
12 Health management issues

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Attachment tables

Attachment tables are identified in references throughout this Indigenous Compendium by an 'A' suffix (for example, in this chapter, table 12A.3). As the data are directly sourced from the 2010 Report, the Compendium also notes where the original table, figure or text in the 2010 Report can be found. For example, where the Compendium refers to '2010 Report, p. 12.15' this is page 15 of chapter 12 of the 2010 Report, and '2010 Report, table 12A.2' is attachment table 2 of attachment 12A of the 2010 Report. A full list of attachment tables is provided at the end of this chapter, and the attachment tables are available from the Review website at (www.pc.gov.au/gsp).

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 distinct from specialist psychiatric wards). Some people with a mental illness are cared for in residential aged care services.

Indigenous data in the Health management issues chapter

The Health management issues chapter in the *Report on Government Services 2010* (2010 Report) contains the following data for Indigenous people:

- participation rates of women screened by BreastScreen Australia (24 month period) (first and subsequent rounds) (per cent), 2007–2008
- specialised mental health care reported, 2006-07

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- suicide deaths, 2003–2007.

Breast cancer

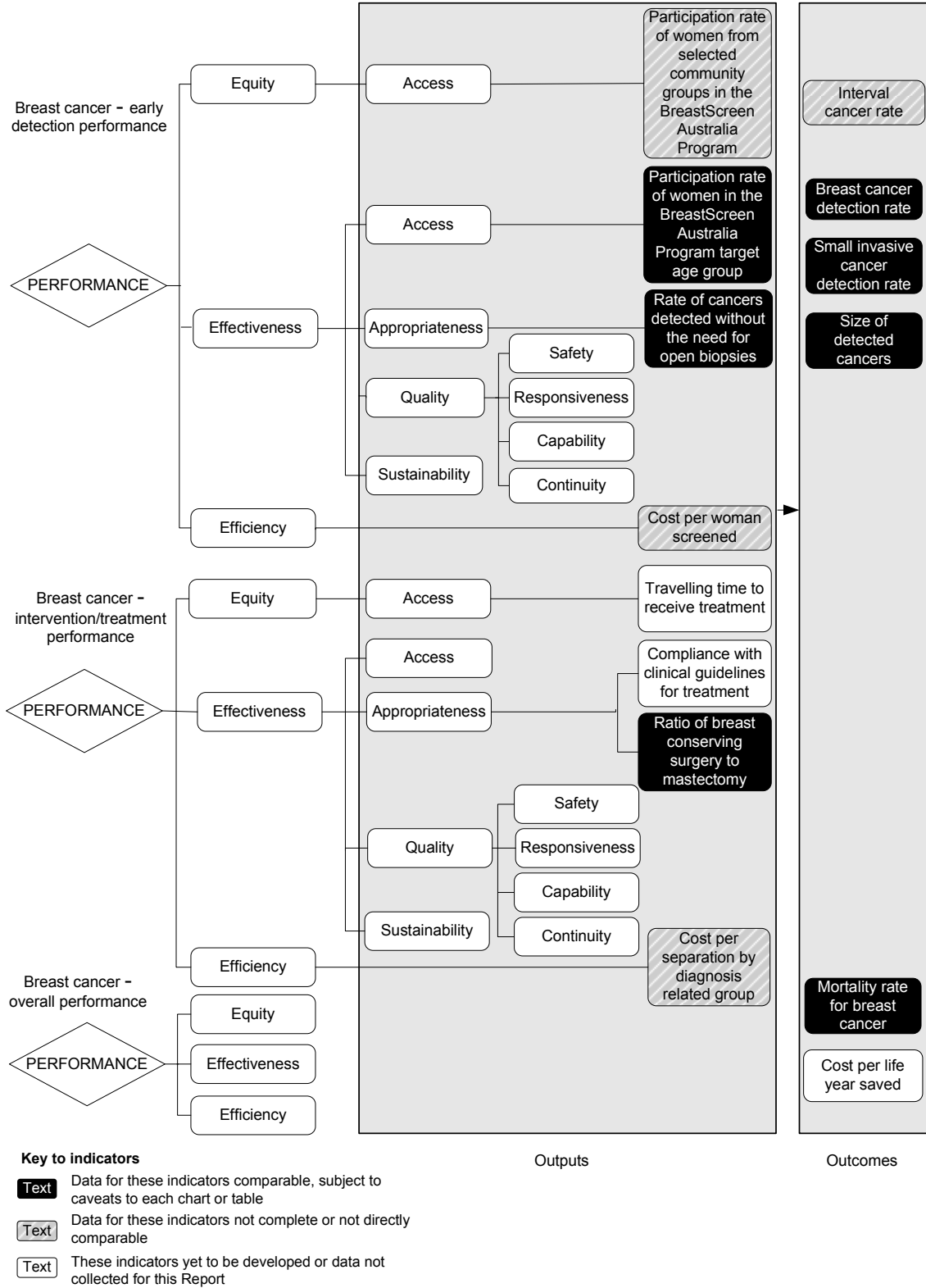
Breast cancer is a disease whereby abnormal cells in the ducts (that carry milk to the nipple) or lobules (where milk is produced) of the breast grow and multiply out of control (2010 Report, box 12.1). Breast cancer can be invasive or non-invasive. Non-invasive breast cancer remains in the ducts or lobules. Invasive breast cancer spreads beyond the ducts or lobules to invade surrounding breast tissue, and can spread to other parts of the body, or metastasize (AIHW 2009). If left untreated, most invasive cancers (tumours) are life-threatening (AIHW 2009).

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 2010 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 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Figure 12.1 Performance indicators for breast cancer detection and management



Source: 2010 Report, figure 12.7, p. 12.15.

Early detection — participation rate of women from selected community groups in the BreastScreen Australia Program

‘Participation rate of women from selected community groups in the BreastScreen Australia Program’ 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 the BreastScreen Australia Program

‘Participation rate of women from selected community groups in the BreastScreen Australia Program’ is defined as the proportion of the target 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 reduced morbidity and mortality for women with breast cancer. Indigenous women, women from non-English speaking backgrounds (NESB) and women living in outer regional, remote and very remote areas can experience particular language, cultural and geographic barriers to accessing breast cancer screening.

In the 24 month period 2007 and 2008, the national age standardised participation rate for Indigenous women aged 50–69 (35.8 per cent) was below the total participation rate in that age group (54.9 per cent), although this can be influenced by the quality of Indigenous identification in screening program records (table 12.1). Care needs to be taken when comparing data across jurisdictions as there is variation in the collection of Indigenous and NESB identification data.

Table 12.1 Age standardised participation rates of women aged 50–69 years from selected communities in BreastScreen Australia programs, 2007 and 2008 (24 month period) (per cent)^{a, b}

	NSW	Vic	Qld	WA	SA	Tas ^c	ACT	NT	Aust
Indigenous ^d	37.0	27.6	46.4	30.8	31.6	39.5	44.2	23.5	35.8
NESB ^e	53.0	34.6	66.6	62.5	55.1	22.2	17.3	38.5	48.1
All women aged 50–69 years	54.6	53.1	57.1	55.2	57.4	54.5	53.8	39.8	54.9

^a First and subsequent rounds. ^b Rates are standardised to the 2001 Australian population standard. ^c Participation rates for NESB women may be understated due to a change in the BreastScreen Tasmania client registration form in the 2005-2006 screening period. This saw self-reporting of NESB status drop by 40 per cent between the 2004-2005 24 month reporting period and the 2006-2007 24 month reporting period. Actual NESB participation is not believed to have changed significantly compared to previous reporting periods. ^d Women who self-identify as being of Aboriginal and/or Torres Strait Islander descent ^e NESB is defined as speaking a language other than English at home.

Source: State and Territory governments (unpublished); ABS (2009) *Population by Age and Sex, Australian States and Territories, June 2008*, Cat. no. 3201.0; ABS (unpublished) *Experimental Estimates And Projections, Aboriginal And Torres Strait Islander Australians, 1991 to 2021*, Cat. no. 3238.0; ABS (unpublished) *2006 Census of Population and Housing*; table 12A.1, 2010 Report, tables 12A.9–12A.10 and 12A.12; 2010 Report, table 12.4, p. 12.17.

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 positive 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.

Impact of mental illness

Mental illnesses contribute significantly to the total burden of disease and injury in Australia (13.3 per cent of the total burden in 2003) (Begg *et al.* 2007). The total burden comprises the amount of ‘years’ lost due to fatal events (years of life lost due to premature death) and non-fatal events (years of ‘healthy’ life lost due to disability). Mental illness is also the leading cause of ‘healthy’ life years lost due to disability (24 per cent of the total non-fatal burden in 2003) (Begg *et al.* 2007).

Mental illness can affect an individual's functioning and quality of life. According to the *2007 National Survey of Mental Health and Wellbeing* (SMHWB), in 2007, people with a lifetime mental disorder who had symptoms in the previous 12 months (20.0 ± 1.1 per cent of the total population), were significantly overrepresented in the populations who had high to very high levels of psychological distress — 57.1 ± 5.1 per cent and 79.6 ± 7.2 per cent of these populations respectively (ABS 2008).

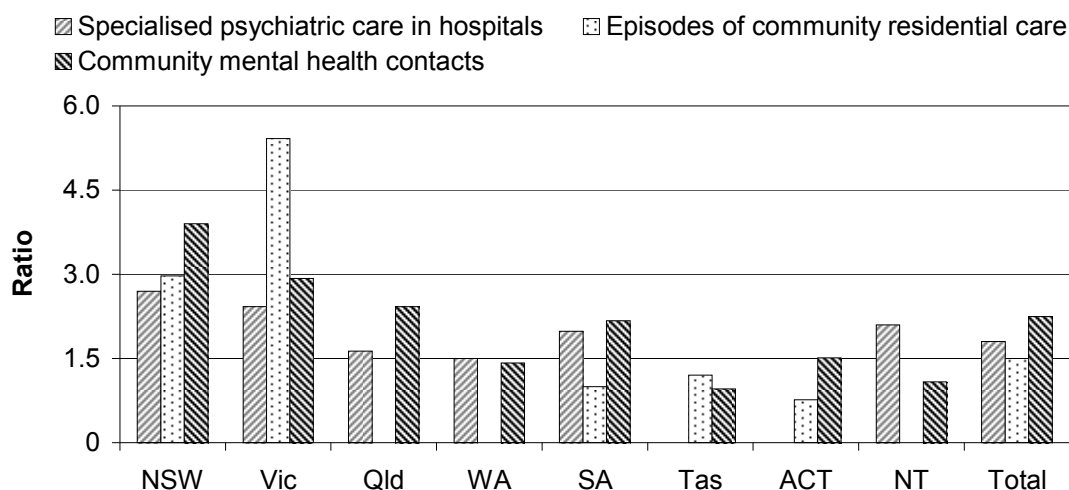
The *National Aboriginal and Torres Strait Islander Health Survey* conducted in 2004-05 found that after adjusting for age, approximately 27 per cent of Indigenous Australians reported high levels of psychological distress (AHMAC 2008). This was more than twice the rate for non-Indigenous adults (13 per cent).

Service use by Indigenous status of patient

Data on service use by the Indigenous status of patients are available, but comparisons are difficult because Indigenous patients are not always correctly identified. Differences in rates of service use could also reflect other factors, including the range of social and physical infrastructure services available to Indigenous people, and differences in the complexity, incidence and prevalence of illnesses.

Combined data for the jurisdictions for which data are available, show that Indigenous people were 1.8 times more likely to receive specialised psychiatric care in hospitals (both public and private hospitals), 1.5 times more likely to have an episode of community residential care and 2.2 times more likely to have a community mental health contact than non-Indigenous people (figure 12.2). Table 12A.2 contains further information on use of these services by Indigenous status.

Figure 12.2 **Ratio of Indigenous to non-Indigenous specialised mental health service use, 2006-07^{a, b, c, d, e, f}**



^a Data for episodes of community residential care should be interpreted with caution due to the varying quality and completeness of Indigenous identification across jurisdictions. Of the jurisdictions for which data are available, only Tasmania and the ACT considered their Indigenous data to be of acceptable quality. ^b Data for community mental health contacts should be interpreted with caution. Across jurisdictions, the data quality and completeness of Indigenous identification varies or is unknown. Data are considered of acceptable quality for Queensland, WA, Tasmania, the ACT and the NT. ^c The ratio is equal to the service use rate (episodes, contacts or separations) for Indigenous people divided by the service use rate for non-Indigenous people. Data for non-Indigenous includes people whose Indigenous status was 'not stated'. ^d Data for specialised psychiatric care in hospitals includes both public and private hospitals. ^e Queensland does not fund community residential services, but funds a number of campus-based and non-campus-based extended treatment services. ^f Data by Indigenous status are not published for WA and the NT for episodes of community residential care and for Tasmania and the ACT for specialised psychiatric care in hospitals.

Source: AIHW (2009) *Mental health services in Australia 2006–07*, Mental health series no. 11, Cat. no. HSE 74 (internet only tables); table 12A.2; 2010 Report, figure 12.27, p. 12.52.

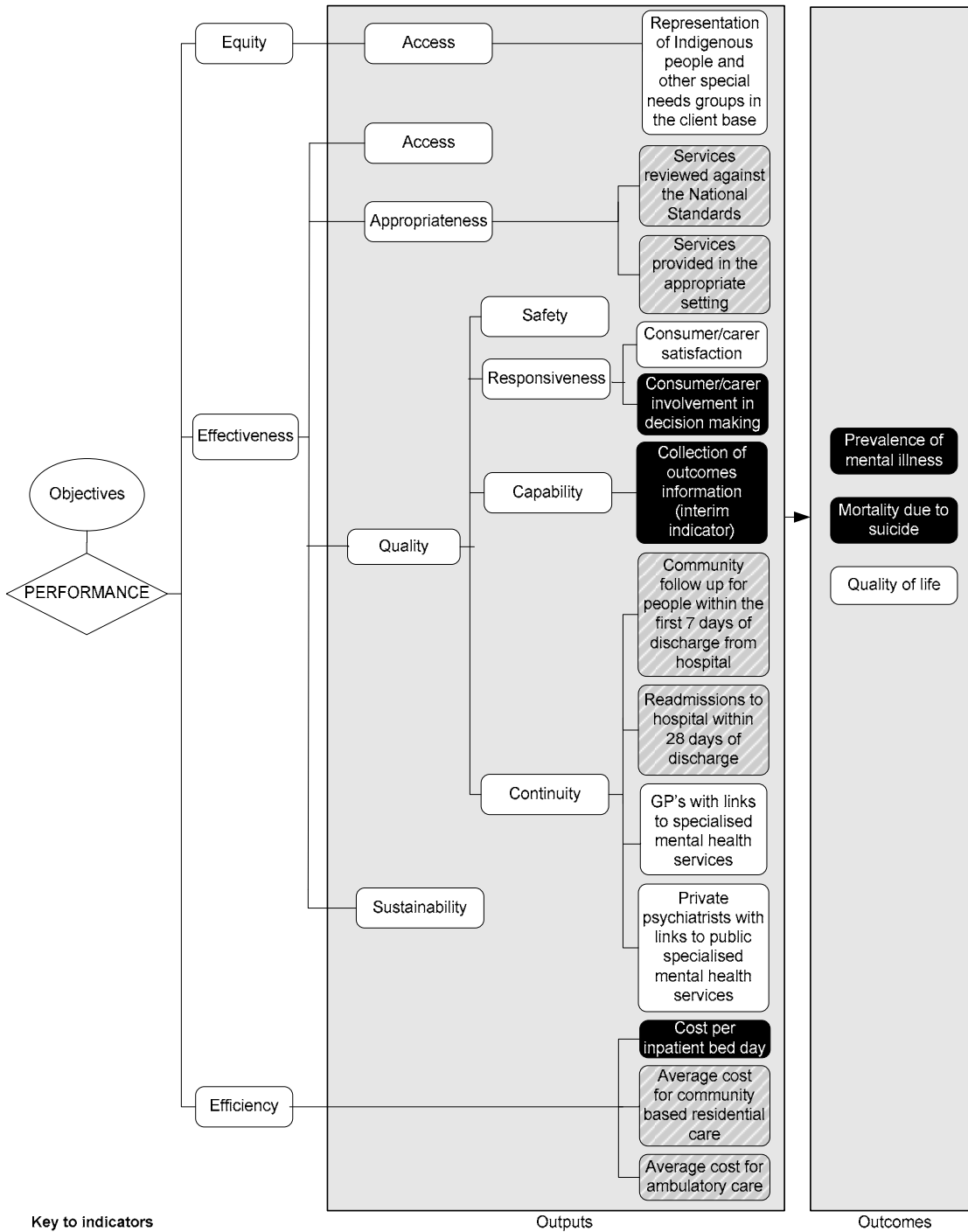
Framework of performance indicators

Data for Indigenous people are reported for a subset of the performance indicators for mental health management in the 2010 Report. It is important to interpret these data in the context of the broader performance indicator framework outlined in figure 12.3. The performance indicator framework shows which data are comparable in the 2010 Report. For data that are not considered directly comparable, the text includes relevant caveats and supporting commentary.

The Report's statistical appendix contains data that may assist in interpreting the performance indicators presented in this chapter. These data cover a range of demographic and geographic characteristics, including age profile, geographic distribution of the population, income levels, education levels, tenure of dwellings and cultural heritage (including Indigenous and ethnic status) (appendix A).

Over the period 2004–2009, 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) provided a basis for action by all governments and communities to improve the social and emotional well being and mental health needs of Indigenous Australians. Ongoing monitoring is provided under the *Aboriginal and Torres Strait Islander Health Performance Framework*. This framework includes 71 performance indicators that measure progress against closing the gap in Indigenous health outcomes. Of these indicators, two relate specifically to social and emotional well being. The performance indicators are reported on biennially.

Figure 12.3 Performance indicators for mental health management



Key to indicators

- Text** Data for these indicators comparable, subject to caveats to each chart or table
- Text Data for these indicators not complete or not directly comparable
- Text These indicators yet to be developed or data not collected for this Report

Source: 2010 Report, figure 12.31, p. 12.59.

Representation of Indigenous people 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 2010 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).

Box 12.3 Mortality due to suicide

‘Mortality due to suicide’ is defined as the suicide rate per 100 000 people. The suicide rate is reported for Indigenous and non-Indigenous people.

A low or decreasing suicide rate per 100 000 people is desirable.

While mental health services contribute to reducing suicides, other government services also have 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 education, housing, justice and community services agencies.

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Box 12.3 (Continued)

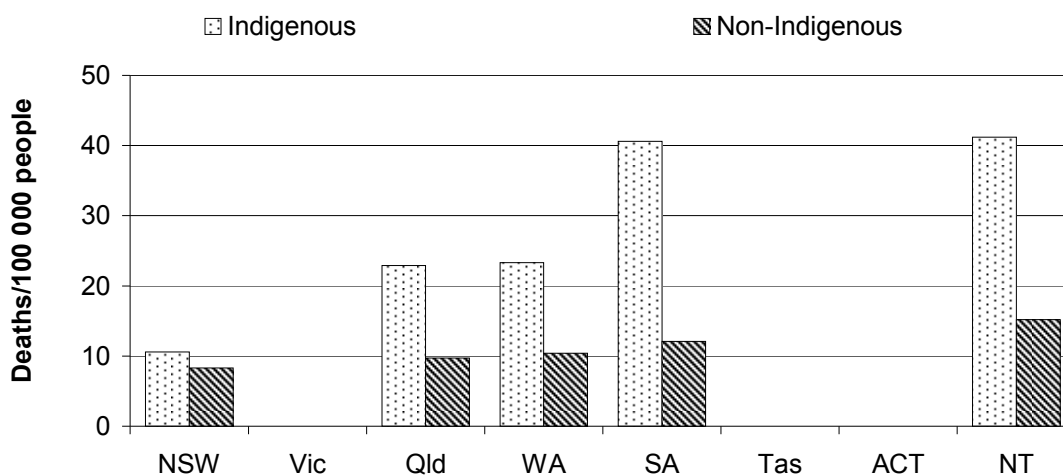
Many factors outside the control of mental health services can influence a person's decision to commit suicide. These include environmental, sociocultural and economic risk factors — for example, adverse childhood experiences (such as sexual abuse) can increase the risk of suicide, particularly in adolescents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

Indigenous suicide rates are presented for NSW, Queensland, WA, SA and the NT (figure 12.4). After adjusting for differences in the age structure of the two populations, the suicide rates for Indigenous people for the period 2003–2007 were 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 12.4 Suicide rates, by Indigenous status, 2003–2007^{a, b}



^a Indigenous population figures are based on ABS's *Experimental Estimates and Projections, Aboriginal and Torres Strait Islander Australians* (series B, 2006 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. ^b Data for Victoria, Tasmania and the ACT are not reported due to varying coverage in the identification of Indigenous deaths in death registrations.

Source: ABS (unpublished) *Causes of Deaths, Australia*; Cat. no. 3303.0; table 12A.3; 2010 Report, figure 12.48, p. 12.88.

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.

COAG developments

Report on Government Services (ROGS) alignment with National Agreement (NA) reporting

It is anticipated that future editions of health chapters will align with applicable NA indicators, including the *National Indigenous Reform Agreement*. Further alignment between the ROGS and NA indicators, and other reporting changes, might result from future developments in NA and National Partnership reporting.

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). Attachment tables are on the Review website (www.pc.gov.au/gsp). Users without access to the website can contact the Secretariat to obtain the attachment tables (see contact details on the inside front cover of the Compendium). 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 mental health care reported, by Indigenous status, 2006-07

Table 12A.3 Suicide deaths, by Indigenous status

References

- ABS 2008, *National Survey of Mental Health and Wellbeing: Summary of Results, 2007*, Cat. no. 4326.0
- AHMAC (Australian Health Ministers' Advisory Council) 2008, *Aboriginal and Torres Strait Islander Health Performance Framework Report 2008*, AHMAC, Canberra.
- AIHW (Australian Institute of Health and Welfare) 2009, *BreastScreen Australia Monitoring Report 2005-2006*, Cancer series no. 48, Cat. no. CAN 44, Canberra.
- Begg S., Vos T., Barker B., Stevenson C., Stanley L. and Lopez A. 2007, *The burden of disease and injury in Australia, 2003*, Cat. no. PHE 82, 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.