HEALTH PRIORITIES IN AUSTRALIA

CQ 1 – HOW ARE PRIORITY ISSUES FOR AUSTRALIA’S HEALTH IDENTIFIED?

MEASURING HEALTH STATUS

⇒ To identify health priority issues within a population, it is necessary to understand the health status of that population and its subgroups. Health status is measured through epidemiology.

Role of epidemiology

**Epidemiology** – the study of the rates and patterns of illness, disease and injury among specific population groups.

**Prevalence** – refers to the number of cases of disease that exists in a defined population at a point in time. Occurrence, commonness.

**Incidence** – refers to the number of new cases of disease occurring in a defined population over a period of time.

Measures of epidemiology

**Mortality** (death rates) – the number of deaths for a given cause in a given population, over a set time period

**Infant mortality** – the number of infant deaths in the first year of life per 1000 live births

**Morbidity** (disease and sickness rates) – the rates, distribution and trends of illness, disease and injury in a given population

**Life expectancy** – indicates the number of years a person is expected to live

Epidemiology is used by governments and health-related organisations to obtain a picture of the health status of a population, to identify the patterns of health and disease, and analyse how health services and facilities are being used. This information helps to:

- Identify specific health issues
- Identify areas of inequity between population groups
- Allocate resources to effectively address specific health needs
- Evaluate health programs and initiatives
- Identify risk factors and promote behaviours that positively impact health

However, it does not provide information about a person’s quality of life in a holistic sense, nor does it accurately describe the determinants of health.
**IDENTIFYING PRIORITY HEALTH ISSUES**

- Addressing priority issues then allow for the equitable allocation of resources and funding, to minimise the gaps in health status that exist between various sub-groups

**Social justice principles**

- Equity – the fair allocation of funding and resources
- Diversity – involves all the community groups in planning and making decision about health issues
- Supportive environments – refers to both the physical and social aspects of surroundings

Social justice is the **promotion** of fundamental and universal **human rights** and the **removal of inequality**. This is the responsibility of all sectors of the health care system.

**Priority population groups**

To achieve social justice for each health issue, specific priority population groups are identified through epidemiology. These groups are those that are shown by research to experience an unnecessarily **high incidence** of the condition.

**Prevalence of condition**

Rates and trends of morbidity and mortality highlight health problems of concern, and the allocation of funding and resources are directed accordingly. The identification of risk factors through epidemiology can indicate the potential for change in a health area.

**Potential for prevention and early intervention**

The majority of diseases and illnesses suffered by Australians result from **poor lifestyle behaviours**. Therefore, health problems that are largely preventable, as well as those that respond well to intervening in its early stages, deserve increased attention by those involved in health promotion.

**Costs to the individual and community**

Disease and illness can place a great **economic** and **health burden** on the individual like financial loss, loss of productivity, diminished quality of life and emotional stress. Also, illness, disease and premature death all place an economic burden on the community, Investments in improving the health outcomes for those affected can alleviate these costs.

- **Direct costs** – money spent on diagnosing, treating, caring for the sick and the amount spent on prevention e.g. hospital charges, medications, travel, pharmaceutical prescriptions, screening and education
- **Indirect costs** – the value of the output when people become too ill to work or die prematurely e.g. loss of quality of life, exclusion, absenteeism
**CQ 2 – WHAT ARE THE PRIORITY ISSUES FOR IMPROVING AUSTRALIA'S HEALTH?**

### GROUPS EXPERIENCING HEALTH INEQUITIES

#### Aboriginal and Torres Strait Islander peoples

<table>
<thead>
<tr>
<th>Nature and extent of the health inequities</th>
<th>Sociocultural, socioeconomic and environmental determinants</th>
<th>Role of individuals, communities and governments</th>
</tr>
</thead>
</table>
| • Life expectancy is at least 10 years ↓  
  • ↑ mortality  
  • ↑ rates of hospitalisation and suicide  
  • 2 x higher infant mortality rates and smoking rates  
  • ↑ rates of depression and anxiety | • Ongoing effects of colonisation like social dislocation, loss of culture, identity and self-worth  
  • ↓ standard of living (water, sanity, food etc.)  
  • ↓ education attainment and disposable income  
  • ↑ unemployment  
  • 24% live in rural and remote areas = ↓ access to health facilities and services | • ↑ decision making through education  
  • Incentives for health professionals to help in communities  
  • ↑ educational opportunities (scholarships)  
  • Ensuring full participation by all ATSI representative groups  
  • Close the Gap campaign: ↑ community and maternal health care  
  • ↑ expenditure on education and health |

#### People in rural and remote areas

<table>
<thead>
<tr>
<th>Nature and extent of the health inequities</th>
<th>Sociocultural, socioeconomic and environmental determinants</th>
<th>Role of individuals, communities and governments</th>
</tr>
</thead>
</table>
| • ↑ rates of mortality and morbidity  
  • ↑ rates of injury  
  • ↑ rates of self-harm, suicide and smoking | • Poor attitudes of men towards personal health care = ↓ chance of seeking help  
  • ↓ relationship breakdown  
  • ↑ social isolation and unemployment  
  • ↓ education and public infrastructure | • Participation in support groups  
  • Access to support networks and health information  
  • Royal Flying Doctor Service  
  • Beyond Blue |
### HIGH LEVELS OF PREVENTABLE CHRONIC DISEASE, INJURY AND MENTAL HEALTH PROBLEMS

**Cardiovascular disease (CVD)**

| Nature | Includes all the diseases and conditions of the heat and blood vessels  
|        | Caused by a build-up of fatty tissue inside the blood vessels (atherosclerosis) and the hardening of the blood vessels (arteriosclerosis)  
|        | - CHD – blockages in the vessels of the heart (i.e. heart attack)  
|        | - Cerebrovascular disease – blockages in the vessels of the brain (i.e. stroke)  
|        | - PVD – blockages in the vessels in the limbs, often legs/feet |
| Extent | CVD kills one Australian nearly every 10 minutes  
|        | Leading cause of death overall  
|        | Responsible for ¼ of all deaths in Australia  
|        | Both mortality and morbidity are decreasing for males and females → increased awareness + improved technology |
| Protective factors | Don’t smoke, exercise regularly, have a good diet, control blood pressure ↓140/80, take tablets, weight control, lower cholesterol, lower blood glucose level |
| Risk factors | Modifiable: obesity, smoking, physical inactivity  
<p>|        | Nonmodifiable: genetic disposition, age, gender, diabetes |
| Sociocultural determinants | Family, peers, media and culture influence food habits, lifestyle choices |
| Socioeconomic determinants | The lower the education, the lower the employment, and therefore lower income. This means that people may not make adequate health choices |
| Environmental | Geographical location can affect health factors, access to health facilities |</p>
<table>
<thead>
<tr>
<th>determinants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Groups at risk</strong></td>
</tr>
<tr>
<td>ATSI people, smokers, overweight or obese people, people with high blood pressure and/or cholesterol levels, people with family history, older age groups, rural and remote areas, low socioeconomic status population and male population</td>
</tr>
</tbody>
</table>

**Cancer (skin, breast, lung)**

<table>
<thead>
<tr>
<th>Nature</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Group of diseases resulting from uncontrolled growth of body cells. These cells multiply in a random manner and form tumours (swellings)</td>
</tr>
<tr>
<td>• Benign – tumours that remain localised with no threat of spreading</td>
</tr>
<tr>
<td>• Malignant – tumours that have potential to spread throughout surrounding normal cells and affect their functioning</td>
</tr>
<tr>
<td>• Metastasis – if left untreated, the cancer cells break off and enter the blood stream and lymphatic system, travelling to other parts of the body where they cause new cancers to grow</td>
</tr>
<tr>
<td>• Cancers are classified according to the area of the body where they began:</td>
</tr>
<tr>
<td>o Carcinoma (cancer of epithelial cells i.e. skin, mouth, throat, breasts and lungs)</td>
</tr>
<tr>
<td>o Sarcoma (cancer of bone muscle or connective tissue)</td>
</tr>
<tr>
<td>o Leukemia (cancer of the body's blood forming organs)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Extent</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Incidence of cancer is increasing but mortality rate is decreasing</td>
</tr>
<tr>
<td>• 1 in 5 will die from cancer before the age of 85</td>
</tr>
<tr>
<td>• Cancer accounts for approximately 3 in 10 deaths</td>
</tr>
<tr>
<td>• Lung cancer is estimated to be the leading cause of cancer death in 2017</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protective factors</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast cancer</strong></td>
</tr>
<tr>
<td>Be aware of family history, regular self-examination, breast screening</td>
</tr>
</tbody>
</table>

| **Lung cancer** |
| Not smoking, avoiding exposure to passive chemicals |

| **Skin cancer** |
| **Risk factors** | Lung cancer  
Tobacco smoking (cause 90% of lung cancers), occupational exposure to cancer-causing agents (e.g. asbestos), air pollution, exposure to radiation (e.g. radon gas in some mines)  
Breast cancer  
Family history or personal history of the disease, gender, high-fat diet, early onset of menstruation, late menopause, obesity, benign breast disease, late age at full-term pregnancy or childlessness  
Skin cancer  
Prolonged exposure to sun’s ultraviolet rays, especially as a child and adolescent, fair skin that burns rather than tans, the number and type of moles on the skin |
| --- | --- |
| **Sociocultural determinants** | • Family history of cancer are more at risk.  
• Higher rates of smoking at an earlier age and less access to health services = ATSI people  
• Tanning habits or excessive sun exposure |
| **Socioeconomic determinants** | • Low socioeconomic status or unemployment = higher death rates = income can limit healthy food choices  
• Lower education levels are more at risk as poor education is linked to poor health choices and less knowledge |
| **Environmental determinants** | • People living in rural and remote areas are more at risk = less access to health information and services  
• Working outdoors, such as lifeguards  
• Occupations involving repeated exposure to carcinogens, such as asbestos, are more at risk of lung cancer |
| **Groups at risk** | Skin cancer  
Young children (to sun burns, and damaging skin cells and the skin is not very mature), people who have had lots of UV ray exposure, people will fairer and lighter skin, and there is less pigment to prevent the UV rays from affecting the cells.  
Breast cancer  
Older women, family history of breast cancer, taking hormones, physical inactivity |
## Lung cancer
Smokers or exposure to second-hand smoke, family history, exposure to chemical like asbestos

### Diabetes

| Nature | A disease that affects the body’s ability to take glucose from the bloodstream to use it for energy  
Caused by a malfunctioning of the pancreas leading to insufficient insulin levels  
Type 1 insulin dependent  
  - Usually present early in life and patients require insulin injections and must monitor diet and physical activity  
Type 2 noninsulin dependent  
  - Usually present later in life as a result of long-term poor health behaviours related to diet and exercise  
  - Requires medication and lifestyle modifications  
Long term effects of diabetes = vision problems, kidney disease, circulatory issues in arms and legs, CVD |
|---|---|
| Extent | World’s fastest growing disease  
5.1% of Australians have diabetes (85% being Type 2)  
Prevalence increases with age  
Accounts for 10% of all deaths |
| Protective factors | Maintaining a healthy weight, regular physical activity, making healthy food choices, managing blood pressure, managing cholesterol levels, not smoking |
| Risk factors | Modifiable: high blood pressure, having CVD, overweight  
Nonmodifiable: > 55 years old, family history, being of Asian descent |
<p>| Sociocultural determinants | Indigenous (10% - 30% may have diabetes), being of Asian descent, social acceptance of binge drinking, ageing population |
| Socioeconomic determinants | Low SES (more likely to have poor diet, drink alcohol and physical inactivity), low education (less awareness of prevention strategies and health lifestyle behaviours) |
| Environmental | People in rural and remote areas have difficulty accessing medical services, junk food advertising |</p>
<table>
<thead>
<tr>
<th>determinants</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Groups at risk</td>
<td>Elderly, Indigenous Australians, socioeconomically disadvantaged, people from rural and remote areas</td>
</tr>
</tbody>
</table>

**A GROWING AND AGEING POPULATION**

Australia’s growing and ageing population has been caused by:

- Decrease in birth rate
- Decline in mortality rates along with an increase in life expectancy
- Sustained rates of immigration from overseas

**Healthy ageing**

Healthy ageing – concerned with quality of life, independence and lengthening the number of healthy years. Benefits include the prevention of disease, extended longevity and enhanced quality of life.

The goal of healthy ageing is to enable the elderly to maintain their health into old age, which allows them to contribute to the workforce longer, and engage in society better. This increases economic growth, but also decreases the use of health services by the elderly, who are the largest users of the healthcare system.

**Increased population living with chronic disease and disability**

Larger elderly population = more people living with chronic disease and disability

Elderly people tend to suffer higher rates of CVD, cancer, arthritis, asthma, osteoporosis, depression, dementia and diabetes. The risk factors for these diseases are largely modifiable and lifestyle based

As a result, improved medical services such as preventative screening programs and detection technology as well as widespread education programs are required.
Demand for health services and workforce shortages
Those in the age group > 55 years are the heaviest consumers of medical services.

To meet the demand of a growing and ageing population, the full range of health services will need to expand dramatically including more specialist health professionals and GP’s, more primary and emergency health services and more housing and accommodation = increased personnel to work in the aged care workforce

Availability of carers and volunteers
Carers – provide informal care of people living with chronic disease and disability e.g. spouse, child, neighbour, friend.

They assist with day-to-day activities. This requires investment of time, energy and resources. The Home and Community Care (HACC) and Community Aged Care Packages (CACP) are 2 programs with services specifically designed for older Australians who need caring.

Volunteers – assist with activities such as transport, shopping, Meals on Wheels and social activities. This does not require formal training.

Volunteers make a valuable contribution to society and the wellbeing of others. This can provide the elderly population with a sense of purpose and promote social interactions. An organisation designed to encouraged volunteers is Volunteers Australia.
CQ 3 – WHAT ROLE DO HEALTH CARE FACILITIES AND SERVICES PLAY IN ACHIEVING BETTER HEALTH FOR ALL AUSTRALIANS?

HEALTH CARE IN AUSTRALIA

- The role of health care is to achieve a delicate balance between resources for prevention and resources for treatment
- Health care is the responsibility of many organisation; predominantly the different levels of government in collaboration with the private sector

Range and types of health facilities and services

<table>
<thead>
<tr>
<th>Category</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public health services</td>
<td>• Focuses on prevention, promotion and protection rather than treatment&lt;br&gt;• Cancer screening: aims to reduce morbidity and mortality&lt;br&gt;  o Breast Screen Australia uses mammography for screening and is free for females in the target age group&lt;br&gt;• Immunisations: vaccinations for children include pertussis, polio, measles, mumps, rubella, meningococcal etc.</td>
</tr>
<tr>
<td>Primary and community health care</td>
<td>• GP’s&lt;br&gt;  o Approximately 85% of Australians see a doctor at least once a year&lt;br&gt;• Royal Flying Doctor Service: aimed to those living in rural and remote areas&lt;br&gt;• Dental services&lt;br&gt;• Ambulance services&lt;br&gt;• Complementary and alternative services</td>
</tr>
<tr>
<td>Hospitals</td>
<td>• Public and private hospitals&lt;br&gt;  o Provide medical, surgical and obstetrical care for inpatient treatment with 24 hr nursing services&lt;br&gt;• Psychiatric hospitals&lt;br&gt;  o Treatment and care of admitted patients with psychiatric, mental or behavioural disorders</td>
</tr>
<tr>
<td>Specialised health services</td>
<td>• Specialised medical practitioners&lt;br&gt;  o Provide specialist services in private practice as well as medical services for private patients&lt;br&gt;  o Examples include obstetrics, pathology, radiotherapy</td>
</tr>
</tbody>
</table>
- Specialised mental health services
- Palliative care services
  - For people who are terminally ill and require specialised care
  - Holistic approach that focuses on maintaining quality of life and reducing the suffering
- Sexual and reproductive health services
  - Includes contraceptive services, counselling and information services, management strategies etc.

**Responsibility for health facilities and services**

<table>
<thead>
<tr>
<th>Health care provider</th>
<th>Facilities and/or services provided</th>
</tr>
</thead>
</table>
| Commonwealth Government               | • Formation of national health policies  
                                          • Collection of taxes to finance the health system  
                                          • Provision of funds to state/territory governments  
                                          • Special concern for ATSI peoples  
                                          • Pharmaceutical funding |
| State/territory Government            | • Hospital services, mental health, family health services, dental health  
                                          • Home and community care  
                                          • Women’s health  
                                          • Health promotion  
                                          • Regulating health industry providers |
| Local Government                      | • Environmental control  
                                          • Meals on Wheels |
| Private organisations                 | • Private hospitals  
                                          • Dentist  
                                          • Alternative health services |
| Community groups                      | • Cancer Council, Diabetes Australia etc. |
Equity of access to health facilities and services
Medicare – designed to allow simple and equitable access to all Australian citizens regardless of location and socioeconomic status. Supporting programs, such as the Medicare Safety Net and Pharmaceutical Benefits Scheme also promotes equity of access.

However, Medicare does not full cover or provide access to a range of medical services, placing people of low SES at a disadvantage.

Also, overcrowding and lack of bed availability in public hospitals has limited equity of access. Other examples include long waiting lists for elective surgery, difficulties in access for those in rural and remote areas, uninformed non-English speaking people etc.

Health care expenditure versus early intervention and prevention expenditure
In 2013-14, health care expenditure was $155 billion with less than 2% for preventative measures. These costs have been steadily increasing as the population grows and ages.

Politicians and governments prefer the instant and measurable option of cure over prevention. A change to a more preventative approach may not be economically viable in the short term.

Impact of emerging new treatments and technologies on health care e.g. cost and access, benefits of early detection
Examples of developments in emerging treatments and technologies include development of new machinery, improvement in materials, drug advancements, prosthetic limb development, artificial organs and transplant technology.

Some of the benefits of early detection include less invasive treatment, less cost to the individual and community and greater chance of recovery.

Health insurance: Medicare and private
Bulk Billing – is when the practitioner bills Medicare directly, accepting the Medicare benefits as full payments for the service.

The Gap – Many people with private health insurance are concerned about the gap. The gap is the difference between what a health fund pays and what a particular medical service costs, which you must pay out of your own pocket.

30% Rebate – For every dollar that you contribute to your private health insurance premium, the Government will give you back at least 30 cents as a Private Health Insurance Rebate.
**Lifetime Health Cover** – Lifetime Health Cover is designed to encourage people to purchase hospital cover earlier in life and to maintain their cover. To avoid paying a LHC loading, you need to purchase hospital cover by 1 July following your 31st birthday.

**PBS (Pharmaceutical Benefits Scheme)** – where certain prescription drugs are subsidised by the Federal government

**Medicare Levy Surcharge** – The Medicare Levy Surcharge is levied on Australian taxpayers who do not have private hospital cover and who earn above a certain income. The surcharge aims to encourage individuals to take out private hospital cover, and where possible, to use the private system to reduce the demand on the public system.

**Medicare:**
- Introduced in 1984
- Designed to provide equity in terms of cost and access for health care services
- Funding for Medicare comes from income tax levy (2% of taxable income) and the Medicare levy surcharge (1-1.5% for high income earners)
- Every Australian is covered for 75% - 85% of the scheduled fee
- Benefits: basic public hospital services, basic medical services, some specialist services, availability of bulk billing

**Private health insurance:**
- People have the option of increasing the health insurance by purchasing private health insurance
- Private insurance gives a choice of one or both of the following forms of cover:
  - Hospital cover
    - Accommodation and related services in a private hospital or as a private patient in a public hospital
    - Own choice of doctor
    - Shorter waiting lists for some treatment
  - Ancillary cover
    - Includes dental services, physiotherapy, glasses/contact lenses, ambulance and some alternative health therapies
- Benefits: hospital cover and services, choice of doctor and hospital, ambulance cover, ancillary cover
COMPLEMENTARY AND ALTERNATIVE HEALTH CARE APPROACHES

Reasons for growth of complementary and alternative health products and services
- 2 in 3 Australians use CA products and services each year
- WHO recognition
- Marketing strategies
- Proven positive results
- Holistic nature
- Societal changes with multiculturalism and globalisation = acceptance

Range of products and services available

<table>
<thead>
<tr>
<th>Product/service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>Based on ancient Chinese beliefs that propose energy flows through the body via meridians. Painless insertion of needles into the skin along the meridians = health benefits. Widely used for pain relief and to help manage conditions like asthma.</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>Aim is to relieve pain and improve health through the manipulation of the spine. Relies on the theory → many ailments are the result of poorly aligned vertebrae.</td>
</tr>
<tr>
<td>Naturopathy</td>
<td>Holistic treatment aiming to treat the underlying cause of the illness. Possible therapies include massage, relaxation techniques, herbal medicine and nutrition.</td>
</tr>
<tr>
<td>Herbal medicine</td>
<td>The use of plants and herbs.</td>
</tr>
<tr>
<td>Osteopathy</td>
<td>Involves manual deep tissue massage and the manipulation of the spine, joints and surrounding tissue. To alleviate back pain, joint problems and muscular disorders.</td>
</tr>
<tr>
<td>Aromatherapy</td>
<td>Use of pure essential oils to influence the mind, body or spirit. Sometimes used to treat stress and skin disorders.</td>
</tr>
</tbody>
</table>
How to make informed consumer choices
Investigate and critique health care providers and services including:

- What they offer
- The benefits
- Experience
- Qualifications
- Governing body
- Cost
- Obtaining feedback and references
- Online research

The Australian Natural Therapists Association (ANTA) has a list of accredited practitioners who have signed a code of ethics.
CQ 4 – WHAT ACTIONS ARE NEEDED TO ADDRESS AUSTRALIA’S HEALTH PRIORITIES?

HEALTH PROMOTION BASED ON THE FIVE ACTION AREAS OF THE OTTAWA CHARTER

Levels of responsibility for health promotion
The Australian government, state and local governments, non-government organisations, communities and individuals are all responsible for promotion health.

<table>
<thead>
<tr>
<th>Level</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>• Create an environment for improving health</td>
</tr>
<tr>
<td></td>
<td>• Providing coordination and leadership</td>
</tr>
<tr>
<td></td>
<td>• Encouraging federal, state and territorial collaboration</td>
</tr>
<tr>
<td></td>
<td>• Providing the public and other stakeholders with the information and resources they need</td>
</tr>
<tr>
<td></td>
<td>• Develop infrastructure</td>
</tr>
<tr>
<td>State and territory</td>
<td>• Work together to develop healthy public policies, balance investments and regularly provide health information</td>
</tr>
<tr>
<td></td>
<td>• Develop health goals and effective frameworks or structures</td>
</tr>
<tr>
<td>Private sector</td>
<td>• Provides a safe and healthy working environment</td>
</tr>
<tr>
<td>Community</td>
<td>• Develop partnerships that address the determinants of health</td>
</tr>
<tr>
<td>Individual</td>
<td>• Taking responsibility for own health and wellbeing</td>
</tr>
<tr>
<td></td>
<td>• Actively seeking information to make informed decisions</td>
</tr>
<tr>
<td></td>
<td>• Participating in community activities</td>
</tr>
</tbody>
</table>

The benefits of partnerships in health promotion, e.g. government sector, non-government agencies and the local community
An intersectoral collaboration is beneficial due to:
• Greater capacity to tackle and resolve complex health and social problems
• A pooling or resources, knowledge and expertise, and development of networks
• Reductions in duplication of effort across sectors
How health promotion based on the Ottawa Charter promotes social justice

<table>
<thead>
<tr>
<th>Ottawa Charter area</th>
<th>Equity</th>
<th>Diversity</th>
<th>Supportive environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Developing personal skills</td>
<td>Mandatory PDHPE K-10</td>
<td>Access to Medicare, Community-based support</td>
<td>Media campaigns</td>
</tr>
<tr>
<td>Creating supportive environments</td>
<td>Provision of health enhancing items</td>
<td>Destigmatising health conditions</td>
<td>Legislative bans, Provision of health enhancing items</td>
</tr>
<tr>
<td>Strengthening community action</td>
<td>Lobby groups</td>
<td>Lobby groups</td>
<td>Lobby groups</td>
</tr>
<tr>
<td>Reorienting health services</td>
<td>Health services for ATSI peoples</td>
<td>Language assistance</td>
<td>Partnerships with the community</td>
</tr>
<tr>
<td>Building health public policy</td>
<td>Bulk billing, PBS</td>
<td>Abstudy, Health care card</td>
<td>Health campaigns</td>
</tr>
</tbody>
</table>

The Ottawa Charter in action

- **Strengthen Community Actions** – community action is strengthened through communities being involved in setting priorities, making decisions, planning strategies and implementing them to improve health outcomes.
- **Build Healthy Public Policy** – policy development at all levels seeks to promote health. It includes legislation, fiscal measures, taxation, and organizational change.
- **Create Supportive Environments** – there is a link between people’s health and their environment, requiring a socioecological approach to health.
- **Develop Personal Skills** – requires the provision of information, education and life skill development. This increases options and control for individuals over their own health.
- **Reorient Health Services** – about the shift towards a system which promotes health, rather than curative services.
## Initiative: *Closing the Gap*

### Developing personal skills
- Provide primary health care services to the Aboriginal and Islander population
- Provide health care and access to early learning support for Indigenous mothers, babies and children

### Creating supportive environments
- Train an adequate number of health professionals to deliver primary health care and other health care services
- Ensure supplies of fresh healthy food are available to Indigenous people
- Provide the necessary housing and waste systems
- Provide extra teachers for remote schools

### Strengthening community action
- Involvement of ATSI people and their representatives in health planning at local and regional levels
- Delivery of culturally appropriate primary health services by Aboriginal Community Controlled Health Services

### Reorienting health services
- Invest in primary health care where prevention and promotion are in balance with curative services
- Provide appropriate education through health services to promote healthy, structured lifestyles

### Building health public policy
- In order to reduce inequality amongst ATSI peoples WHO have developed the policy document ‘Closing the Gap in a Generation’.
- The ‘Close the Gap Statement of Intent’ was signed by the Prime Minister in March 2008
- Establish a national Indigenous representative body
- Provide funding to build a skilled and professional workforce to cope with the challenges of remote Indigenous education

## Initiative: *Road safety*

### Developing personal skills
- School education road safety programs
- Provision of adequate road crossing facilities

### Creating supportive environments
- Fixed speed cameras near schools
- Upgrading existing roads and higher safety standards in new road construction to improve road safety
- Construction of cycle ways to separate cyclists from other traffic
| Strengthening community action | • Continuing to work with community-based organisations to provide ‘driver reviver’ sites to combat driver-fatigue-related accidents  
| | • RTA SpeedBlitz Blues is an ongoing campaign raising awareness about the consequences of speeding, and to change attitudes |
| Reorienting health services | • The ‘Slow Down Roadshow’ travels around the state educating the community about the consequences of speeding |
| Building health public policy | • Legislation to permit fixed digital speed cameras to operate in NSW  
| | • The 50 km/h urban limit is part of a nationwide strategy  
| | • Mandatory road safety courses will be developed to enable offenders to change their behaviour and develop safer driving habits  
| | • Policy reform in relation to the requirements of progressing through driver training  
| | • Penalties have increased for drink driving, excessive speeding, and ‘road rage’ offences |