Developing an understanding of disability in Mount Gambier City to further social inclusion

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Introduction
Disability, defined as a physical or mental condition that limits a person’s movement, senses or activities and has been, or is expected to have an impact on an individual for greater than 6 months, affects almost 1 in 5 Australians (ABS, 2012). Disability tends to be more common in rural and remote areas of Australia, compared to metropolitan areas (Gething, 1997), affecting 21.2% of the rural population and 22.1% of the remote population (Business career.edu.au, 2012). Having a disability in rural and remote Australia presents these persons with a double disadvantage, in which the disadvantageous effects of disability are amplified by degrees of remoteness (NDCDA and NRHA report, 2013). Such issues include distance and accessibility to services and facilities, the disparity in quality of health care between metropolitan and rural areas and the disparity in acute medical care and chronic disability care.

The Mount Gambier City Council has been making progress towards social equality within their community, particularly their advocacy for the Indigenous population and those with mental health issues. They have recently directed their interests towards those with disabilities in their region. Based on the 2011 Mount Gambier City census, 6% of the population reported as having a disability.

Objectives
To critically appraise Mt Gambier Hospital admissions data of the first half of 2014, in order to develop a preliminary profile describing the disabled population of the city. We expect that this study will provide a clearer population description for which the local council can base new implementations and services within the City to better cater to the needs of disabled residents in the area.

Method
Diagnosis Related Groups (DRGs) data was used to do a retrospective study of types of patients admitted to the Mt Gambier Hospital from 1 January 2014 until 30 June 2014. Patients were categorized under 4 disability codes: (immobility (paraplegia, quadriplegia, cerebral palsy, arthritis), mental illness (schizophrenia, schizoaffective disorder, bipolar, depressive episodes, persistent mood disorder), dementia and intellectual disabilities (intellectual retardation, Asperger’s syndrome, childhood autism)). The sex, postcode, number of admissions in 2014, and socio-economic clinical codes were used to identify possible duplicate admissions of the same patient. These codes were also used to create a more integral picture of the disabled population.

A literature review was also performed, identifying the statistics, issues and potential solutions arising from living with a disability in similar rural and remote Australian communities. Scientific literature published in a peer reviewed journal and grey literature which was organizational, governmental and research community developed were included. Any publication that was non English, perspective of invited comments or not easily accessible publicly were excluded.

Constant consultation with the members from Mount Gambier City Council allowed us to direct our research and interpretation of findings to cater to the Council’s interest in social equality and increased engagement within the community.

Discussion
From the 2011-2012 Australian Institute of Health and Welfare’s Australian hospital statistics report, 4% were admitted to hospital Australia-wide for mental and behavioural health (in Mount Gambier, 4% of hospitalised individuals experienced schizophrenia, bipolar disorder). An incoherent pattern of prevalence was observed between dementia in our study (11%) and that of government data (0%). We could not make any accurate comparison between nationwide and Mt Gambier Hospital admittance for intellectual disabilities. Disability due to immobility in Mount Gambier Hospital (40%) was higher than the nationwide hospital data (10%).

We encountered a number of barriers in completing this project. Firstly, the term ‘disability’ had to be defined and quantified. The term encompasses a very broad range of conditions form disparate, and often unrelated medical fields including not only to rheumatology, immunology and respiratory medicine. In addition, many of the conditions are not equally debilitating for all patients. Rather, the amount of functional loss of patient is dependent on both the severity of the condition and subjective experience with the condition. To assess the functional needs of this population, further study which takes account of opinion of the patients may be needed.

Furthermore, as disabling conditions rarely have acute presentation, most patients would be admitted to hospital for that reason. Instead, we found that disability was more often a coincidental finding in the history that accompanied their true reasons for hospital admittance. Therefore it was patients with multiple co-morbidities or acute exacerbations of their disability who were mostly likely to present. Hence, hospital admittance may not accurately reflect those living with disability in the Mount Gambier area, as reporting across all health care settings, including but not limited to Primary Care centers, Disability Services, and Private health care, were not included. There was also a lack of existing research on the burden of disability on healthcare at Mt Gambier Hospital.

Finally, as this project was limited by a time constraint of four weeks we were forced to omit some major disabling conditions including: sensory deficiencies, and neurological conditions. Although under the scope of our used definition of disability, it was impossible to analyze all the hospital records in the predetermined time that we had. This means that our results discount a possibly significant subset of the disabled population within Mt Gambier. We would recommend further studies to be conducted including these conditions in addition to including health care records from other health care services to gain a more reliable understanding of the disability profile and needs in Mt Gambier.

We anticipate that our findings will assist the Mount Gambier City Council in:
1. Raising awareness of disability in the Mt Gambier community to encourage discussion and development of plans to improve quality of life for the disadvantaged
2. Encouraging community-wide engagement in disability service provision to reduce social inequality by:
   - Identify and rectify problematic areas regarding accessibility
   - Implement Programs and services aiding in social inclusion
3. Expanding data collection from Mt Gambier Public Hospital records and other sources to develop a better understanding of the disability population

Conclusion
The data collected enabled the quantification of different disability types and in a rural community setting. Immobility and mental illness are the two main areas of impairment of patients admitted to the Mt Gambier Hospital. In particular, the number of hospital admission days, gender differences, age and geographic distribution of patients were the major points of focus of this study. This information may be used by local councillors to advocate for improved service provision for affected residents and patients.