12.1 **Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2006 and 2007 (24 month period) (per cent)<sup>a, b</sup>**

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Indigenous <sup>c</sup>	41.7	36.1	51.6	34.7	35.3	31.3	36.6	26.5	40.3
NESB <sup>d</sup>	54.7	36.5	65.0	64.8	54.0	22.2	35.0	37.0	49.7
All women aged 50–69 years	56.0	55.9	56.6	57.5	55.8	54.2	57.0	40.2	56.1

<sup>a</sup> First and subsequent rounds. <sup>b</sup> Rates are standardised to the 2001 Australian population standard. <sup>c</sup> Those women who self-identify as being of Aboriginal or Torres Strait Islander descent. <sup>d</sup> Non-English speaking background (NESB) is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2008) *Population by Age and Sex, Australian States and Territories, June 2002-2007*, Cat. no. 3201.0; ABS (unpublished), derived from *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2009*, Cat. no. 3238.0; ABS (unpublished), derived from *2006 Census of Population and Housing*; table 12A.1, 2009 Report, tables 12A.9 and 12A.11; 2009 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). The World Health Organization (WHO) describes mental health as:

... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO 2001).

There is a wide range of mental illnesses that can affect an individual's mental health, functioning and quality of life. Each mental illness is unique in terms of its incidence across the lifespan, causal factors and treatments.

### *Specialised mental health services provided in hospitals*

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 and non-Indigenous people 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 illnesses. For the jurisdictions for which data are available, Indigenous people were 1.8 times more likely to receive specialised psychiatric care in hospitals than non-Indigenous people. However, the average

length of stay for Indigenous people (18.5) was shorter than for non-Indigenous people (21.7) (table 12.2).

**Table 12.2 Specialised psychiatric care, by Indigenous status, 2005-06<sup>a, b, c</sup>**

	<i>Unit</i>	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Total</i>
Indigenous										
Separation rate <sup>d</sup>	per 1000 people	13.6	10.9	8.2	9.3	12.2	np	np	7.9	10.4
Average length of stay <sup>e</sup>	no.	18.0	14.5	22.5	23.3	15.0	20.1	10.6	10.3	18.5
Non-Indigenous										
Separation rate <sup>d</sup>	per 1000 people	5.5	5.0	6.6	5.6	6.4	np	np	4.2	5.7
Average length of stay <sup>e</sup>	no.	23.0	19.4	21.3	19.9	27.2	19.8	15.3	9.8	21.7
Rate ratio <sup>f</sup>		2.5	2.2	1.2	1.7	1.9	np	np	1.9	1.8

<sup>a</sup> The completeness of data on Indigenous status varies, so these data need to be used with care.

<sup>b</sup> Specialised psychiatric care refers to separations in which at least one day of specialised psychiatric care was received. <sup>c</sup> Indigenous identification is likely to be incomplete and to vary among jurisdictions. <sup>d</sup> Data for NSW, Victoria, Queensland, WA, SA and the NT (public hospitals only for the NT) are considered to be of acceptable quality for analytical purposes. <sup>e</sup> Includes data for overnight separations only. <sup>f</sup> The rate ratio is equal to the separation rate for Indigenous persons divided by the separation rate for non-Indigenous. **np** Not published.

Source: AIHW (2008) *Mental Health Services in Australia 2005-06*, Cat. no. HSE 56, Mental Health Series no. 10, [www.aihw.gov.au/publications/hse/mhsa05-06/mhsia\\_05-06\\_internet.xls](http://www.aihw.gov.au/publications/hse/mhsa05-06/mhsia_05-06_internet.xls) (accessed 2 December 2008); table 12A.2; 2009 Report, table 12.7, p. 12.52.

## Framework of performance indicators

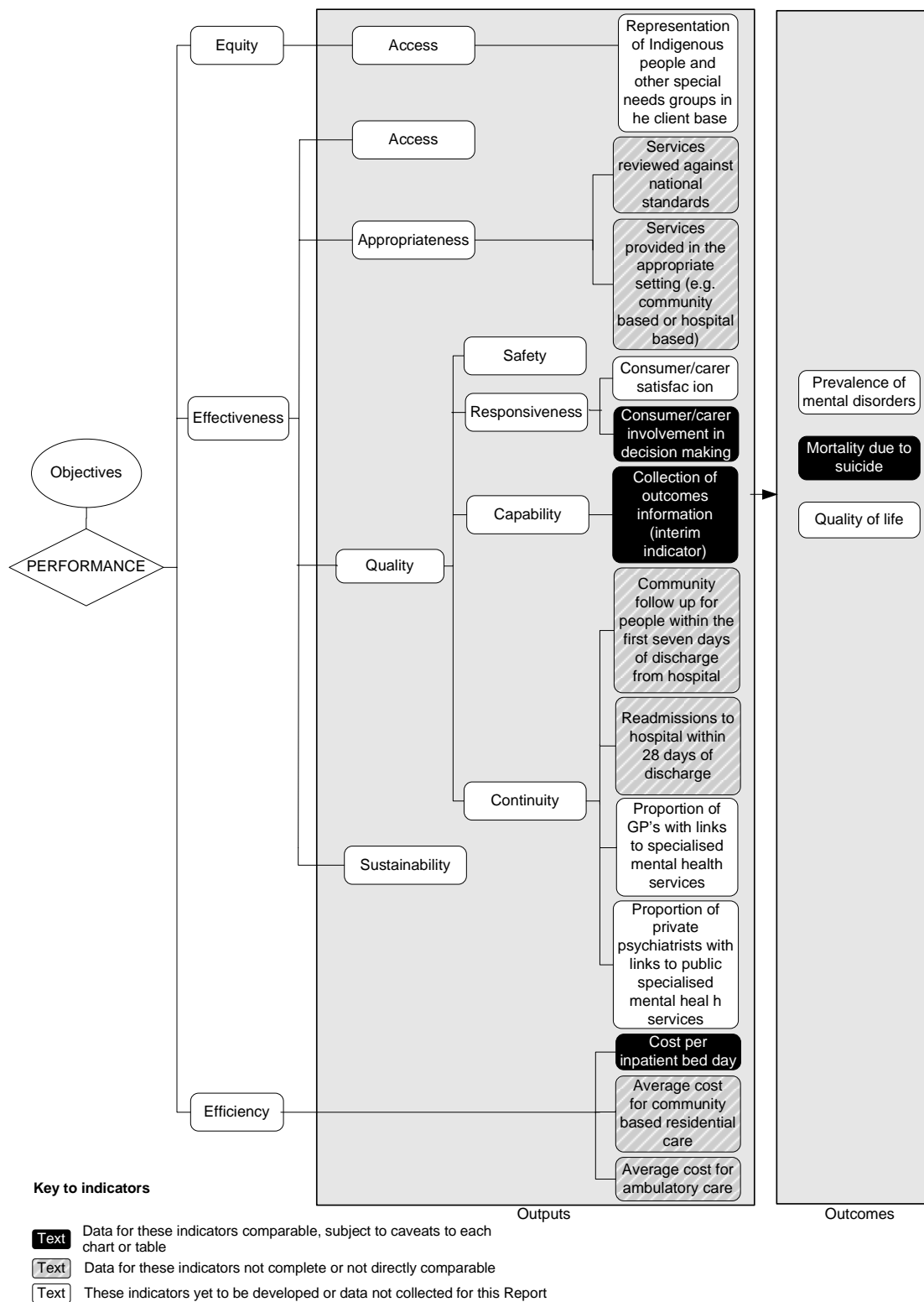
The framework of performance indicators for specialised mental health services draws on governments' broad objectives for national mental health policy, as encompassed in the National Mental Health Strategy (NMHS) and the Council of Australian Governments (COAG) National Action Plan on Mental Health (2009 Report, box 12.18 p.12.56). The framework reports on the equity, effectiveness and efficiency of specialised mental health services. It covers a number of service delivery types (admitted patient and community-based services) and includes outcome indicators of systemwide performance.

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.

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Data for Indigenous people are reported for a subset of the performance indicators for mental health management in the 2009 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 12.2. The performance indicator framework shows which data are comparable in the 2009 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

Figure 12.2 Performance indicators for mental health management



Source: 2009 Report, figure 12.32, p. 12.59.

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## Representation of Indigenous people and others in the client base

‘Representation of Indigenous people and other special needs groups in the client base’ is an indicator of governments’ objective to provide mental health services in an equitable manner, including access to services by special needs groups such as Indigenous people (box 12.2).

**Box 12.2 Representation of Indigenous people and other special needs groups in the client base**

‘Representation of Indigenous people and other special needs groups in the client base’ is yet to be defined.

Data for this indicator were not available for the 2009 Report.

## Mortality due to suicide

‘Mortality due to suicide’ is an indicator of governments’ objective under the NMHS to prevent mental health problems, mental illness and suicide, and identify and intervene early with people at risk (box 12.3). People with a mental illness 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.)

**Box 12.3 Mortality due to suicide**

Mortality due to suicide’ is defined as the suicide rate per 100 000 people for all people, for males and females, for people of different ages (including those 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 contributes to reducing suicides, 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 severe 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.

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**Box 12.3 (Continued)**

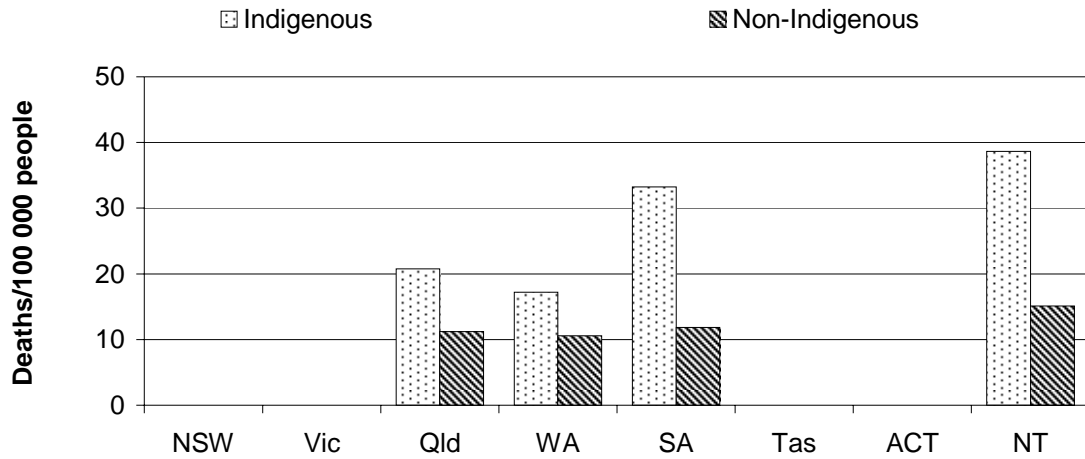
In addition, many factors outside the control of mental health services may influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly 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.

Data reported for this indicator are comparable.

The Indigenous suicide rate is presented for the period 2002–2006 for four jurisdictions: Queensland, WA, SA and the NT (figure 12.3). After adjusting for age differences between populations, the suicide rates for Indigenous people for the period 2002–2006 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. 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 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 12.3 **Suicide rates, by Indigenous status, 2002–2006<sup>a, b</sup>**



<sup>a</sup> 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. <sup>b</sup> Data for NSW, Victoria, Tasmania and the ACT are not reported due to varying coverage across states and territories in the identification of Indigenous deaths in death registrations.

Source: ABS (unpublished), derived from *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.3; 2009 Report, figure 12.43, p. 12.85.

## Future directions for reporting on mental health management

### *Mental health*

Similar to previous years, a key challenge for improving the reporting of mental health management is improving the reporting of effectiveness and efficiency indicators for Indigenous people.

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## 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 Indigenous women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent)

### Mental health

**Table 12A.2** Specialised psychiatric care separations reported for Indigenous patients, Australia, 2005-06

**Table 12A.3** Suicide deaths, by Indigenous status

## References

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

WHO (World Health Organization) 2001, *Strengthening mental health promotion*, (Fact sheet no. 220), Geneva.